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EVALUATION OF THE EUROPEAN UNION EXTERNAL ACTION

THEMATIC EVALUATION

COMBINED EVALUATION OF DG ECHO'S HUMANITARIAN RESPONSE TO EPIDEMICS, AND OF DG ECHO'S PARTNERSHIP WITH THE WORLD HEALTH ORGANIZATION, 2017-2021

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Prepared by:

Landell Mills International

The Old Station House, 15a Main Street,

Blackrock, Co. Dublin A94 T8P8, Ireland

Contact person: Hannah Isaac hannah_isaac@landell-mills.com

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Authors

Nigel Clarke
Eric Sattin
Jean-Pierre Veyrenche
Saba Moussavi

Contact information:

European Commission
Directorate-General for European Civil Protection and Humanitarian Aid Operations – DG ECHO
Unit ECHO.E.2 Programming, Control and Reporting
Email: ECHO-EVAL@ec.europa.eu
B-1049 Brussels, Belgium

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Contents

List of acronyms 7

Table of figures 9

List of tables 10

Acknowledgements 11

Abstract 12

Executive Summary 13

Résumé exécutif 24

1. Introduction, purpose and scope 37

2. Methodology 38

2.1. Overall evaluation approach 38

2.2. Analytical framework 40

2.3. Sampling and data collection methodology 41

2.3.1. Country visits 41

2.3.2. Data collection methodology 42

2.4. Data processing and reporting 43

2.4.1. Strength of evidence 44

2.5. Limitations of the data 44

2.6. Ethical standards and principles 46

2.6.1. Statement of validity 46

3. Context and portfolio analysis 47

3.1. The resurgence of infectious disease epidemics 47

3.2. Epidemics and global health security 48

3.3. The response of the EU and DG ECHO to infectious disease outbreaks 50

3.4. The WHO response to humanitarian health emergencies and humanitarian emergencies with health impacts 56

3.4.1. What is WHO? 56

3.4.2. The legal framework for health emergencies - International Health Regulations 56

3.4.3. Debate surrounding WHO's role in health emergencies 57

3.4.4. The WHO Health Emergencies Programme 57

3.5. Partnership between DG ECHO and WHO 58

3.5.1. Twenty years to a strategic partnership 58
3.5.2. Officialising the partnership as strategic 59
3.5.3. DG ECHO's investments in WHO/PAHO 60
3.6. Epidemic response in the wider context of humanitarian action 61

4. Findings 64

4.1. Findings – Part A 64

EQ 1 How appropriate were DG ECHO's plans and interventions in response to epidemics? 64
EQ 2 To what extent did DG ECHO's Actions seek the participation of affected populations at all stages of the humanitarian project cycle, and seek to address their needs and priorities? 67
EQ 3 How coherent was DG ECHO's response with that of relevant external actors? 72
EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security? 76
EQ 5 How effective have DG ECHO's tools and instruments been in addressing epidemics? 80
EQ 6 What results were achieved by DG ECHO's epidemics response? 85
EQ 7 Have DG ECHO's Actions in response to epidemics been cost-effective? 88
EQ 8 To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses? 90
EQ 9 To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works? 96

4.2. Findings – Part B 102

EQ 10 Is the DG ECHO-WHO partnership strategic and synergistic, with a shared vision that leverages collaborative advantages at all levels? 102
EQ 11 Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanisms to deliver on its objectives at all levels? 108
EQ 12 What is the added value of the DG ECHO-WHO partnership in terms of better health outcomes and health advocacy in humanitarian health emergencies? contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings? 116

5. Conclusions and recommendations 121

5.1. Conclusions and recommendations (Part A) 121
5.1.1. Overall conclusions and Recommendations – Part A 121
5.2. Conclusions and recommendations – part B 125
5.2.1. Overall conclusions and recommendations – Part B 125

Annexe 1 – Evaluation Matrix 131

Annexe 2 – Key Informant Interviews and Focus Group Discussions conducted 139

Annexe 3 – List of KIIs 143

Annexe 4 – Sampling Frameworks of DG ECHO Actions 149

Annexe 5 – WHE Work Area Aims and Activities 195

Annexe 5 – Focus Group Discussion (minutes) 197

Annexe 6 – Online Survey 243

Annexe 7 - Bibliography 255

Annexe 8 – Terms of Reference (TOR) 259

List of acronyms

AAP	Accountability to Affected Populations
ACT	Access to COVID-19 Tools
ALIMA	Alliance for International Medical Action
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
CAI	Integrated Analytics Cell
CBRN	Chemical, Biological, Radiological and Nuclear
CDC	US Centres for Disease Control and Prevention
CEPI	Coalition for Epidemic Preparedness Innovations
CFE	Contingency Fund for Emergencies
CP	Civil Protection
DG ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
DG HERA	Directorate-General for Health Emergency Preparedness and Response Authority
DG INTPA	Directorate-General for International Partnerships
DG NEAR	Directorate-General for Neighbourhood and Enlargement Negotiations
DG RTD	Directorate-General for Research and Innovation
DG SANTE	Directorate General for Health and Food Safety
DNH	Do No Harm
DRC	Democratic Republic of Congo
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EHRC	European Humanitarian Response Capacity
EM	Evaluation Matrix
EMC	European Medical Corps
EMRO	WHO Regional Office for the Eastern Mediterranean
EMT	Emergency Medical Teams
EQ	Evaluation Question
ERCC	Emergency Response Coordination Centre
ESG	Evaluation Steering Group
ET	Evaluation Team
EU	European Union
EUD	European Union Delegations
EUR	Euro
EWARS	Early Warning, Alert and Response System
FAFA	Financial and Administrative Framework Agreement
FAO	Food and Agriculture Organisation
FGD	Focus Group Discussion
FTS	United Nations Office for the Coordination of Humanitarian Affairs - Financial Tracking Service
GHC	Global Health Cluster
GHS	Global Health Security
GHSA	Global Health Security Agenda
GHSI	Global Health Security Initiative
GOARN	Global Outbreak Alert and Response Network

HAB	Humanitarian Air Bridge
HIP	Humanitarian Implementation Plan
HSD	High-Level Strategic Dialogue
HOPE	The HOPE Database
HQ	Headquarters
HRP	Humanitarian Response Plan
ICRC	International Committee of the Red Cross
ICVA	International Council of Voluntary Agencies
IDSR	Integrated Disease Surveillance and Response
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
IP	Implementing Partner
IPC	Infection Prevention and Control
JC	Judgement Criteria
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSF	Médecins Sans Frontières
MT	Monitoring Table
NGO	Non-Governmental Organisation
OCHA	UN Office for the Coordination of Humanitarian Affairs
OECD-DAC	Organisation for Economic Co-operation and Development - Development Assistance Committee
PAHO	Pan American Health Organisation
PHEIC	Public Health Emergency of International Concern
PPE	Personal Protective Equipment
PPP	Pilot Programmatic Partnerships
R&D	Research and Development
RCCE	Risk Communication and Community Engagement
SF	eSingleForm
SOM	Senior Official Meeting
SPD	Strategic Programming Dialogue
SPHERE	Sphere Handbook
TOR	Terms of Reference
UCPM	Union Civil Protection Mechanism
UN	United Nations
UNICEF	United Nations Children Fund
USA	United States of America
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

Table of figures

Figure 1 Evaluation approach 40
Figure 2 Theoretical model, levels and pillars for successful global health partnerships 41
Figure 3 A snapshot of the 'Evidence Matrix' used by the Evaluation Team to cross tabulate data points against judgement criteria 44
Figure 4 Number of countries experiencing significant disease outbreaks, 1995-2018 47
Figure 5 Total disbursements from Epidemics Tool (2017-2021) 52
Figure 6 Average size of DG ECHO Action budgets by funding decision type (2017-2021) 53
Figure 7 Funding disbursed from the Epidemics Tool by epidemic type (2017-2021) 53
Figure 8: DG ECHO funding of sampled actions (n=23) by typology and year 54
Figure 9 DG ECHO wiring diagram for epidemics network 55
Figure 10 DG ECHO funding to WHO/PAHO by year (2017-2021) 60
Figure 11 Distribution of single country grants (by country) between 2017-2021 61
Figure 12 Funding gap (2012-2020) 62
Figure 13 An example from DRC of the use of social science to combat epidemics 71
Figure 14 e-Survey results on DG ECHO's added value compared to other donors 75
Figure 15 Timeliness of request approval by year and type of funding (median of time gap in months) 91
Figure 16 Timeliness of request approval and first fund release by type of partner (median of time gap in months) 92
Figure 17 Crisis modifiers 94
Figure 18 Responses to open survey questions on best aspect of DG ECHO's response to epidemics 95
Figure 19 Positive ratings of DG ECHO's flexibility by respondent organisation type 95
Figure 20 DG ECHO's long-term support to South Sudan 99
Figure 21 Responses to e-Survey (Q21) on DG ECHO performance in linking across the nexus 100
Figure 22 E-survey results on DG ECHO/WHO partnership - understanding the partnership 103
Figure 23 Survey results on DG ECHO/WHO partnership - alignment 104
Figure 24 Average duration of DG ECHO/WHO proposal and funding processes (months) 112
Figure 25 "How to do DG ECHO" 112
Figure 26 COVID-19: a test case for a newly strategic partnership 114
Figure 27 The DG ECHO-WHO partnership in South Sudan 117
Figure 28 Average duration of DG ECHO/WHO Action by country crisis status and type of Action (in months) 118
Figure 29 Average duration of DG ECHO/WHO Action by country crisis status and type of Action (in months) 118
Figure 30 Lost opportunities to strengthen resilience 119
Figure 31 Interviewees by stakeholder category 140

List of tables

Table 1 Evaluation Criteria and Evaluation Questions 38
Table 2 Timeline of field visits 42
Table 3 Lines and quantitative levels of evidence 42
Table 4 DG ECHO funding disbursements for epidemics by year and instrument compared to overall humanitarian disbursements (2017-2021) 52
Table 5: Number and total DG ECHO funding of sampled actions (n=23) by typology 54
Table 6 Funding awarded to WHO/PAHO by DG ECHO between 2017-2021 60
Table 7 Health sector requirements/funding 62
Table 8 Comparison of funding disbursements under the Epidemics Tool and Geographical HIPs, 2017-2021 81
Table 9: Sampled actions by epidemic response pillars 83
Table 10 Timeliness of request approval and first fund release by type of funding 91
Table 11 Survey results on WHO's added value in health emergencies 106
Table 1 Evaluation Matrix 131
Table 2: Summary of KIIs conducted by stakeholder category 139
Table 3: Interviewees by sex 140
Table 4 KII list by Stakeholder Category and Organisation 140
Table 5 List of KIIs 143
Table 6 Actions within scope of evaluation (n=201) 149
Table 7 Sampling frame 1 (Selected countries) (n=39) 179
Table 8: Sampling frame 2 (Actions selected for detailed review within selected countries) (n=23) 191
Table 9 WHE Work area aims and activities 195
Table 10 FGD tables 197
Table 11 EQs selected for survey targeting 244
Table 12 Survey timeframe 245

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Abstract

This combined, independent evaluation focused on DG ECHO's humanitarian response to epidemics and its strategic partnership with WHO between 2017-2021.

The evaluation found that DG ECHO supported relevant and effective interventions that contributed to controlling disease outbreaks. Its strong field presence served as a platform to make appropriate funding decisions, and support humanitarian coordination and advocacy in epidemics. Initiatives to deploy civil protection assets in epidemic response show promise, but are currently underdeveloped. Specific policies on epidemics were lacking, and there were gaps between stated humanitarian policies and field-level practice. Major recommendations include bridging these gaps, fuller participation in relevant EU global health security initiatives, and expanding the specialist epidemics' funding tool.

The DG ECHO-WHO partnership lacked a clear documented vision, and DG ECHO lacked a nucleus of health policy experts to guide strategy. Instead the relationship was governed by ad-hoc High-level Strategic Dialogue meetings where mutual priorities were discussed but not filtered down to operational levels. Opportunities to work across the nexus exist, but these are hampered by the lack of a common vision to guide collaboration. Recommendations include developing a common framework for engagement; intensifying multi-level dialogues; and collaboration on strategic programming that leverages both partner's respective strengths.

Executive Summary

Introduction, Purpose and Scope

This is the report of an independent evaluation of two separate, but related, aspects of Directorate-General for European Civil Protection and Humanitarian Aid Operations' (DG ECHO) performance in the humanitarian health sector during the five-year period 2017-2021. It is a combined evaluation, but divided into two parts:

- Part A: DG ECHO's Humanitarian Response to Epidemics
- Part B: DG ECHO's Partnership with the World Health Organization (WHO)

In recent years epidemics have re-emerged as the predominant global health security issue, in humanitarian contexts as much as in development. Climate change, environmental degradation, conflict, mixed migration and other factors are combining in ways that make humanitarian situations high-risk locations for infectious disease outbreaks, including novel zoonotic diseases. And populations caught up in humanitarian crises are especially vulnerable to epidemics. The European Union (EU) is currently strengthening its own capacity to support global health security initiatives. DG ECHO aims to be part of this effort.

Historically, WHO has not been a primary humanitarian partner for DG ECHO, due to its primarily normative role and limited operational capacity to respond to health in emergencies and humanitarian settings. Lessons learned from the 2014 West Africa Ebola crisis led to major reforms for WHO, including the establishment of the Health Emergencies Programme (WHE) in 2016. This reform was a critical step to transforming WHO into an operational agency, increasing WHO's importance for DG ECHO as an implementing partner (IP) in humanitarian health operation. In late 2019, WHO became a strategic humanitarian partner for DG ECHO[1], which was marked by its first High-level Strategic Dialogue (HSD) in January 2020. These HSDs have taken place annually and have been the hallmark of a growing partnership between DG ECHO and WHO.

The specific purpose of the evaluation, according to its Terms of Reference (TOR) was:

1. To provide an external, independent and thematic assessment of DG ECHO's worldwide Actions in response to epidemics in third countries;
2. To contextualise DG ECHO's response to epidemics in the broader EU response, and provide an analysis of how to strengthen its position in future responses; and
3. To provide a retrospective assessment of DG ECHO's partnership with WHO globally, with a focus on identifying lessons learned and good practices

As WHO was also one of many organisations that DG ECHO partnered with in responding to epidemics (Part A), there was a very small degree of convergence in scope between Parts A and B. Otherwise, the two parts were largely treated as separate.

The evaluation was global in scope. Although data collection involved some geographical sampling, the findings, conclusions and recommendations are all applicable at a global level. Through discussions between the Evaluation Team (ET) and the Evaluation Steering Group (ESG) during the Inception Phase, it was clarified that the focus for Part A would mainly be on DG ECHO's performance as a humanitarian donor in emergency contexts. The contribution of DG ECHO's Civil Protection (CP) capacities to epidemic response was considered, but to a lesser degree. It was also agreed that DG ECHO's humanitarian response to the

[1] Terms of Reference for the combined evaluation of DG ECHO's humanitarian response to epidemics, and of DG ECHO's partnership with the World Health Organization, 2017-2021; DG ECHO

wider socio-economic effects of epidemics (e.g., nutrition, protection, cash transfers) would not be covered; instead, Part A would focus on the more 'classic' areas of a public health response (including epidemic preparedness measures).

It was further clarified by the ESG that for Part A the focus was on DG ECHO's own performance as an institution in the humanitarian domain, rather than on the collective performance of its IPs. Thus, the ET examined the way DG ECHO made decisions and used valuable resources to best effect when tackling epidemics. In a similar vein, the focus of Part B was on the DG ECHO-WHO partnership itself, rather than on how WHO performed in humanitarian settings as a DG ECHO implementing partner.

Methodology

The evaluation was divided into four phases: an Inception Phase, during which the scope was refined and a more detailed methodology was devised; a Desk Phase, which focused mainly on documentary evidence; a Field Phase during which the majority of interviews and all focus group discussions were held; and, finally, a Synthesis Phase, when all the data was collated and analysed to derive findings, conclusions, and recommendations. Each phase culminated with a report, this document being the Final Report.

Evaluation Questions (EQs) were set out in the TOR. During the Inception Phase these were refined and judgement criteria (JC) were developed for each EQ to provide further guidance for data collection. Together, these formed an evaluation matrix (EM) which was further developed by the ET into an evidence matrix that allowed all relevant data, from whatever source, to be mapped against relevant EQs and JCs. Evaluation questions were grouped by widely-used humanitarian evaluation criteria for Part A and partnership criteria for Part B.

Evaluation Criteria and Evaluation Questions

	Evaluation Criteria	Evaluation Questions
Part A	Relevance	1. How appropriate were DG ECHO's plans and interventions in response to epidemics?
		2. To what extent did DG ECHO's actions seek the participation of affected populations at all stages of the humanitarian project cycle, and seek to address their needs and priorities?
	Coherence	3. How coherent was DG ECHO's response with that of relevant external actors?
		4. How coherent was DG ECHO's response with that of other EU/EC actions including those of individual Member States, and how should DG ECHO's role evolve given the EC's strategic intent to strengthen European and global health security?
	Effectiveness	5. How effective have DG ECHO's tools and instruments been in addressing epidemics?
		6. What results were achieved by DG ECHO's epidemics response?
	Efficiency	7. Have DG ECHO's actions in response to epidemics been cost-effective?
		8. To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?
	Resilience/ Connectedness	9. To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?
Part B	Collaborative	10. Is the DG ECHO-WHO partnership strategic and synergistic, with a shared vision that leverages collaborative advantages at all levels?
	Transactional	11. Is the DG ECHO-WHO partnership supported by effective dialogue and fit-for-purpose structures and mechanisms to deliver on its objectives at all levels?

	Transformational	12. What is the added value of the DG ECHO-WHO partnership in contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings?

It was agreed that the main sources of evidence would be:

- Documents, including DG ECHO Action (project) documents, key policy documents and documents relevant to the partnership with WHO
- Key Informant Interviews (KIIs)
- Focus Group Discussions (FGDs) with persons affected by epidemics
- Online survey

A purposive sampling approach was used to ensure the limited time and resources available to the ET were used effectively and that the selected data sources were as representative as possible, according to the purpose and scope of the evaluation. An important element of this sampling approach was the selection of particular countries where the evaluation could look in reasonable depth at the performance of DG ECHO's response to epidemics and its partnership with WHO. Overall, the ET collected a considerable amount of evidence during the field and desk phases. From KIIs, reviewed documents and FGDs there were over 1,300 separate data items recorded against 26 individual judgement criteria, and this is not factoring in the data recorded by the online survey.

Regular meetings between the ET and the ESG provided opportunities to track progress, discuss constraints, and resolve any difficulties. Of these, some limitations relating to the country studies were the most significant, but not enough to cast doubt on the validity of the overall findings.

Summary findings

Part A: DG ECHO's humanitarian response to epidemics

Relevance

Summary Finding 1: The appropriateness of DG ECHO's epidemic response. DG ECHO-funded interventions in response to epidemics were appropriate, in the sense that they were broadly relevant and made valid contributions to overall response efforts. In choosing which interventions to support, DG ECHO rightly leant heavily on the rich understanding of local context gained by its field experts, the technical advice of its regional health experts ('Anopheles Group'), and on the suggestions and capabilities of Implementing Partners (IP) already present on the ground. However, this strong capacity for analysis was not well evidenced in DG ECHO's project documents where there was limited inclusion of fresh and specific assessment data, insufficient analysis of specific context and virtually no treatment of epidemic magnitude or trajectory. In the absence of a more rounded problem analysis and a documented consideration of the various intervention options and their pros and cons – either by the IPs or DG ECHO's experts - it was hard for the ET to determine whether the selected interventions were the most appropriate options available, rather than those that were simply relevant, or perhaps even the ones most convenient for the IPs. DG ECHO appears to be strong in applying its knowledge to decide how to intervene, but rather weak in documenting the rationale.

Summary Finding 2: Accountability to Affected Populations (AAP). Overall, Actions funded by DG ECHO did not always seek the participation of affected populations at all stages of the project cycle[2], and DG ECHO's implementation of this policy was uneven. Indeed, several DG ECHO experts were quite candid in their view that community engagement was definitely not a priority in the design phase of an epidemic response intervention. Supporting this, there was little evidence of meaningful consideration of AAP mechanisms by DG ECHO experts in the Action documents, although some of DG ECHO's IPs did exemplify good practice in respect of community engagement in initiative design, and sought ways of being accountable

[2] As called for in the Grand Bargain commitment to a "Participation Revolution", and earlier commitments to AAP

to the populations they served. It was often these same agencies that sought to identify persons with particular needs or vulnerabilities, and targeted them for assistance.

Coherence

Summary Finding 3: Coherence with external actors. DG ECHO not only sought coherence with other actors, but showed leadership by actively promoting and encouraging response coordination efforts, especially among donors and international humanitarian actors. It supported and participated in United Nations (UN) led coordination mechanisms, and encouraged its IPs to engage with the Cluster system and ensure their interventions were coherent with those of other actors at the local level. There was less direct evidence of government-led plans guiding DG ECHO's response, although broad coherence with such plans was assured through the UN-led (or UN-facilitated) coordination structures and through regular dialogue between IPs and local health officials. There was strong evidence of DG ECHO adding value to overall epidemic response efforts in multiple ways, including its technical understanding, backed by knowledge of local context; its ability to work flexibly with experienced long-term partners; and its role in humanitarian advocacy.

Summary Finding 4: Coherence with other EU/EC bodies. There is a growing number of EU bodies and initiatives which have some responsibility for epidemic preparedness and response, although most are focused inwardly (within the EU's borders). In respect of external humanitarian action on epidemics, the ET found that the relevant EU bodies were not sufficiently tied together by coordination mechanisms or policy direction, leading to some incoherence. In humanitarian settings, DG ECHO has the potential to play a bigger role in the coordination of epidemic preparedness and response, as well as in the EU's related global health security dispositions. DG ECHO has privileged information and expertise, and could use this more within the EU to emphasise the associations between humanitarian crises and epidemics, and to champion the need for prevention, preparedness and early response. At present, however, DG ECHO appears to be diffident about coordination with other EC services, and lacking sufficient policy capacity to lead on those aspects of the EU Global Health Strategy that relate to international humanitarian action.

Effectiveness

Summary Finding 5: The effectiveness of DG ECHO's tools and instruments. The scale of DG ECHO's response to epidemics was generally considered appropriate in relative terms, given that the needs arising from COVID-19 were particularly overwhelming. By being agile, DG ECHO could sometimes plug important gaps before donors with bigger resources were able to respond. The Epidemics (funding) Tool is a very specific and highly-valued instrument, but stakeholders thought it could be used more often, especially to support preparedness work, and would be more effective if the grants were larger. The Humanitarian Air Bridge provided effective logistical support to the COVID-19 response. Some of DG ECHO's civil protection capacities have the potential to support humanitarian response to epidemics, but they had not been deployed at scale within the evaluation timeframe. DG ECHO's system of managing Actions through the SingleForm/FicheOp[3] documentation system may have led to efficiencies, but at the cost of richer analysis and clearer rationales explaining how interventions have been prioritised. A lot of trust and responsibility is therefore placed on the advice of DG ECHO's highly-appreciated network of field experts. Interviewees felt that good technical expertise and field knowledge needed to be balanced by additional capacity for policy development and strategic thinking, especially at Brussels level.

Summary Finding 6: The results of DG ECHO's response to epidemics. The results of most Actions were self-reported by the IPs and not subjected to independent evaluation, although DG ECHO field experts did conduct field monitoring visits, scrutinised project reports and sought clarifications when necessary. Around 65% of project targets were achieved or exceeded and explanations were provided for missed targets. Understandably, results were most impressive in Actions focused specifically on epidemic response rather

[3] The eSingleform is a single external-facing online platform that contains IP proposals, project descriptions, modification requests and reporting. The FicheOp is an internal DG ECHO platform that records staff activities (monitoring visits, operational communications, technical assessments) as well as gender and resilience marker scores and financial information. To fully appreciate an Action, the observer needs to combine the IP view (eSingleform) and the DG ECHO staff view (FicheOp)

than those (the majority) where existing projects had been lightly adapted through Modification Requests to incorporate epidemic intervention measures, which sometimes lacked ambition and probably had negligible impact on epidemic trajectory. Several stakeholders, including affected persons, thought DG ECHO-funded interventions had had a lasting effect, beyond the life of the Actions themselves. Data about unintended consequences were very scant, making it hard to formulate any overall judgements, although the ET was made aware of a number of active measures taken by IPs to avoid such consequences resulting from their project implementation.

Efficiency

Summary Finding 7: Cost-effectiveness. DG ECHO has no established framework for measuring cost-effectiveness, so the ET interpreted this as 'the achievement of intended outcomes in relation to costs'. By this yardstick DG ECHO's response to epidemics was broadly found to be cost-effective, achieving decent levels of results (see Finding 6 above) in return for relatively modest and proportionate amounts of funding. DG ECHO field experts were conscious of the need to achieve appropriate balance between costs and outputs, and sought cost efficiencies where they could. Also relevant to the consideration of cost-effectiveness is Finding 1 above on appropriateness, because it is possible that in some places another intervention might have yielded even more impressive results for the same investment.

Summary Finding 8: Timeliness and Flexibility. There was very strong evidence that DG ECHO was quick in responding to epidemics and that its project management systems, combined with its close relationships with respected partners, allowed DG ECHO to be flexible in adapting its response to changing situations. Adaptation was easiest and quickest where DG ECHO had an existing project partnership and adjustments could be managed through Modification Requests. Where epidemics were a well-recognised risk, IPs had the opportunity to include a specific Crisis Modifier in their funding application, although in practice this was seldom used among the Actions reviewed in detail by the ET. The Epidemics Tool was seen as a particularly quick project funding instrument, although the release of funds from this tool has slowed significantly since 2019. Against the overwhelmingly positive views on timeliness and flexibility, a minority of respondents questioned how flexible DG ECHO was in responding to new emergencies in places where it did not have existing project partnerships, and noted that flexibility in adding activities through a Modification Request was not always matched by flexibility in providing additional funding, for example additional support costs.

Resilience/ Connectedness

Summary Finding 9: DG ECHO's contribution to resilient public health systems. DG ECHO contributes to resilience through its epidemic response projects and especially through those few projects which are focused on specific preparedness activities. Many of the activities contributing towards resilience were part and parcel of humanitarian delivery in the context of chronic crises, such as training local personnel. The Resilience Marker sections of Action documents received minimal treatment in most cases, by IPs and DG ECHO experts alike. Typically, activities were described as contributing to resilience, rather than having resilience as a goal in its own right. Interviewees had mixed views on the humanitarian-development nexus: some yearned for a more joined-up approach and for more work on prevention and preparedness; while others felt that precious humanitarian resources should be preserved for crisis response and not expected to address development failures. There were good examples of collaboration across the nexus with partners external to the EU, although these were few in number. Within the EU/EC family of institutions, the ET found the most evidence on the relationship between DG ECHO and Directorate-General for International Partnerships (DG INTPA), which was found to be very cordial, although the dialogue at all levels was seen as ad hoc, not always productive, and suffering from a lack of operational guidance on how to work together.

Part B: DG ECHO's Partnership with the World Health Organization

The 'collaborative' dimension

Summary Finding 10: Shared strategic purpose and vision, and leveraging the partnership's strengths. The partnership extends beyond the donor-recipient relationship and has become more strategic

due to strengthened dialogue, its exchange of technical knowledge, and its pursuit of joint initiatives with results. Most WHO stakeholders at all levels, and DG ECHO respondents at Headquarters (HQ) level, view the partnership as strategic and one which extends beyond that of a donor-recipient relationship. However, this is less the case for DG ECHO operational staff, who expressed that the partnership lacks both a joint vision and a strategic framework. The partnership lacks an overarching strategy to frame both partner's vision. Instead, at the global level the partnership is marked by annual HSDs and a set of jointly agreed priority actions that are not widely shared or understood across partnership levels. This lack of a shared vision and strategic framework for engaging in humanitarian settings has led to misunderstandings on the partnership's priorities and frustration on both sides. This is especially prevalent at the operational level, where agreements at the global level do not necessarily trickle down to the field level and vice versa.

There is also confusion on alignment on health approaches. WHO has up-to-date and documented frameworks, strategies and guidelines for different areas relevant to health emergencies and health in humanitarian settings (i.e. on the nexus, resilience building and epidemics). DG ECHO has a health policy and general guidance on addressing health in humanitarian emergencies, however, these documents, whilst for the most part still largely valid, are out of date and do not include its approaches to important areas of health in humanitarian settings such as epidemics, strengthening resilience and bridging the nexus. DG ECHO does not have an established and clarified process to identify organisational priorities in health. Within DG ECHO, health is fragmented across different units, with most of the health expertise seated at the operational level in the Anopheles Group, which is not involved in policy decisions at HQ level. Furthermore, there is no official working group on health that meets regularly and can represent the organisations' position on the highly evolving areas of health and humanitarian emergencies. This results in incoherence on health areas beyond the immediate response to health emergencies, placing DG ECHO on uneven footing with WHO to jointly develop a shared vision and identify strategic priorities for the partnership.

The ET found both partners recognise and appreciate each other's comparative advantages, however there were differing views on both sides about what strengths each institution was bringing to the partnership and how the partnership could best leverage these strengths. There exist strongly-held views within DG ECHO that, barring WHO's work in pandemics and on some protracted crises, WHO is not operational in humanitarian settings. Furthermore, this is not seen by some within DG ECHO to be an area where WHO brings added value, especially when compared to its normative and technical strengths in managing public health events. Paradoxically, DG ECHO staff at both HQ and operational levels expressed that the partnership would strengthen if WHO had more operational capacity and resources for implementation. This suggests a misalignment in expectations between WHO and DG ECHO, as well as within DG ECHO itself. WHO/WHE sees itself as straddling both humanitarian and development arenas, and very much wants to expand its operational capacities and receive increased operational funding from the partnership. For WHO, the partnership would benefit if DG ECHO had more technical health expertise at HQ level.

The 'transactional' dimension

Summary Finding 11: Effective dialogue and fit-for-purpose structures. Dialogue between DG ECHO and WHO has improved within levels (global-global, country-country), but not across levels (global-country), leading to disjointed communication that affects partnership decisions and actions. At the global level, high level dialogue has improved in both quantity and quality, through the Senior Official Meetings (SOMs) and HSDs and regular dialogue between DG ECHO and WHO HQ focal points. For senior management at DG ECHO and WHO HQ, the HSDs are seen as the hallmark of the strategic partnership, having more firmly set DG ECHO and WHO as humanitarian partners. However, while the HSDs provide the forum for frank discussions on areas of common interest at the highest level, both WHO and DG ECHO interviewees felt the approach to the HSDs was formulaic and not strategically driven. Rather than stemming from a collaborative discussion on institutional health priorities, the HSDs revolve around DG ECHO units and WHE providing their inputs on agenda items. Furthermore, the HSDs are limited to HQ staff and do not include direct inputs from, nor are they shared with, operational and field levels of the partnership, thus limiting its value beyond HQ level. At the country level, strategic and effective dialogue is varied and dependent on country context, tending to be stronger in more protracted crises where both organisations can rely on a history of good

partner relations. There were no instances of regional dialogue during the evaluation period, despite the autonomous and influential role of WHO regional offices.

There was evidence of improved transparency according to Action documents, which reported irregular procedures in 2017. The partnership portfolio has increased substantially between 2017 and 2021, with funds more than doubling. Further, the average grant size increased annually, and more WHO Actions were funded each year than prior to 2017, including multi-country Actions. Part of this increase can be attributed to COVID-19, both in terms of COVID-19 focused funds, and the increasing health character of humanitarian programming uplifting general funding to health. There is, however, strong evidence that WHO's efforts to strengthen its capacity in DG ECHO engagement and processes have contributed to an increased frequency and quality of WHO proposal submissions, DG ECHO-funded Actions, and therefore increased DG ECHO funding.

There have been some improvements in partnership efficiencies – for WHO, the average duration of DG ECHO proposal and funding processes decreased during the evaluation period. However, some inefficiencies remain, with DG ECHO's heavy reporting requirements and the repetitive Single Form forms on the one side, and WHO's slow administrative processes leading to delays in implementation on the other. While DG ECHO has made some strides in implementing alternative modalities of financing, for example in response to COVID-19 with large multi-million USD grants, WHO's efforts to explore alternative and innovative financing approaches have either been slow in pickup (multi-year regional grants) or futile (programmatic partnership).

The onset of the COVID-19 pandemic was a test case for the newly strategic partnership. The € 30M COVID-19 grant was an important manifestation of DG ECHO's strategic partnership with WHO, given its infancy. For DG ECHO, the grant was ground-breaking as it had many firsts – the first EC organisation to fund WHO's response plan, the first large sum of € 30M, the first loosely earmarked grant, the first global multi-country grant, and the first 18-month grant cycle - all of which were out of the norm for DG ECHO. This flexibility allowed WHO to determine how best to use the funds. The partnership was able to show its maturity by finding middle ground on certain reporting requirements, while other grant processes are still deemed burdensome. There remains room for improvement on both sides, with DG ECHO reconsidering the level of detail needed on multi-country grants and WHO finding ways to report enough detail to at least minimise the need for timely verification. DG ECHO followed the same funding approach in 2021 with a € 16M loosely earmarked contribution for the rollout of COVID-19 national vaccination campaigns in 15 African countries. The two large-scale COVID-19 grants worked well and demonstrated to DG ECHO the potential viability and efficiency of allocating unearmarked funds and the need for greater flexibility in its financing mechanisms.

The 'transformational' dimension

Summary Finding 12: Working together on resilience. Most stakeholders thought the partnership supported the resilience of health systems to respond to health emergencies, and good examples of this were provided in Action documents as well as through interviews. A promising trend towards longer Actions was noted, suggesting joint recognition that building resilience requires a slightly slower and more sustained approach in order to have impact. Nonetheless, there may be limits to this trend, as DG ECHO lacks a unifying framework on resilience, especially regarding health emergency preparedness, so efforts to work on these areas through the partnership are governed by the outlook of individual DG ECHO field experts and field offices, rather than stemming from a single point of reference. In WHO's eyes this has led to lost opportunities, especially when DG ECHO and WHO agree at the policy level on joint initiatives to include preparedness, but such proposals are rejected due to the aversion of some DG ECHO counterparts to interventions which divert scarce resources away from 'pure' humanitarian response. Without a dually agreed strategic approach to strengthening resilience, both organisations run the risk of entrenched complacency, as experienced in South Sudan, where the same preparedness activities have been funded yearly for over a decade without addressing how to progress towards both DG ECHO and WHO's own policies of sustainable resilience.

The two organisations also approach the nexus differently. WHO has a strong and (especially since 2016) well-institutionalised 'dual mandate' to work across the nexus. In contrast, DG ECHO's stance is less

symmetrical: it is an organisation focused primarily on humanitarian action, but with a policy to support work across the nexus. However, in a resource-constrained environment and in the absence of specific guidance on the nexus, DG ECHO staff, especially at field level, have a propensity to steer its support towards traditional response activities.

Strategic recommendations

Part A

Strategic Recommendation 1: Forge a strategic vision and policy on epidemics

The importance of epidemics for global health security and for DG ECHO's work require that it sets out a clear direction, backed by a coherent policy framework. DG ECHO's current policy on epidemics is quite thin and is scattered among several reference documents. It also lacks some internal coherence and fails to provide adequate guidance and direction to staff and potential implementing partners. This creates 'grey areas' that could undermine consistency and quality. Based on the findings of this evaluation, key areas demanding better guidance include the balance between epidemic prevention, preparedness and response; using epidemiological data to consider epidemic trajectory and then factor that into programming; selecting the most appropriate funding tool; prioritising which response pillars to support in different situations; and how to complement humanitarian assistance and civil protection interventions in meaningful ways.

Strategic Recommendation 2: Reinforce policy discipline on important cross-cutting issues

DG ECHO has developed important areas of cross-cutting policy that underpin all its humanitarian work, including its response to epidemics. These policies often embody the leading edge of humanitarian thinking and reflect commitments the EU has made to its own citizens and in international fora. DG ECHO must find ways to ensure practice conforms with policy. The ET found several areas where there was a discrepancy between published DG ECHO policy, and the attitudes and practices of field staff. These divergent and relatively pervasive attitudes ranged from deliberate 'blind spots' at the mild end of the spectrum, to very dismissive comments about policy at the extreme end. They related in particular to AAP, to building resilience, and to working across the humanitarian-development nexus, but practice also deviated from policy on the treatment of vulnerability in project design, and on the importance of using needs assessments to inform planning (rather than to justify spending). While there are often differences of opinion about policy in large organisations, the gap between policy and practice in DG ECHO seemed particularly wide in the opinion of the ET, and it clearly spilt over into the quality of Action documents, where sections relevant to policy compliance (such as the Resilience Marker) received weak attention. To espouse bold policy statements that are not complied with in practice can increase DG ECHO's reputational risk, undermine accountability and send out confusing messages to IPs.

Strategic Recommendation 3: Adopt a more proactive role within the EU on epidemics in emergencies

This is a formative time in the EU for its positioning on global health security. DG ECHO needs to engage more strongly and help shape the agenda, so the mutually compounding effects of humanitarian crisis and epidemics, and the potential of humanitarian action in epidemic contexts are not overlooked. In the wake of the COVID-19 pandemic, the EU is moving quickly to strengthen its own resilience to health shocks, especially epidemics, and to play a fuller part in global health security. The creation of the Directorate-General for Health Emergency Preparedness and Response Authority (DG HERA) the new Regulation on cross-border health threats, the new extended mandate of the European Centre for Disease Prevention and Control (ECDC), and the announcement of a new Global Health Security Strategy are major examples of this agenda (under the general heading of European Health Union). Within DG ECHO, a new response tool - the European Humanitarian Response Capacity (EHRC) - was also announced recently, building on experience gained during COVID-19 and other high impact epidemics. These are exciting new initiatives, but will also add some organisational complexity, especially in the short to medium term. This evaluation has several findings relevant to this challenge. There is already a crowded field of agencies, delivery units and initiatives within the

EU which all have a bearing on epidemics. EU stakeholders lacked awareness of how they all work together currently and how the creation of new bodies, tools and initiatives might change things. There is also a finding that relevant EU entities had not been well coordinated in responding to epidemics in the recent past. Lastly, although DG ECHO has a key role to play - and ambition to do more in the future – it is seen as reticent among EU stakeholders, and as ceding all leadership on the humanitarian dimensions of global health security to other EC services. This diffidence within the EU at headquarters level is in stark contrast to DG ECHO's leadership and appetite for coordination among external actors in field settings.

Strategic Recommendation 4: Enhance the effectiveness of existing tools, instruments and practice

DG ECHO already makes effective contributions to addressing epidemics in humanitarian contexts, but it could boost its performance even further by making relatively simple adjustments to its current tools and ways of working.

Firstly, the Epidemics Tool should be updated and given a more prominent place within DG ECHO's suite of funding instruments. In the absence of strong policies or specific programme on epidemics, the Epidemics Tool is DG ECHO's only instrument dedicated to epidemics. It is highly valued, but not used as often as it could be. The current average grant size is probably too small to have an impact on the trajectory of an epidemic even in its early stages, and the release of funds under this instrument slowed significantly in 2020-21. The guidelines governing how it can be used are also rather ambiguous in relation to preparedness.

Secondly, more careful attention should be given to how epidemic interventions are selected, and the rationale for the specific approach should be described more fully in the Action documents. The ET found that the majority of epidemic response proposals selected for funding lacked sufficient explanation of context, especially needs and response gaps, and why the proposed intervention was the optimal one, rather than the one most convenient for the IP. From the Action documents it seemed that too many such proposals were approved with minimal challenge or commentary by DG ECHO field experts and desk officers. The ET therefore doubted whether the selected interventions were always the most apt and ambitious.

Thirdly, potential civil protection and similar in-kind interventions need to be harmonised with humanitarian aid delivery in an objective and holistic way, based on humanitarian principles. DG ECHO incorporates a civil protection wing (that has largely been focused inwardly within the EU) with a humanitarian aid wing (that is focused externally). Recent initiatives to deploy civil protection instruments to support humanitarian assistance – moving 'from donor to doer' - show some promise. However, there was good evidence that some of these initiatives were driven by the political needs of EU stakeholders for visible 'action' rather than being prioritised on the basis of need. This widens divisions between the civil protection and humanitarian arms when they still need to complement and add value to each other. In addition, rather exaggerated claims are being made about the contribution of civil protection to humanitarian action. Some of these initiatives are still underdeveloped; and some of them will always be of marginal importance given the often-difficult contexts in which humanitarian aid operates.

Fourthly, DG ECHO should explore ways of accessing epidemic response capacities in flexible ways, especially by seeking partnerships with trusted specialist institutions. Epidemics are episodic and unpredictable. It makes sense to be able to draw upon external expertise when needed, but within long-term frameworks. In particular DG ECHO could benefit from epidemiological expertise to better understand the trends within disease outbreaks. Other kinds of potential support could come from the likes of DG ECHO's strategic partners, health anthropologists, experts on resilience and epidemic preparedness, and governance advisers.

Strategic Recommendation 5: Step up work to bridge the nexus by focusing on preparedness

DG ECHO should begin programming purposeful and well-structured work on epidemic preparedness in selected humanitarian contexts, possibly including action research. The strategic recommendations above are all relevant to working better across the humanitarian-development nexus, but this issue is so important it warrants being brought together through a specific recommendation. Senior DG ECHO leadership has already accepted that a major lesson of recent epidemics is the need to take a longer-term approach and to

work alongside others across the nexus. DG ECHO already has some experience of this (e.g., in South Sudan), but the examples are relatively few, ad hoc and lack a sense of direction. Field practitioners feel they lack agency without clear guidance and a strong push from senior management. Bridging the nexus can seem daunting when the gap between humanitarian aid and development is very wide. However, work on epidemic preparedness is a good place to start. It can sit within humanitarian action, but can borrow heavily from development practice, employ action research and offers a potential pathway into further health systems' strengthening if the humanitarian situation resolves.

Part B

Strategic Recommendation 1: Co-develop a strategic framework for engaging in humanitarian settings

Forging a strategic partnership requires shared vision, structure, and mutual understanding of each partner's strengths and gaps. The annual high-level meetings and associated follow up actions do not provide the momentum to strengthen the partnership across levels to realise its potential added value. The partnership needs a framework to define what it wants to achieve and how it wants to engage in humanitarian settings, as well as the areas of health it wants to invest resources and expertise, including policy and advocacy.

The first step in this process is for DG ECHO and WHO to come together to map the areas of common interest, each organisation's strengths, areas of complementarity and synergy, and areas of misalignment or barriers to achieving a unified approach. Ideally, the partnership can identify strategic priorities that can be mainstreamed into both organisations and across all levels, whether it's ensuring mental health services in all responses or integrating resilience strengthening across all Actions.

The framework's development is not just an exercise at HQ level, it requires global ownership, and needs the inputs across all levels, building the strategic priorities from the bottom-up so they reflect the humanitarian health needs on the ground. This requires a collective look at the needs across countries. Multi-level formal dialogues can be used as a forum for different stages of developing the framework.

The framework can serve as a guide across levels and functions, ensuring coherence on policy and strategic priorities across HQ, policy and operational arms of the partnership. To ensure the framework is mutual, both partners must bring cohesive and strategic thinking on health to the table and find the natural alignment of their respective frameworks that can guide the partnership. This may be a challenge for DG ECHO without an updated and unified approach to health, an area to prioritise moving forward.

Strategic Recommendation 2: Engage in more frequent, more inclusive, and more strategically driven dialogue and communication

The partnership has experienced improved dialogue within levels (global-global, country-country), but the lack of coherence across levels has created a disconnect which impacts the partnership's efforts. Even though the HSD - at the apex of the of the strategic partnership - has strengthened the partnership between DG ECHO and WHO, it does not come from a strategically driven process and remains highly exclusive, having little impact at the operational level. The HSDs need to be further strengthened through a more inclusive and strategically driven process, expanding participation to engage DG ECHO and WHO technical and operational levels, and formalising the outcomes for more widespread dissemination.

Dialogue at the regional level has been limited and at the country level is inconsistent, dependent on country context and marked by communication breakdowns within each organisation. An overarching strategic framework for engagement (Strategic Recommendation 1) can address many of these issues by providing a common frame for dialogue at all levels, and by establishing the linkages between functional levels. However, the partnership also needs to directly address the quality and frequency of dialogue. DG ECHO can bolster quality by supporting WHO's continued efforts to strengthen its capacities to engage in DG ECHO processes. An example of such support is helping to demystify DG ECHO processes by inviting WHO to participate in country-held DG ECHO process workshops.

The partnership needs to expand formal and documented dialogues to all levels, HQ, regional and country. The dialogues should be strategically driven with clear objectives. Cross fertilisation is important, bringing the operational experience closer to HQ by involving more field and technical people at the HSD, and including HQ policy people at operational dialogues.

<u>Strategic Recommendation 3:</u> Explore innovative partnership arrangements that combine the unique strengths of each organisation to work on higher level shared goals

There are important examples where the partnership has successfully leveraged its comparative advantages to save lives. For example, at the global level with the Mental Health and Psychosocial Support (MHPSS) and Emergency Medical Teams (EMT) programs, and in Yemen, Syria and Afghanistan through joint health advocacy. Both DG ECHO and WHO agree on the value of more efficient, effective and impactful investments in health in humanitarian settings.

Of the two partners – and especially at the operational level - DG ECHO is less clear about what value it thinks WHO adds to humanitarian settings. However through structured dialogue at all levels – and mutual recognition and appreciation of comparative strengths - DG ECHO can leverage WHO's normative and technical expertise to help bridge gaps in DG ECHO's health policy (such as a framework for epidemic response). At the highest level, DG ECHO does recognise WHO as a multipurpose development organisation with a humanitarian dimension. DG ECHO can build on this to implement its commitments under the Grand Bargain.

On the WHO side, the perception is that DG ECHO's Humanitarian Implementation Plans (HIP) and Epidemics Toolbox are valued, but limited in scope, timeframe and funding, leading to missed opportunities, especially for progress in protracted crises and towards bridging the nexus. For WHO, the strategic partnership would preferably establish financing mechanisms outside the HIPs by exploring alternative mechanisms that extend beyond multi-country grants. Alternative and innovative financing approaches can secure impactful work on preparedness, and more timely and appropriate responses to future public health emergencies in humanitarian settings.

Committing to alternative financing modalities such as pilot programmatic partnerships (PPP) can better integrate resilience approaches into investments, so the partnership can have a longer-term impact. Increased investment in innovative financing will require leadership buy-in and an appetite for risk, especially at HQ levels. This is a big stretch without a better understanding of WHO's performance and potential: a first step could be for DG ECHO to commission an independent review of WHO as an implementer, something which was beyond the mandate of this evaluation.

In addition, the two organisations could explore tripartite and multilateral collaborations with other EC services such as DG INTPA to address resilience and nexus-bridging activities; or with other technical/implementing agencies to maximise technical exchange and consider joint initiatives.

Recommendations one and two can both feed into this process of leveraging each other's strengths respective strengths.

Résumé exécutif

Introduction, objectif et portée

Le présent document est le rapport d'une évaluation indépendante de deux aspects distincts, mais liés, de la performance de la Direction générale de la protection civile européenne et des opérations d'aide humanitaire (DG ECHO) dans le secteur de la santé humanitaire au cours de la période quinquennale 2017-2021. Il s'agit d'une évaluation combinée, mais divisée en deux parties :

- Partie A : La réponse humanitaire de la DG ECHO aux épidémies.
- Partie B : Le partenariat de la DG ECHO avec l'Organisation mondiale de la santé (OMS)

Ces dernières années, les épidémies sont réapparues comme le problème prédominant de la sécurité sanitaire mondiale, dans les contextes humanitaires comme dans le développement. Le changement climatique, la dégradation de l'environnement, les conflits, les migrations mixtes et d'autres facteurs se combinent de telle sorte que les situations humanitaires deviennent des lieux à haut risque pour l'apparition d'épidémies de maladies infectieuses, y compris les nouvelles zoonoses. De plus les populations prises dans des crises humanitaires sont particulièrement vulnérables aux épidémies. L'Union européenne (UE) renforce actuellement sa propre capacité à soutenir les initiatives de sécurité sanitaire mondiale. La DG ECHO entend participer à cet effort.

Historiquement, l'OMS n'a pas été un partenaire humanitaire majeur pour la DG ECHO, en raison de son rôle principalement normatif et de sa capacité opérationnelle limitée à répondre aux problèmes de santé dans les situations d'urgence et les contextes humanitaires. Les enseignements tirés de la crise d'Ebola en Afrique de l'Ouest en 2014 ont conduit à des réformes majeures pour l'OMS, notamment la création du programme d'urgences sanitaires (WHE) en 2016. Cette réforme a été une étape critique pour transformer l'OMS en une agence opérationnelle, augmentant l'importance de l'OMS pour la DG ECHO en tant que partenaire de mise en œuvre (IP) d'une opération humanitaire dans le domaine de la santé. Fin 2019, l'OMS est devenue un partenaire humanitaire stratégique pour la DG ECHO[1], ce qui a été marqué par son premier dialogue stratégique de haut niveau (DSH) en janvier 2020. Ces DHS ont eu lieu chaque année et ont été la marque d'un partenariat croissant entre la DG ECHO et l'OMS.

L'objectif spécifique de l'évaluation, selon ses termes de référence (TOR), était de :

1. Fournir une évaluation externe, indépendante et thématique des actions mondiales de la DG ECHO en réponse aux épidémies dans les pays tiers ;

2. Replacer la réponse de la DG ECHO aux épidémies dans le contexte plus large de la réponse de l'UE, et de fournir une analyse sur la manière de renforcer sa position dans les réponses futures ; et

3. Fournir une évaluation rétrospective du partenariat de la DG ECHO avec l'OMS au niveau mondial, en mettant l'accent sur l'identification des leçons apprises et des bonnes pratiques.

L'OMS étant également l'une des nombreuses organisations avec lesquelles la DG ECHO s'est associée pour répondre aux épidémies (Partie A), il y a eu un très faible degré de convergence entre les parties A et B. Pour le reste, les deux parties ont été largement traitées séparément.

L'évaluation était de portée mondiale. Bien que la collecte des données ait impliqué un certain échantillonnage géographique, les résultats, les conclusions et les recommandations sont tous applicables à un niveau mondial. Lors des discussions entre l'équipe d'évaluation (ET) et le groupe de pilotage de l'évaluation (ESG) au cours de la phase de démarrage, il a été précisé que la Partie A serait principalement

[1] Termes de référence pour l'évaluation combinée de la réponse humanitaire de la DG ECHO aux épidémies et du partenariat de la DG ECHO avec l'Organisation mondiale de la santé, 2017-2021 ; DG ECHO.

axée sur la performance de la DG ECHO en tant que bailleur de fonds humanitaire dans des contextes d'urgence. La contribution des capacités de protection civile (PC) de la DG ECHO à la réponse aux épidémies a été prise en compte, mais dans une moindre mesure. Il a également été convenu que la réponse humanitaire de la DG ECHO aux effets socio-économiques plus larges des épidémies (par exemple, la nutrition, la protection, les transferts d'argent) ne serait pas couverte ; la partie A se concentrerait plutôt sur les domaines plus "classiques" d'une réponse de santé publique (y compris les mesures de préparation aux épidémies).

L'ESG a également précisé que, pour la partie A, l'accent était mis sur la performance propre de la DG ECHO en tant qu'institution dans le domaine humanitaire, plutôt que sur la performance collective de ses Partenaires d'Exécution (PE). Ainsi, l'équipe d'évaluation (ET) a examiné la manière dont la DG ECHO prenait ses décisions et utilisait au mieux ses précieuses ressources dans la lutte contre les épidémies. Dans le même ordre d'idées, la partie B s'est concentrée sur le partenariat DG ECHO-OMS lui-même, plutôt que sur la façon dont l'OMS s'est comportée dans les contextes humanitaires en tant que partenaire de mise en œuvre de la DG ECHO.

Méthodologie

L'évaluation a été divisée en quatre phases : une phase initiale, au cours de laquelle le champ d'application a été affiné et une méthodologie plus détaillée a été élaborée ; une phase documentaire, qui s'est principalement concentrée sur les preuves documentaires ; une phase de terrain au cours de laquelle la majorité des entretiens et toutes les discussions de groupe ont eu lieu ; et, enfin, une phase de synthèse, au cours de laquelle toutes les données ont été rassemblées et analysées pour en tirer des résultats, des conclusions et des recommandations. Chaque phase s'est terminée par un rapport, le présent document étant le rapport final.

Les questions d'évaluation (QE) ont été définies dans les termes de référence. Au cours de la phase de démarrage, elles ont été affinées et des critères de jugement (CJ) ont été élaborés pour chaque QE afin de fournir des orientations supplémentaires pour la collecte des données. Ensemble, ils ont formé une matrice d'évaluation (ME) qui a été développée par l'ET en une matrice de preuves permettant à toutes les données pertinentes, quelle que soit leur source, d'être mises en correspondance avec les QE et les CJ pertinents. Les questions d'évaluation ont été regroupées par critères d'évaluation humanitaire largement utilisés pour la partie A et par critères de partenariat pour la partie B.

	Critères d'évaluation	Questions d'évaluation
Partie A	Pertinence	1. Dans quelle mesure les plans et les interventions de la DG ECHO en réponse aux épidémies étaient-ils appropriés?
		2. Dans quelle mesure les actions de la DG ECHO ont-elles cherché à obtenir la participation des populations affectées à tous les stades du cycle des projets humanitaires, et à répondre à leurs besoins et priorités?
	Cohérence	3. Dans quelle mesure la réponse de la DG ECHO a-t-elle été cohérente avec celle des acteurs externes concernés?
		4. Quelle a été la cohérence de la réponse de la DG ECHO avec celle des autres actions de l'UE/CE, y compris celles des États membres individuels, et comment le rôle de la DG ECHO devrait-il évoluer compte tenu de l'intention stratégique de la CE de renforcer la sécurité sanitaire européenne et mondiale?
	Efficacité	5. Quelle a été l'efficacité des outils et instruments de la DG ECHO dans la lutte contre les épidémies?
		6. Quels sont les résultats obtenus par la réponse de la DG ECHO aux épidémies?
	Efficience	7. Les actions de la DG ECHO en réponse aux épidémies ont-elles été efficientes ?

		8. Dans quelle mesure les interventions de la DG ECHO en réponse aux épidémies ont-elles été opportunes et flexibles, permettant ainsi aux partenaires d'avoir des réponses adaptées?
	Résilience/ Connectivité	9. Dans quelle mesure la DG ECHO a-t-elle contribué à la résilience des systèmes de santé publique pour la prévention et la réponse aux épidémies dans les pays où elle travaille?
Partie B	Collaboration	10. Le partenariat DG ECHO-OMS est-il stratégique et synergique, avec une vision commune qui tire parti des avantages de la collaboration à tous les niveaux?
	Transactionnel	11. Le partenariat DG ECHO-OMS est-il soutenu par un dialogue efficace et des structures et mécanismes adaptés pour atteindre ses objectifs à tous les niveaux?
	Transformationnel	12. Quelle est la valeur ajoutée du partenariat DG ECHO-OMS pour contribuer à la mise en place de systèmes de santé durables et résilients, et à l'obtention de résultats plus équitables et meilleurs en matière de santé dans les contextes humanitaires?

Il a été convenu que les principales sources de preuves seraient :

- Des documents, notamment les documents d'action (de projet) de la DG ECHO, les principaux documents politiques et les documents relatifs au partenariat avec l'OMS.
- Des entretiens avec des informateurs clés (KII).
- Des discussions de groupe (FGD) avec des personnes touchées par les épidémies.
- Enquête en ligne

Une approche d'échantillonnage intentionnel a été utilisée pour s'assurer que le temps et les ressources limités dont disposait l'ET étaient utilisés efficacement et que les sources de données sélectionnées étaient aussi représentatives que possible, conformément à l'objectif et à la portée de l'évaluation. Un élément important de cette approche d'échantillonnage a été la sélection de pays particuliers où l'évaluation pouvait examiner de manière raisonnablement approfondie la performance de la réponse de la DG ECHO aux épidémies et son partenariat avec l'OMS. Dans l'ensemble, l'ET a recueilli une quantité considérable de preuves au cours des phases de terrain et de documentation. A partir des KII, des documents examinés et des FGD, plus de 1 300 éléments de données distincts ont été enregistrés par rapport à 26 critères de jugement individuels, sans compter les données enregistrées par l'enquête en ligne.

Des réunions régulières entre l'ET et l'ESG ont permis de suivre les progrès, de discuter des contraintes et de résoudre les difficultés. Parmi celles-ci, certaines limitations liées aux études nationales ont été les plus importantes, mais pas suffisamment pour mettre en doute la validité des résultats globaux.

Conclusions sommaires

Partie A : la réponse humanitaire de la DG ECHO aux épidémies.

Pertinence

Résumé des constatations 1 : le caractère approprié de la réponse de la DG ECHO aux épidémies. Les interventions financées par la DG ECHO en réponse aux épidémies étaient appropriées, dans le sens où elles étaient largement pertinentes et contribuaient valablement aux efforts de réponse globaux. Pour choisir les interventions à soutenir, la DG ECHO s'est, à juste titre, largement appuyée sur la bonne compréhension du contexte local acquise par ses experts de terrain, sur les conseils techniques de ses experts sanitaires régionaux (le "groupe anophèle"), ainsi que sur les suggestions et les capacités des partenaires d'exécution (PE) déjà présents sur le terrain. Cependant, cette forte capacité d'analyse n'était pas bien valorisée dans les documents de projet de la DG ECHO, où l'inclusion de nouvelles données d'évaluation spécifiques était

limitée, l'analyse du contexte spécifique était insuffisante et l'ampleur ou la trajectoire de l'épidémie n'était pratiquement pas traitée. En l'absence d'une analyse plus complète du problème et d'un examen documenté des différentes options d'intervention et de leurs avantages et inconvénients - que ce soit par les PE ou par les experts de la DG ECHO - il a été difficile pour l'ET de déterminer si les interventions sélectionnées étaient les options disponibles les plus appropriées, plutôt que celles qui étaient simplement pertinentes, ou peut-être même celles qui convenaient le mieux aux PE. La DG ECHO semble être forte dans l'application de ses connaissances pour décider de la manière d'intervenir, mais plutôt faible dans la documentation du raisonnement.

Résumé des constatations 2 : Responsabilité envers les populations affectées (RPA). Dans l'ensemble, les actions financées par la DG ECHO n'ont pas toujours cherché à obtenir la participation des populations concernées à tous les stades du cycle du projet[2], et la mise en œuvre de cette politique par la DG ECHO était inégale. En effet, plusieurs experts de la DG ECHO n'ont pas caché que l'engagement de la communauté n'était absolument pas une priorité dans la phase de conception d'une intervention de réponse à une épidémie. A l'appui de ce constat, les experts de la DG ECHO n'ont guère pris en compte les mécanismes de RPA dans les documents d'action, bien que certains PE de la DG ECHO aient donné l'exemple de bonnes pratiques en matière d'engagement communautaire dans la conception des initiatives et aient cherché des moyens de rendre des comptes aux populations qu'ils servaient. Ce sont souvent ces mêmes agences qui ont cherché à identifier les personnes ayant des besoins ou des vulnérabilités particulières, et qui les ont ciblées pour leur apporter une assistance.

Cohérence

Résumé des constatations 3 : cohérence avec les acteurs externes. La DG ECHO a non seulement recherché la cohérence avec d'autres acteurs, mais elle a également fait preuve de leadership en promouvant et en encourageant activement les efforts de coordination de la réponse, notamment parmi les bailleurs de fonds et les acteurs humanitaires internationaux. Elle a soutenu et participé aux mécanismes de coordination dirigés par les Nations Unies (ONU), et a encouragé ses PE à s'engager dans le système des Clusters et à s'assurer que leurs interventions étaient cohérentes avec celles des autres acteurs au niveau local. Il y a eu moins de preuves directes que les plans gouvernementaux guidaient la réponse de la DG ECHO, bien qu'une large cohérence avec ces plans ait été assurée par les structures de coordination dirigées (ou facilitées) par les Nations unies et par un dialogue régulier entre les PE et les responsables locaux de la santé. Il a clairement été démontré que la DG ECHO a apporté une valeur ajoutée aux efforts globaux de réponse à l'épidémie de multiples façons, notamment par sa compréhension technique, étayée par sa connaissance du contexte local, par sa capacité à travailler de manière flexible avec des partenaires expérimentés de longue date et par son rôle dans le plaidoyer humanitaire.

Résumé des constatations 4 : Cohérence avec les autres organes de l'UE/CE. Il y a un nombre croissant d'organes et d'initiatives de l'UE qui ont une certaine responsabilité dans la préparation et la réponse aux épidémies, bien que la plupart soient axés sur l'intérieur (à l'intérieur des frontières de l'UE). En ce qui concerne l'action humanitaire extérieure en matière d'épidémies, l'ET a constaté que les organes de l'UE concernés n'étaient pas suffisamment liés par des mécanismes de coordination ou une orientation politique, ce qui entraîne une certaine incohérence. Dans les contextes humanitaires, la DG ECHO a le potentiel pour jouer un rôle plus important dans la coordination de la préparation et de la réponse aux épidémies, ainsi que dans les dispositions connexes de l'UE en matière de sécurité sanitaire mondiale. La DG ECHO dispose d'informations et d'une expertise privilégiée qu'elle pourrait utiliser davantage au sein de l'UE pour souligner les liens entre les crises humanitaires et les épidémies, et pour défendre la nécessité de la prévention, de la préparation et de la réponse rapide. À l'heure actuelle, cependant, la DG ECHO semble hésiter à coordonner son action avec celle d'autres services de la CE et ne dispose pas d'une capacité politique suffisante pour diriger les aspects de la stratégie de l'UE en matière de santé mondiale qui ont trait à l'action humanitaire internationale.

[2] Comme le prévoit l'engagement du Grand Bargain en faveur d'une " révolution de la participation ", et les engagements antérieurs en faveur du PAA

Efficacité

Résumé des constatations 5 : l'efficacité des outils et instruments de la DG ECHO. L'ampleur de la réponse de la DG ECHO aux épidémies a généralement été jugée appropriée en termes relatifs, étant donné que les besoins découlant de COVID-19 étaient particulièrement énormes. Du fait de sa souplesse, la DG ECHO a parfois pu combler des lacunes importantes avant que les donateurs disposant de ressources plus importantes ne soient en mesure de réagir. L'outil (de financement) des épidémies est un instrument très spécifique et très apprécié, mais les parties prenantes ont estimé qu'il pourrait être utilisé plus souvent, notamment pour soutenir le travail de préparation, et qu'il serait plus efficace si les subventions étaient plus importantes. Le pont aérien humanitaire a fourni un soutien efficace pour la réponse au COVID-19 tandis que d'autres capacités de protection civile disponibles ont un certain potentiel pour soutenir la réponse humanitaire, mais n'ont pas été déployées à grande échelle au cours de la période d'évaluation. Le système de gestion des actions de la DG ECHO par le biais du système de documentation SingleForm/FicheOp[3] a peut-être permis des gains d'efficacité, mais au prix d'une analyse plus riche et de justifications plus claires expliquant comment les interventions ont été classées par ordre de priorité. Une grande confiance et une grande responsabilité sont donc placées dans les conseils du réseau très apprécié d'experts de terrain de la DG ECHO. Les personnes interrogées ont estimé qu'une bonne expertise technique et une bonne connaissance du terrain devaient être contrebalancées par des capacités supplémentaires en matière d'élaboration de politiques et de réflexion stratégique, en particulier au niveau de Bruxelles.

Résumé des constatations 6 : Les résultats de la réponse de la DG ECHO aux épidémies. Les résultats de la plupart des actions ont été communiqués par les PE et n'ont pas fait l'objet d'une évaluation indépendante, bien que les experts de terrain de la DG ECHO aient effectué des visites de contrôle sur le terrain, examiné les rapports de projet et demandé des clarifications si nécessaire. Environ 65% des objectifs des projets ont été atteints ou dépassés et des explications ont été fournies pour les objectifs manqués. Naturellement, les résultats ont été les plus impressionnants dans les actions axées spécifiquement sur la réponse aux épidémies plutôt que dans celles (la majorité) où les projets existants avaient été légèrement adaptés par le biais de demandes de modification pour incorporer des mesures d'intervention contre les épidémies, qui manquaient parfois d'ambition et avaient probablement un impact négligeable sur la trajectoire des épidémies. Plusieurs parties prenantes, y compris des personnes affectées, ont estimé que les interventions financées par la DG ECHO avaient eu un effet durable, au-delà de la durée de vie des actions elles-mêmes. Les données sur les conséquences involontaires étaient très rares, ce qui rendait difficile la formulation d'un jugement global, bien que l'ET ait été informée d'un certain nombre de mesures actives prises par les PE pour éviter de telles conséquences résultant de la mise en œuvre de leur projet.

Rendement

Résumé des constatations 7 : Rentabilité. La DG ECHO ne dispose pas d'un cadre établi pour mesurer le rapport coût-efficacité. L'ET l'a donc interprété comme "la réalisation des résultats escomptés par rapport aux coûts". Selon ce critère, la réponse de la DG ECHO aux épidémies a été jugée globalement rentable, atteignant des niveaux de résultats décents (voir la conclusion 6 ci-dessus) en échange de montants de financement relativement modestes et proportionnés. Les experts de terrain de la DG ECHO étaient conscients de la nécessité d'atteindre un équilibre approprié entre les coûts et les résultats, et ont cherché à réaliser des économies lorsqu'ils le pouvaient. La conclusion 1 ci-dessus sur le caractère approprié est également pertinente pour l'examen du rapport coût-efficacité, car il est possible qu'à certains endroits, une autre intervention aurait pu produire des résultats encore plus importante pour le même investissement.

Résumé des constatations 8 : Rapidité et Flexibilité. Des éléments très probants montrent que la DG ECHO a réagi rapidement aux épidémies et que ses systèmes de gestion de projets, associés à ses relations étroites avec des partenaires respectés, lui ont permis de faire preuve de souplesse pour adapter sa réponse

[3] L'eSingleform est une plateforme en ligne unique, tournée vers l'extérieur, qui contient les propositions de PE, les descriptions de projet, les demandes de modification et les rapports. La FicheOp est une plateforme interne de la DG ECHO qui enregistre les activités du personnel (visites de suivi, communications opérationnelles, évaluations techniques) ainsi que les scores des marqueurs de genre et de résilience et les informations financières. Pour apprécier pleinement une action, l'observateur doit combiner la vue PE (eSingleform) et la vue du personnel de la DG ECHO (FicheOp).

à l'évolution des situations. L'adaptation était la plus facile et la plus rapide lorsque la DG ECHO avait un partenariat de projet existant et que les ajustements pouvaient être gérés par le biais de demandes de modification. Lorsque les épidémies constituaient un risque bien reconnu, les PE avaient la possibilité d'inclure un modificateur de crise spécifique dans leur demande de financement, bien que, dans la pratique, cette possibilité ait rarement été utilisée parmi les actions examinées en détail par l'ET. L'outil Epidémies a été considéré comme un instrument de financement de projet particulièrement rapide, bien que le déblocage des fonds de cet outil ait considérablement ralenti depuis 2019. Face aux avis très majoritairement positifs sur la rapidité et la flexibilité, une minorité de répondants s'est interrogée sur la flexibilité de la DG ECHO à répondre à de nouvelles urgences dans des endroits où elle n'avait pas de partenariats de projet existants, et a noté que la flexibilité dans l'ajout d'activités par le biais d'une demande de modification n'était pas toujours assortie d'une flexibilité dans la fourniture de financements supplémentaires, par exemple des coûts de soutien supplémentaires.

Résilience/ Connectivité

Résumé des constatations 9 : La contribution de la DG ECHO à des systèmes de santé publique résilients. La DG ECHO contribue à la résilience par ses projets de réponse aux épidémies et surtout par les quelques projets qui sont axés sur des activités spécifiques de préparation. De nombreuses activités contribuant à la résilience font partie intégrante de la fourniture d'aide humanitaire dans le contexte de crises chroniques, comme la formation du personnel local. Les sections des documents d'Action relatives au marqueur de résilience n'ont reçu qu'un traitement minimal dans la plupart des cas, tant de la part des PE que des experts de la DG ECHO. En général, les activités étaient décrites comme contribuant à la résilience, plutôt que comme un objectif à part entière. Les personnes interrogées avaient des avis partagés sur le lien entre l'humanitaire et le développement : certaines souhaitaient une approche plus concertée et davantage de travail sur la prévention et la préparation, tandis que d'autres estimaient que les précieuses ressources humanitaires devaient être préservées pour la réponse aux crises et non pour remédier aux échecs du développement. Il existe de bons exemples de collaboration avec des partenaires extérieurs à l'UE, bien qu'ils soient peu nombreux. Au sein de la famille d'institutions UE/CE, c'est entre la DG ECHO et la Direction Générale des Partenariats Internationaux (DG INTPA) que l'ET a trouvé le plus de preuves de relations, qui ont été jugées très cordiale, bien que le dialogue à tous les niveaux ait été considéré comme ad hoc, pas toujours productif, et souffrant d'un manque d'orientation opérationnelle sur la façon de travailler ensemble.

Partie B : Le partenariat de la DG ECHO avec l'Organisation mondiale de la santé (OMS)

La dimension collaborative

Résumé des constatations 10 : Objectif et vision stratégiques partagés, et exploitation des forces du partenariat. Le partenariat va au-delà de la relation donateur-bénéficiaire et est devenu plus stratégique grâce au renforcement du dialogue, à l'échange de connaissances techniques et à la poursuite d'initiatives conjointes avec résultats. La plupart des parties prenantes de l'OMS à tous les niveaux, et les répondants de la DG ECHO au niveau du siège (HQ), considèrent que le partenariat est stratégique et qu'il va au-delà de la relation donateur-bénéficiaire. Toutefois, c'est moins le cas du personnel opérationnel de la DG ECHO, qui estime que le partenariat manque à la fois d'une vision commune et d'un cadre stratégique. Le partenariat manque d'une stratégie globale pour encadrer la vision des deux partenaires. Au lieu de cela, au niveau mondial, le partenariat est marqué par des DSH annuels et un ensemble d'actions prioritaires convenues conjointement qui ne sont pas largement partagées ou comprises à tous les niveaux du partenariat. Cette absence de vision commune et de cadre stratégique pour s'engager dans des contextes humanitaires a conduit à des malentendus sur les priorités du partenariat et à des frustrations des deux côtés. Cela est particulièrement vrai au niveau opérationnel, où les accords au niveau mondial ne se répercutent pas nécessairement sur le terrain et vice versa.

Il existe également une confusion quant à l'alignement sur les approches sanitaires. L'OMS dispose de cadres, de stratégies et de lignes directrices actualisés et documentés pour différents domaines relatifs aux urgences sanitaires et à la santé dans les contextes humanitaires (par exemple sur le lien, le renforcement de

la résilience et les épidémies). La DG ECHO dispose d'une politique de santé et d'orientations générales sur la santé dans les situations d'urgence humanitaire. Toutefois, ces documents, bien qu'ils soient pour la plupart encore valables, sont obsolètes et ne comprennent pas ses approches dans des domaines importants de la santé dans les situations humanitaires, tels que les épidémies, le renforcement de la résilience et la mise en place d'un lien. La DG ECHO ne dispose pas d'un processus établi et clarifié pour identifier les priorités organisationnelles en matière de santé. Au sein de la DG ECHO, la santé est fragmentée entre différentes unités, la plupart des compétences en matière de santé se situant au niveau opérationnel dans le groupe anophèle, qui n'est pas impliqué dans les décisions politiques au niveau du siège. En outre, il n'existe pas de groupe de travail officiel sur la santé qui se réunisse régulièrement et puisse représenter la position des organisations dans les domaines très évolutifs de la santé et des urgences humanitaires. Il en résulte une incohérence dans les domaines de la santé au-delà de la réponse immédiate aux urgences sanitaires, ce qui place la DG ECHO dans une situation inégale avec l'OMS pour développer conjointement une vision commune et identifier les priorités stratégiques du partenariat.

L'ET a constaté que les deux partenaires reconnaissent et apprécient leurs avantages comparatifs respectifs, mais qu'il existe des divergences de vues de part et d'autre sur les forces que chaque institution apporte au partenariat et sur la manière dont celui-ci pourrait les exploiter au mieux. Il existe des opinions bien ancrées au sein de la DG ECHO selon lesquelles, à l'exception du travail de l'OMS sur les pandémies et sur certaines crises prolongées, l'OMS n'est pas opérationnelle dans les contextes humanitaires. En outre, certains membres de la DG ECHO ne considèrent pas qu'il s'agisse d'un domaine dans lequel l'OMS apporte une valeur ajoutée, notamment par rapport à ses atouts normatifs et techniques dans la gestion des événements de santé publique. Paradoxalement, le personnel de la DG ECHO, tant au siège qu'au niveau opérationnel, a déclaré que le partenariat se renforcerait si l'OMS disposait de plus de capacités opérationnelles et de ressources pour la mise en œuvre. Cela suggère un décalage des attentes entre l'OMS et la DG ECHO, ainsi qu'au sein de la DG ECHO elle-même. L'OMS/WHE se considère comme étant à cheval sur les domaines de l'humanitaire et du développement, et souhaite vivement étendre ses capacités opérationnelles et recevoir un financement opérationnel accru de la part du partenariat. Pour l'OMS, le partenariat gagnerait à ce que la DG ECHO dispose de plus d'expertise technique en matière de santé au niveau du siège.

La dimension transactionnel

Résumé des constatations 11: Dialogue efficace et structures adaptées aux besoins. Le dialogue entre la DG ECHO et l'OMS s'est amélioré au sein des niveaux (mondial-mondial, pays-pays), mais pas entre les niveaux (mondial-pays), ce qui conduit à une communication décousue qui affecte les décisions et les actions du partenariat. Au niveau mondial, le dialogue de haut niveau s'est amélioré en quantité et en qualité, grâce aux réunions des hauts fonctionnaires (SOM) et aux DSH, ainsi qu'au dialogue régulier entre les points focaux de la DG ECHO et du siège de l'OMS. Pour les hauts responsables de la DG ECHO et du siège de l'OMS, les DSH sont considérés comme la marque du partenariat stratégique, ayant plus fermement établi la DG ECHO et l'OMS comme partenaires humanitaires. Cependant, alors que les DSS constituent un forum pour des discussions franches sur des domaines d'intérêt commun au plus haut niveau, les personnes interrogées à l'OMS et à la DG ECHO ont estimé que l'approche des DSH était formelle et non stratégique. Plutôt que d'être le fruit d'une discussion collaborative sur les priorités institutionnelles en matière de santé, les DSH tournent autour des unités de la DG ECHO et de WHE qui apportent leurs contributions aux points de l'ordre du jour. En outre, les DSH sont limités au personnel du siège et ne comprennent pas de contributions directes des niveaux opérationnels et de terrain du partenariat, ni ne sont partagés avec eux, ce qui limite leur valeur au-delà du siège. Au niveau national, le dialogue stratégique et efficace est varié et dépend du contexte du pays, tendant à être plus fort dans les crises plus prolongées où les deux organisations peuvent compter sur un historique de bonnes relations entre partenaires. Il n'y a pas eu de cas de dialogue régional pendant la période d'évaluation, malgré le rôle autonome et influent des bureaux régionaux de l'OMS.

Il y avait des preuves d'une amélioration de la transparence selon les documents d'Action, qui ont rapporté des procédures irrégulières en 2017. Le portefeuille de partenariats a considérablement augmenté entre 2017 et 2021, les fonds ayant plus que doublé. En outre, le montant moyen des subventions a augmenté chaque

année, et davantage d'Actions de l'OMS ont été financées chaque année qu'avant 2017, y compris des Actions multi-pays. Une partie de cette augmentation peut être attribuée à la COVID-19, à la fois en termes de fonds ciblés sur la COVID-19, et au caractère de plus en plus sanitaire des programmes humanitaires, ce qui augmente le financement général de la santé. Il est toutefois évident que les efforts de l'OMS pour renforcer ses capacités en matière d'engagement et de processus de la DG ECHO ont contribué à une augmentation de la fréquence et de la qualité des soumissions de propositions de l'OMS, des actions financées par la DG ECHO et, par conséquent, à une augmentation du financement par la DG ECHO.

L'efficacité des partenariats s'est quelque peu améliorée - pour l'OMS, la durée moyenne des processus de proposition et de financement de la DG ECHO a diminué au cours de la période d'évaluation. Toutefois, certaines inefficacités subsistent, avec, d'une part, les lourdes exigences de la DG ECHO en matière de rapports et les formulaires répétitifs du SingleForm et, d'autre part, la lenteur des processus administratifs de l'OMS qui entraîne des retards dans la mise en œuvre. Si la DG ECHO a fait quelques progrès dans la mise en œuvre de modalités de financement alternatives, par exemple en réponse à la COVID-19 avec d'importantes subventions de plusieurs millions de dollars, les efforts de l'OMS pour explorer des approches de financement alternatives et innovantes ont été soit lents à venir (subventions régionales pluriannuelles), soit futiles (partenariat programmatique).

Le début de la pandémie de COVID-19 a servi de test pour le nouveau partenariat stratégique. La subvention COVID-19 de 30 millions d'euros a été une manifestation importante du partenariat stratégique entre la DG ECHO et l'OMS, étant donné son caractère récent. Pour la DG ECHO, cette subvention était révolutionnaire car elle comportait de nombreuses premières - la première CE à financer le plan d'intervention de l'OMS, la première somme importante de 30 millions d'euros, la première subvention à affectation libre, la première subvention mondiale multi-pays et le premier cycle de subvention de 18 mois - autant d'éléments hors norme pour la DG ECHO. Cette flexibilité a permis à l'OMS de déterminer la meilleure façon d'utiliser les fonds. Le partenariat a pu montrer sa maturité en trouvant un terrain d'entente sur certaines exigences en matière de rapports, alors que d'autres processus de subvention sont encore considérés comme lourds. Des améliorations peuvent encore être apportées de part et d'autre, la DG ECHO devant reconsidérer le niveau de détail requis pour les subventions multi-pays et l'OMS devant trouver des moyens de communiquer suffisamment de détails pour au moins minimiser la nécessité d'une vérification en temps utile. La DG ECHO a suivi la même approche de financement en 2021 avec une contribution de 16 millions d'euros vaguement affectée au déploiement des campagnes nationales de vaccination COVID-19 dans 15 pays africains. Les deux subventions COVID-19 à grande échelle ont bien fonctionné et ont démontré à la DG ECHO la viabilité et l'efficacité potentielles de l'allocation de fonds non affectés et la nécessité d'une plus grande flexibilité dans ses mécanismes de financement.

La dimension transformationnel

Résumé des constatations 12: travailler ensemble sur la résilience. La plupart des parties prenantes pensent que le partenariat soutient la résilience des systèmes de santé pour répondre aux urgences sanitaires, et de bons exemples en ce sens ont été fournis dans les documents d'Action ainsi que lors des entretiens. Une tendance prometteuse vers des actions plus longues a été notée, suggérant une reconnaissance commune que le renforcement de la résilience nécessite une approche légèrement plus lente et plus soutenue pour avoir un impact. Néanmoins, cette tendance peut avoir des limites, car la DG ECHO ne dispose pas d'un cadre unifié sur la résilience, notamment en ce qui concerne la préparation aux urgences sanitaires, de sorte que les efforts déployés dans ces domaines par le biais du partenariat sont régis par les perspectives des experts de terrain et des bureaux locaux de la DG ECHO, plutôt que de découler d'un point de référence unique. Aux yeux de l'OMS, cette situation a fait perdre des occasions, notamment lorsque la DG ECHO et l'OMS conviennent au niveau politique d'initiatives conjointes pour inclure la préparation, mais que ces propositions sont rejetées en raison de l'aversion de certains homologues à la DG ECHO pour des interventions qui détournent des ressources rares de la réponse humanitaire "pure". En l'absence d'une approche stratégique concertée pour renforcer la résilience, les deux organisations courent le risque d'une complaisance bien ancrée, comme cela a été le cas au Sud-Soudan, où les mêmes activités de préparation

ont été remboursées chaque année depuis plus de dix ans sans que l'on se soit demandé comment progresser vers les politiques de résilience durable de la DG ECHO et de l'OMS.

Les deux organisations abordent également le lien de manière différente. L'OMS dispose d'un " double mandat " fort et (surtout depuis 2016) bien institutionnalisé pour travailler sur le nexus. En revanche, la position de la DG ECHO est moins symétrique : c'est une organisation axée principalement sur l'action humanitaire, mais qui a pour politique de soutenir le travail à travers le nexus. Cependant, dans un environnement où les ressources sont limitées et en l'absence de directives spécifiques sur le nexus, le personnel de la DG ECHO, en particulier sur le terrain, a tendance à orienter son soutien vers les activités de réponse traditionnelles.

Recommandation stratégiques

Partie A

Recommandation stratégique n° 1 : élaborer une vision et une politique stratégique en matière d'épidémies

L'importance des épidémies pour la sécurité sanitaire mondiale et pour le travail de la DG ECHO exige que celle-ci définisse une orientation claire, étayée par un cadre politique cohérent. La politique actuelle de la DG ECHO en matière d'épidémies est assez mince et se trouve dispersée entre plusieurs documents de référence. Elle manque également d'une certaine cohérence interne et ne fournit pas de conseils et d'orientations adéquats au personnel et aux partenaires potentiels de mise en œuvre. Cela crée des "zones d'ombre" qui pourraient nuire à la cohérence et à la qualité. Sur la base des résultats de cette évaluation, les domaines clés nécessitant une meilleure orientation comprennent l'équilibre entre la prévention, la préparation et la riposte aux épidémies ; l'utilisation des données épidémiologiques pour envisager la trajectoire de l'épidémie et en tenir compte dans la programmation ; le choix de l'outil de financement le plus approprié ; la priorisation des piliers de la riposte à soutenir dans différentes situations ; et la manière de compléter les interventions d'aide humanitaire et de protection civile de manière significative.

Recommandation stratégique 2: renforcer la discipline politique sur les questions transversales importantes

La DG ECHO a développé d'importants domaines de politique transversale qui sous-tendent l'ensemble de son action humanitaire, y compris sa réponse aux épidémies. Ces politiques sont souvent à la pointe de la réflexion humanitaire et reflètent les engagements pris par l'UE envers ses propres citoyens et dans les forums internationaux. La DG ECHO doit trouver des moyens de s'assurer que la pratique est conforme à la politique. L'ET a trouvé plusieurs domaines où il y avait un écart entre la politique publiée de la DG ECHO et les attitudes et pratiques du personnel de terrain. Ces attitudes divergentes et relativement répandues allaient des "angles morts" délibérés, pour les positionnement modérés, aux commentaires très dédaigneux sur la politique, pour les plus extrêmes. Elles concernaient en particulier la Redevabilité envers les Populations Affectées, le renforcement de la résilience et le travail sur le lien entre l'humanitaire et le développement, mais la pratique s'écartait également de la politique en ce qui concerne le traitement de la vulnérabilité dans la conception des projets et l'importance d'utiliser les évaluations des besoins pour informer la planification (plutôt que pour justifier les dépenses). Bien qu'il y ait souvent des divergences d'opinion sur la politique dans les grandes organisations, le fossé entre la politique et la pratique à la DG ECHO semblait particulièrement large de l'avis de l'ET, et il s'est clairement répercuté sur la qualité des documents d'action, où les sections relatives à la conformité à la politique (comme le marqueur de résilience) ont reçu une faible attention. Adopter des déclarations politiques audacieuses qui ne sont pas respectées dans la pratique peut accroître le risque de réputation de la DG ECHO, miner la responsabilité et envoyer des messages confus aux PE.

Recommandation stratégique 3: Adopter un rôle plus proactif au sein de l'UE sur les épidémies dans les situations d'urgence

C'est un moment formateur dans l'UE pour son positionnement sur la sécurité sanitaire mondiale. La DG ECHO doit s'engager plus fortement et contribuer à l'élaboration de l'agenda, afin de ne pas négliger les effets mutuellement combinés des crises humanitaires et des épidémies, ainsi que le potentiel de l'action humanitaire dans les contextes épidémiques. À la suite de la pandémie de COVID-19, l'UE agit rapidement pour renforcer sa propre résilience aux chocs sanitaires, notamment aux épidémies, et pour jouer un rôle plus important dans la sécurité sanitaire mondiale. La création de la direction générale de l'Autorité de préparation et de réaction aux urgences sanitaires (DG HERA), le nouveau règlement sur les menaces sanitaires transfrontalières, le nouveau mandat étendu du Centre européen de prévention et de contrôle des maladies (ECDC) et l'annonce d'une nouvelle stratégie de sécurité sanitaire mondiale sont des exemples majeurs de cet agenda (sous le titre général d'Union européenne de la santé). Au sein de la DG ECHO, un nouvel outil de réponse - la capacité européenne de réponse humanitaire (EHRC) - a également été annoncé récemment, sur la base de l'expérience acquise lors de l'épidémie COVID-19 et d'autres épidémies à fort impact. Ces nouvelles initiatives sont passionnantes, mais elles vont également ajouter une certaine complexité organisationnelle, en particulier à court et moyen terme. L'évaluation a permis de dégager plusieurs conclusions relatives à ce défi. Il existe déjà une multitude d'agences, d'unités de mise en œuvre et d'initiatives au sein de l'UE qui ont toutes une incidence sur les épidémies. Les parties prenantes de l'UE n'ont pas conscience de la manière dont elles travaillent toutes ensemble actuellement et de la manière dont la création de nouveaux organes, outils et initiatives pourrait changer les choses. Il a également été constaté que les entités européennes concernées n'avaient pas été bien coordonnées dans la réponse aux épidémies dans un passé récent. Enfin, bien que la DG ECHO ait un rôle clé à jouer - et l'ambition d'en faire plus à l'avenir - elle est considérée comme réticente par les parties prenantes de l'UE, et comme cédant tout leadership sur les dimensions humanitaires de la sécurité sanitaire mondiale à d'autres services de la CE. Cette méfiance au sein de l'UE au niveau du siège contraste fortement avec le leadership de la DG ECHO et son appétit pour la coordination entre les acteurs externes sur le terrain.

Recommandation stratégique 4: renforcer l'efficacité des outils, instruments et pratiques existants

La DG ECHO contribue déjà efficacement à la lutte contre les épidémies dans les contextes humanitaires, mais elle pourrait encore améliorer ses performances en apportant des ajustements relativement simples à ses outils et méthodes de travail actuels.

Tout d'abord, l'outil Epidémies devrait être mis à jour et occuper une place plus importante dans l'ensemble des instruments de financement de la DG ECHO. En l'absence de politiques fortes ou de programme spécifique sur les épidémies, l'outil Epidemics est le seul instrument de la DG ECHO consacré aux épidémies. Il est très apprécié, mais n'est pas utilisé aussi souvent qu'il pourrait l'être. Le montant moyen actuel des subventions est probablement trop faible pour avoir un impact sur la trajectoire d'une épidémie, même dans ses premiers stades, et le déblocage des fonds au titre de cet instrument a ralenti de manière significative en 2020-21. Les lignes directrices régissant la manière dont il peut être utilisé sont également assez ambiguës en ce qui concerne la préparation.

Deuxièmement, il convient d'accorder une plus grande attention à la manière dont les interventions épidémiques sont sélectionnées, et la justification de l'approche spécifique devrait être décrite de manière plus complète dans les documents d'Action. L'ET a constaté que la majorité des propositions de réponse aux épidémies sélectionnées pour le financement n'expliquaient pas suffisamment le contexte, en particulier les besoins et les lacunes de la réponse, et pourquoi l'intervention proposée était la meilleure, plutôt que celle qui convenait le mieux au PE. D'après les documents d'Action, il semble qu'un trop grand nombre de ces propositions aient été approuvées avec un minimum de contestation ou de commentaires de la part des experts de terrain et des responsables géographiques de la DG ECHO. L'ET a donc douté que les interventions sélectionnées soient toujours les plus appropriées et les plus ambitieuses.

Troisièmement, la protection civile potentielle et les interventions en nature similaires doivent être harmonisées avec la fourniture de l'aide humanitaire de manière objective et holistique, sur la base des principes humanitaires. La DG ECHO comprend une aile de protection civile (qui s'est largement concentrée sur l'intérieur de l'UE) et une aile d'aide humanitaire (qui se concentre sur l'extérieur). Les initiatives récentes

visant à déployer des instruments de protection civile pour soutenir l'aide humanitaire - en passant "du bailleur de fonds à l'acteur" - sont prometteuses. Cependant, il a été démontré que certaines de ces initiatives étaient motivées par les besoins politiques des parties prenantes de l'UE pour une "action" visible, plutôt que d'être priorisées sur la base des besoins. Cela creuse les divisions entre les branches de la protection civile et de l'humanitaire, alors qu'elles doivent encore se compléter et se valoriser mutuellement. En outre, des affirmations plutôt exagérées sont faites sur la contribution de la protection civile à l'action humanitaire. Certaines de ces initiatives sont encore sous-développées ; et certaines d'entre elles seront toujours d'une importance marginale étant donné les contextes souvent difficiles dans lesquels l'aide humanitaire opère.

Quatrièmement, la DG ECHO devrait explorer les moyens d'accéder aux capacités de réponse aux épidémies de manière flexible, notamment en recherchant des partenariats avec des institutions spécialisées de confiance. Les épidémies sont épisodiques et imprévisibles. Il est logique de pouvoir faire appel à une expertise externe en cas de besoin, mais dans des cadres à long terme. En particulier, la DG ECHO pourrait bénéficier d'une expertise épidémiologique pour mieux comprendre les tendances des épidémies. D'autres types de soutien potentiel pourraient provenir de partenaires stratégiques de la DG ECHO, d'anthropologues de la santé, d'experts en résilience et en préparation aux épidémies, et de conseillers en gouvernance.

Recommandation stratégique 5: intensifier les travaux visant à combler le lien en mettant l'accent sur la préparation.

La DG ECHO devrait commencer à programmer des travaux ciblés et bien structurés sur la préparation aux épidémies dans certains contextes humanitaires, en incluant éventuellement une recherche-action. Les recommandations stratégiques ci-dessus sont toutes pertinentes pour mieux travailler sur le lien entre l'humanitaire et le développement, mais cette question est si importante qu'elle mérite d'être regroupée dans une recommandation spécifique. Les hauts responsables de la DG ECHO ont déjà reconnu que l'une des principales leçons des récentes épidémies est la nécessité d'adopter une approche à plus long terme et de travailler avec d'autres acteurs du nexus humanitaire-développement. La DG ECHO a déjà une certaine expérience en la matière (par exemple, au Sud-Soudan), mais les exemples sont relativement peu nombreux, ponctuels et manquent d'orientation. Les praticiens sur le terrain ont l'impression de manquer d'autorité en l'absence d'orientations claires et d'une forte impulsion de la part de la direction. Combler le lien entre l'aide humanitaire et le développement peut sembler décourageant lorsque le fossé entre l'aide humanitaire et le développement est très large. Cependant, le travail sur la préparation aux épidémies est un bon point de départ. Il peut s'inscrire dans le cadre de l'action humanitaire, mais peut s'inspirer fortement des pratiques de développement, utiliser la recherche-action et offrir une voie potentielle vers un renforcement des systèmes de santé si la situation humanitaire se résorbe.

Partie B

Recommandation stratégique 1: élaborer conjointement un cadre stratégique pour l'engagement dans les contextes humanitaires

L'établissement d'un partenariat stratégique nécessite une vision et une structure communes, ainsi qu'une compréhension mutuelle des forces et des lacunes de chaque partenaire. Les réunions annuelles de haut niveau et les actions de suivi associées n'apportent pas l'élan nécessaire pour renforcer le partenariat à tous les niveaux afin de réaliser sa valeur ajoutée potentielle. Le partenariat a besoin d'un cadre pour définir ce qu'il veut réaliser et comment il veut s'engager dans les contextes humanitaires, ainsi que les domaines de la santé dans lesquels il veut investir des ressources et de l'expertise, y compris la politique et le plaidoyer.

La première étape de ce processus consiste pour la DG ECHO et l'OMS à se réunir pour recenser les domaines d'intérêt commun, les points forts de chaque organisation, les domaines de complémentarité et de synergie, ainsi que les domaines de désalignement ou les obstacles à la réalisation d'une approche unifiée. Idéalement, le partenariat peut identifier les priorités stratégiques qui peuvent être intégrées dans les deux organisations et à tous les niveaux, qu'il s'agisse de garantir des services de santé mentale dans toutes les réponses ou d'intégrer le renforcement de la résilience dans toutes les Actions.

Le développement du cadre n'est pas seulement un exercice au niveau du siège, il nécessite une appropriation globale et des contributions à tous les niveaux, en élaborant les priorités stratégiques de bas en haut afin qu'elles reflètent les besoins humanitaires en matière de santé sur le terrain. Cela nécessite un regard collectif sur les besoins des différents pays. Les dialogues formels à plusieurs niveaux peuvent servir de forum pour les différentes étapes de l'élaboration du cadre.

Le cadre peut servir de guide entre les niveaux et les fonctions, garantissant la cohérence des priorités politiques et stratégiques entre le siège, les branches politiques et opérationnelles du partenariat. Pour que le cadre soit mutuel, les deux partenaires doivent apporter à la table une réflexion cohérente et stratégique sur la santé et trouver l'alignement naturel de leurs cadres respectifs qui peut guider le partenariat. Cela peut être un défi pour la DG ECHO sans une approche actualisée et unifiée de la santé, un domaine auquel il faudra accorder la priorité à l'avenir.

Recommandation stratégique 2 : engager un dialogue et une communication plus fréquents, plus inclusifs et plus stratégiques.

Le partenariat a connu une amélioration du dialogue à différents niveaux (mondial-mondial, pays-pays), mais le manque de cohérence entre les niveaux a créé une coupure qui a un impact sur les efforts du partenariat. Même si le DSH - au sommet du partenariat stratégique - a renforcé le partenariat entre la DG ECHO et l'OMS, il n'est pas issu d'un processus stratégique et reste très exclusif, ayant peu d'impact au niveau opérationnel. Les DSH doivent être renforcés par un processus plus inclusif et plus stratégique, en élargissant la participation pour impliquer les niveaux techniques et opérationnels de la DG ECHO et de l'OMS, et en formalisant les résultats pour une diffusion plus large.

Le dialogue au niveau régional a été limité et au niveau national il est incohérent, dépendant du contexte du pays et marqué par des ruptures de communication au sein de chaque organisation. Un cadre stratégique global pour l'engagement (recommandation stratégique n° 1) peut résoudre bon nombre de ces problèmes en fournissant un cadre commun pour le dialogue à tous les niveaux et en établissant des liens entre les niveaux fonctionnels. Toutefois, le partenariat doit également s'attaquer directement à la qualité et à la fréquence du dialogue. La DG ECHO peut améliorer la qualité en soutenant les efforts continus de l'OMS pour renforcer ses capacités à s'engager dans les processus de la DG ECHO. Un exemple d'un tel soutien est d'aider à démystifier les processus de la DG ECHO en invitant l'OMS à participer aux ateliers de processus de la DG ECHO organisés dans les pays.

Le partenariat doit étendre les dialogues formels et documentés à tous les niveaux, siège, régions et pays. Les dialogues doivent être menés de manière stratégique avec des objectifs clairs. Il est important de procéder à un enrichissement mutuel, en rapprochant l'expérience opérationnelle du siège, en impliquant davantage de personnes sur le terrain et de techniciens au sein du DSH, et en incluant les responsables politiques du siège dans les dialogues opérationnels.

Recommandation stratégique 3: explorer des accords de partenariat innovants qui combinent les forces uniques de chaque organisation pour travailler sur des objectifs communs de plus haut niveau.

Il existe des exemples importants où le partenariat a su tirer parti de ses avantages comparatifs pour sauver des vies. Par exemple, au niveau mondial, avec les programmes de santé mentale et de soutien psychosocial (MHPSS) et d'équipes médicales d'urgence (EMT), et au Yémen, en Syrie et en Afghanistan par le biais d'un plaidoyer commun en faveur de la santé. La DG ECHO et l'OMS s'accordent à reconnaître la valeur d'investissements plus efficients, plus efficaces et plus percutants dans la santé dans les contextes humanitaires.

Parmi les deux partenaires - et surtout au niveau opérationnel - la DG ECHO est moins claire sur la valeur qu'elle pense que l'OMS ajoute aux contextes humanitaires. Toutefois, grâce à un dialogue structuré à tous les niveaux - et à la reconnaissance mutuelle et à l'appréciation des forces comparatives - la DG ECHO peut

tirer parti de l'expertise normative et technique de l'OMS pour aider à combler les lacunes de sa politique de santé (comme un cadre pour la réponse aux épidémies). Au plus haut niveau, la DG ECHO reconnaît que l'OMS est une organisation de développement polyvalente ayant une dimension humanitaire. La DG ECHO peut s'appuyer sur cette reconnaissance pour mettre en œuvre ses engagements dans le cadre du Grand Bargain.

Du côté de l'OMS, on a l'impression que les plans de mise en œuvre de l'aide humanitaire (HIP) et la boîte à outils sur les épidémies de la DG ECHO sont appréciés, mais limités en termes de portée, de calendrier et de financement, ce qui conduit à des occasions manquées, en particulier pour progresser dans les crises prolongées et pour combler le lien. Pour l'OMS, le partenariat stratégique établirait de préférence des mécanismes de financement en dehors des HIP en explorant des mécanismes alternatifs qui vont au-delà des subventions multi-pays. Des approches de financement alternatives et innovantes peuvent garantir un travail efficace sur la préparation et des réponses plus rapides et plus appropriées aux futures urgences de santé publique dans les contextes humanitaires.

S'engager dans des modalités de financement alternatives telles que les partenariats programmatiques pilotes (PPP) peut mieux intégrer les approches de résilience dans les investissements, afin que le partenariat puisse avoir un impact à plus long terme. L'augmentation des investissements dans les financements innovants nécessitera l'adhésion des dirigeants et un goût du risque, en particulier au niveau du siège. Il s'agit là d'un grand pas en avant sans une meilleure compréhension des performances et du potentiel de l'OMS : une première étape pourrait consister pour la DG ECHO à commander un examen indépendant de l'OMS en tant qu'exécutant, ce qui dépassait le mandat de cette évaluation.

En outre, les deux organisations pourraient explorer des collaborations tripartites et multilatérales avec d'autres services de la CE, tels que la DG INTPA, pour traiter des activités de résilience et de liaison, ou avec d'autres agences techniques/de mise en œuvre pour maximiser les échanges techniques et envisager des initiatives conjointes.

Les recommandations 1 et 2 peuvent toutes deux s'inscrire dans ce processus d'exploitation des forces respectives de chacun.

1. Introduction, purpose and scope

This evaluation has three purposes: 1) to provide an external, independent and thematic assessment of Directorate-General for European Civil Protection and Humanitarian Aid Operations' (DG ECHO) worldwide Actions in response to epidemics in third countries; 2) to contextualise the DG ECHO response to epidemics in the broader European Union (EU) response, and provide an analysis of how to strengthen its position in future responses; and 3) to provide a retrospective assessment of DG ECHO's partnership with the World Health Organization (WHO) globally, with a focus on identifying lessons learned and good practices (Terms of Reference (TOR)).

In accordance with the TOR, this evaluation is divided into two parts:

- Part A: DG ECHO's Humanitarian Response to Epidemics
- Part B: DG ECHO's Partnership with the World Health Organization[1]

These parts are understood to be separate, but related. There are predictable overlaps regarding epidemic response, but also in terms of policy, coordination, advocacy and collaboration on preparedness and response to health emergencies. Both Part A and Part B are global in scope, together covering over 190 separate interventions in over 50 countries.

Through discussions between the Evaluation Team (ET) and the Evaluation Steering Group (ESG) it was clarified that the focus for Part A should mainly be on DG ECHO's performance as a humanitarian donor in developing countries. DG ECHO's role in Civil Protection (CP) remains relevant, particularly in terms of interaction between the Union Civil Protection Mechanism (UCPM) and the humanitarian field network, but was considered to a lesser degree.

Through the same dialogue during the evaluation's inception phase, it was also agreed that DG ECHO's humanitarian response to the wider socio-economic effects of epidemics (e.g., nutrition, protection, cash transfers) would not be covered. The ET regarded this 'filter' as especially important in the context of the COVID-19 pandemic, which affected everything and everyone in multiple ways during the second half of the period under evaluation. The Part A evaluation was therefore only focused on the classic activities or 'pillars' of any public health response to infectious disease outbreaks (including preparedness measures). In terms of funding instruments, it was agreed this evaluation would focus only on the Humanitarian Implementation Plans (HIPs) and the Epidemics Tool.

Clarification was also received from the ESG that particular attention should be given to Relevance and Coherence – and that the evaluation should be strategic in nature and represent more than a simple 'audit' of results. The background to this is the global re-emergence of infectious disease as a key health concern, and the rapid and unprecedented evolution of a response to this threat at European and global levels. There is a sense that this epidemic response architecture has not yet settled – and also that the *health security* response has not been equitable, having prioritised the safety of populations in high-income countries at the expense of those where DG ECHO typically operates. DG ECHO has a pivotal role in health emergencies in humanitarian contexts – as a response arm which spans humanitarian aid and civil protection – and has a mandate to coordinate these efforts with other EU bodies. Nonetheless, some of these other bodies (e.g., Directorate-General for Health and Food Safety (DG SANTE), Directorate-General for International Partnerships (DG INTPA), European Centre for Disease Prevention and Control (ECDC), etc.) also have important roles in relation to epidemics, and more are emerging (i.e., Directorate-General for Health Emergency Preparedness and Response Authority (DG HERA) – which was created in the aftermath of

[1] It is important to note that while PAHO serves as the regional office for WHO in the Americas, it also serves as the specialised health agency of the Inter-American System, rendering it independent from WHO. As such, PAHO has a separate relationship with DG ECHO which is not the focus of Part B. However, PAHO is covered as one of DG ECHO's implementing partners for Part A.

COVID-19 pandemic). The ET was therefore asked to examine DG ECHO's performance as an institution in an increasingly crowded and high-profile policy and coordination space, and to offer suggestions on how it should adapt to this context. This implies less emphasis on the performance of DG ECHO's implementing partners in crisis-affected countries than might usually be the case.

Similarly, the focus of Part B is on the WHO - DG ECHO partnership itself, rather than on how WHO performed in humanitarian settings as a DG ECHO implementing partner. The DG ECHO – WHO partnership has been described as strengthening since 2019, when WHO became an official "strategic humanitarian partner" of DG ECHO. In light of the partnership's evolution, it was agreed with the ESG that Part B should review the "strengthening" and strategic aspects of the partnership, effective communication, governance structures, mechanisms and processes, efficiency, transparency, and the added value of the partnership in addressing health in emergency and humanitarian settings.

2. Methodology

This section outlines how the evaluation was conducted (i.e., the overall approach, data collection and analysis, synthesis and reporting) and will explain which specific methods and tools were used.

2.1. Overall evaluation approach

The ET employed a 'mixed-methods' approach to answer the evaluation questions (EQs). This approach is designed to seek out evidence from a mixture of purposively selected qualitative and quantitative sources, both primary and secondary, and to then triangulate and synthesise the collected data in order to arrive at reasoned assumptions. This research method is well-suited to complex and multi-faceted evaluations. All of the EQs were addressed by the evaluation team's mixed-methods approach, as evidenced in the Evaluation Matrix (Annexe 1).

The TOR initially proposed 17 EQs which, after numerous refinements by the ET and the ESG during the Inception Phase, were reduced to 12 EQs. The resultant EQs were developed to enable the ET to best tackle the dual aspects of this complex evaluation and are laid out in Table 1.

Table 1 Evaluation Criteria and Evaluation Questions

	Evaluation Criteria	Evaluation Questions
Part A	Relevance	1. How appropriate were DG ECHO's plans and interventions in response to epidemics?
		2. To what extent did DG ECHO's actions seek the participation of affected populations at all stages of the humanitarian project cycle, and seek to address their needs and priorities?
	Coherence	3. How coherent was DG ECHO's response with that of relevant external actors?
		4. How coherent was DG ECHO's response with that of other EU/EC actions including those of individual Member States, and how should DG ECHO's role evolve given the EC's strategic intent to strengthen European and global health security?
	Effectiveness	5. How effective have DG ECHO's tools and instruments been in addressing epidemics?
		6. What results were achieved by DG ECHO's epidemics response?
	Efficiency	7. Have DG ECHO's actions in response to epidemics been cost-effective?
		8. To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?

	Resilience/ Connectedness	9. To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?
Part B[2]	Collaborative	10. Is the DG ECHO-WHO partnership strategic and synergistic, with a shared vision that leverages collaborative advantages at all levels?
	Transactional	11. Is the DG ECHO-WHO partnership supported by effective dialogue and fit-for-purpose structures and mechanisms to deliver on its objectives at all levels?
	Transformational	12. What is the added value of the DG ECHO-WHO partnership in contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings?

To supplement the overarching EQs, the ET proposed a series of judgement criteria (JC) during the Inception Phase which served to provide a basis from which to assess the various the merits or successes of DG ECHO's response to epidemics and its partnership with WHO. For each JC, one or more indicators was defined according to the kind of information required to assess how the JC was observed.

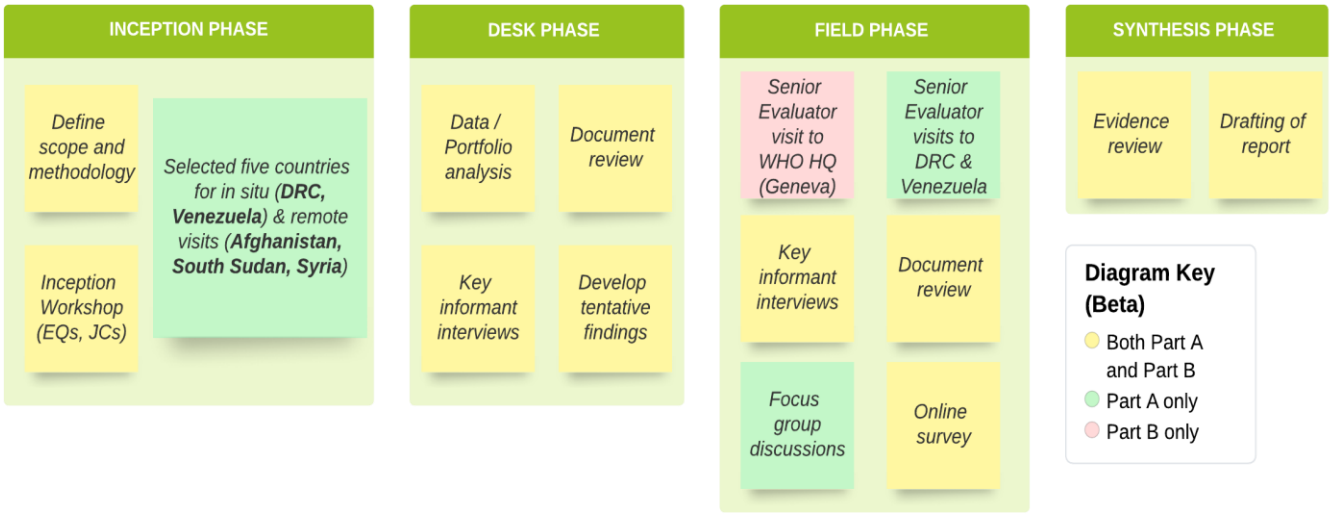
Due to the broad scope of this evaluation, some of the EQs required a high-level policy and global portfolio analysis in order to elicit satisfactory answers. Equally, others necessitated a ground-level lens to observe results from DG ECHO's funded Actions and activities, including drawing from the perspectives of affected persons and other local stakeholders. As a result, the ET was required to source data from both the portfolio/global level (i.e., a quantitative/systematic analysis of relevant HOPE[3] data, policy document review, interviews with DG ECHO and WHO Headquarters (HQ)) and from country/field level (i.e., through interviews with field staff, relevant IPs, representatives from government ministries and conducting focus group discussions (FGDs) with affected populations). The ET's sampling strategy and country visits can be found in Chapter 2.3.

The evaluation (for Part A and Part B) was conducted in four phases: i) the inception phase, wherein which the ET developed a detailed inception report which outlined the scope and methodology of the proposed combined evaluation, as well as confirming the five countries that would be subject to physical visits and remote visits ; ii) the desk phase, which included preliminary Key Informant Interviews (KII) – mainly at a global level – with informants who could provide the ET with a good overview of DG ECHO's policies and partnership structures, and an in-depth study of available data in DG ECHO's HOPE database, in addition to other relevant documentation, in order to produce a desk report which amalgamated tentative findings derived from secondary sources and a detailed portfolio analysis; iii) the field phase which resulted in a field report detailing the key findings from the five field visits for Part A and one mission to WHO's Geneva headquarters for Part B; and iv) the synthesis phase which culminated with the development of this final report which synthesises all the data and settles on findings and recommendations (Figure 1). During the desk phase the ESG approved minor modifications to a few of the EQs and JCs. For Part A, two similar JCs were merged into one, with the EQs and three JCs being reworded for clarity.

[2] Note: part B evaluation questions were slightly modified during the desk phase to strengthen their clarity. These were approved by the ESG in the final Desk Report.

[3] An online database which contains records for all DG ECHO-funded humanitarian health actions.

Figure 1 Evaluation approach



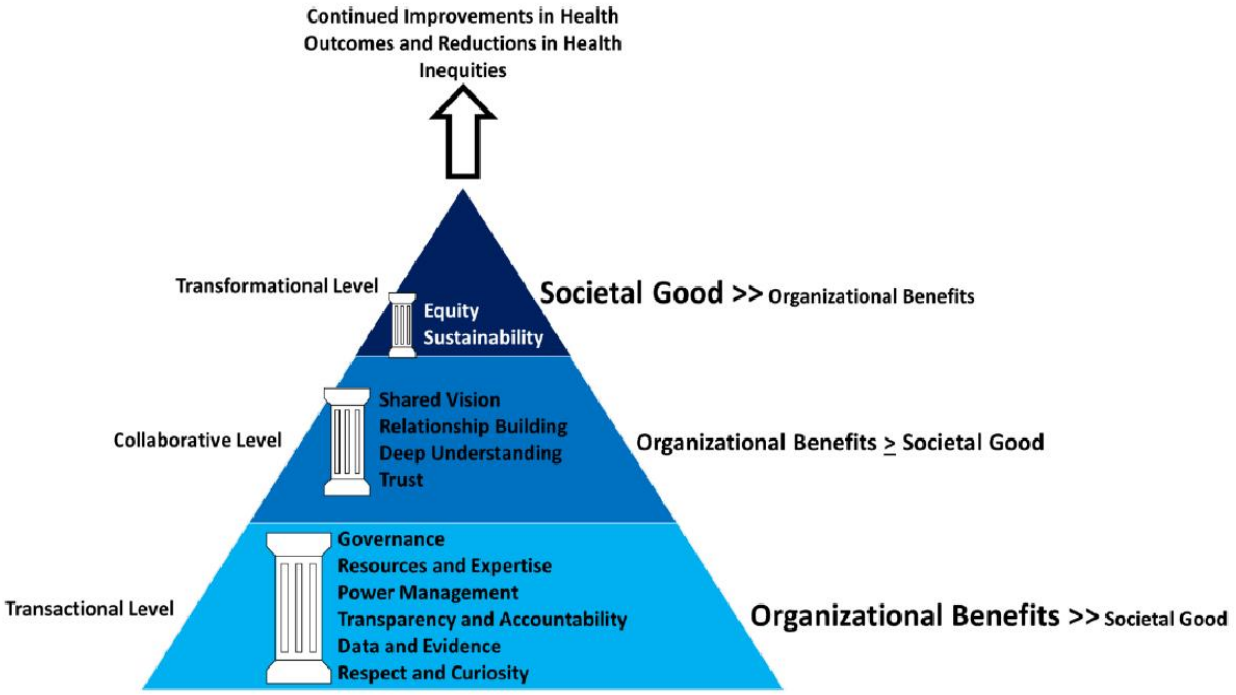
2.2. Analytical framework

For Part A the ET mapped the EQs to Organisation for Economic Co-operation and Development - Development Assistance Committee (OECD-DAC) evaluation criteria, such as relevance, coherence, effectiveness, efficiency. These criteria served as a normative framework from which to evaluate the breadth of DG ECHO's epidemics related activities within the scope of the evaluation.

To frame the evaluation for Part B, the ET adapted a widely accepted theoretical model to achieve successful global partnerships.[4] The model presents 12 pillars spanning three interconnected partnership levels – transactional, collaborative and transformational (Figure 2). The ET subsequently identified three pillars at the transactional level - governance, resources and expertise, transparency and accountability; three pillars at the collaborative level – shared vision; relationship building; and deep understanding; and two pillars at the transformational level – equity and sustainability, and then mapped the EQs and JCs to these levels and pillars.

[4] Schriger SH, Binagwaho A, Keetile M, et al. Hierarchy of qualities in global health partnerships: a path towards equity and sustainability. BMJ Global Health 2021;6:e007132. doi:10.1136/bmjgh-2021-007132

Figure 2 Theoretical model, levels and pillars for successful global health partnerships



2.3. Sampling and data collection methodology

This section outlines the various sources of data used by the evaluation team and characterises the process by which the ET ensured that the data collected was representative of DG ECHO's activities covering epidemic response and its partnership with WHO.

2.3.1. Country visits

The global scope of the evaluation, with its two major components Part A and Part B, posed a significant challenge for the ET in terms of devising a sampling strategy for selecting countries for more detailed analysis. The ET adopted a purposive approach which reduced the "Actions" (i.e., DG ECHO-funded projects and their associated documents) – and countries where the Actions took place – to a representative sample using a number of filters and parameters. A 'long list' of options was produced through this sampling method and, after several rounds of meetings with the ESG and regional health experts, five countries were selected from this list: Afghanistan, Democratic Republic of Congo (DRC), South Sudan, Syria and Venezuela. It is worth noting that the ET argued against the inclusion of some of the countries finally selected due to difficulty of access and a relative lack of DG ECHO-funded epidemics interventions, among other reasons (see 'Limitations Section' [Section 2.5] for a more comprehensive overview).

The long list of Actions from these five countries provided a sample of 23 Actions for the evaluation period between 2017 and 2021 (see annexe 4 for details). The disease types covered were Ebola, Cholera, Measles, COVID-19 and Yellow Fever.

As mentioned previously, a blended approach was used to conduct these country studies, with DRC and Venezuela being visited by Senior International Experts from the ET – supported by local experts; and remotely-managed visits to Afghanistan, South Sudan and Syria – also support by local experts.

The country visits were primarily focused on data collection for Part A. However, there was some degree of crossover with Part B, especially in countries where WHO/ Pan American Health Organisation (PAHO) had a strong presence (i.e., South Sudan, Syria and Venezuela).

The scope of Part B was not limited to the five selected countries in Part A, therefore Actions were selected from a much broader geographic pool. Due to the substantial number of key informants located at WHO HQ for Part B, a one-week mission to Geneva was organised with the assistance of WHO.

Table 2 Timeline of field visits

Country	Field Phase dates	Lead senior expert	Direct / remote
Switzerland	1-5 May	Saba Moussavi	Direct
Venezuela	18 – 31 May*	Jean-Pierre Veyrenche	Direct
DRC	23 – 28 May*	Dr Eric Sattin	Direct
Afghanistan (remote)	23 May – 27 June	Nigel Clarke (TL)	Remote
South Sudan (remote)	30 May – 12 July	Dr Eric Sattin	Remote
Syria (remote)	1 – 10 June	Jean-Pierre Veyrenche	Remote

**The latter date denotes when the Senior Expert left the country. In both Venezuela and DRC data collection activities, such as FGDs, were conducted beyond these dates.*

2.3.2. Data collection methodology

Table 3 Lines and quantitative levels of evidence

Lines of evidence	Quantitative level of evidence
Document review	N=100 (including eSingleForms, FicheOps, HIPs, academic literature, etc.)
KIIs	N=155
Focus Group Discussions Individual discussions with field stakeholders in lieu of FGDs	N=10 N=12
Survey	N=95 (70 from direct invitation and 25 through snowball sampling within the DRC Health Cluster)

Document review

A thematic evaluation of this scale necessitated a continuous process of document harvesting and review which started at the Desk Phase and continued up until the formulation of this final report. Senior Experts on the ET were allotted secondary data acquisition responsibilities by geography and theme (i.e., a specific epidemic type or activity, or various different tools or funding mechanisms). The documentation sources combined a mixture of public documents (i.e., strategic policy documents, factsheets and crisis reports, previous EU assessments/ evaluations and various external documents) and private documents (i.e., eSingleForms (SF) and FicheOps, and internal working documents shared with the ET by DG ECHO). For Part A the Action documents were primarily focused on the five countries. For Part B an in-depth review was conducted on 38 Actions and financial analysis of 61 Actions.

Key informant interviews

The ET carried out a number of semi-structured interviews with an extensive range of stakeholders, as guided by the ET's sample stakeholder analysis from the Inception Phase. The evaluation team conducted a total of 155 key informant interviews across the Desk and Field phases (116 for Part A, 34 for Part B and five were combined.[5] A full breakdown of the target stakeholder groups can be found in Annexe 2).

Focus Group Discussions (FGDs) and informal discussions with local stakeholders

In total ten FGDs were conducted – six in Venezuela and four in DRC – with a combined total of 98 affected persons in attendance. The ET deemed it an integral aspect of this evaluation to ensure that the voices of affected persons were documented, an endeavour which was more relevant for Part A than it was for Part B (as the latter mainly focuses on strategic and institutional relationships). Where possible the Local Experts were encouraged to provide a balanced sample of attendees, both in terms of age and gender. In DRC, there were a total of 37 focus group participants, 49% female and 51% male, with participant age range falling between 27 and 60 years old. In Venezuela, of a total of 61 participants, 87% were female and 13% were male, with a participant age range falling between seven and 98 years old. The disparity in gender representation in Venezuela is circumstantial: women tend to be the health leaders in their communities and are more likely to participate in these activities. Additionally, the programmes which had been implemented by the IP within the region were mainly focused on women and children, hence they were more likely to provide a keener insight during FGDs.

Since DG ECHO-funded Actions in South Sudan during the period 2017-2021 did not include community-level Actions relating to epidemics, it became apparent that facilitating focus group discussions would hold little merit. Instead, the ET sought to include the voices of health personnel on the ground who had benefitted from Early Warning, Alert and Response System (EWARS) and Integrated Disease Surveillance and Response (IDSR) training events. A total of 12 such local stakeholder interviews took place.

Online survey

The ET designed an online survey that covered relevant questions for Part A and Part B. To increase and encourage stakeholder participation, the ET translated the survey into four languages: English, French, Spanish and Arabic. This decision was made so that stakeholders were provided the opportunity to respond to questions in their native language, which may have encouraged more articulate and comprehensive responses.

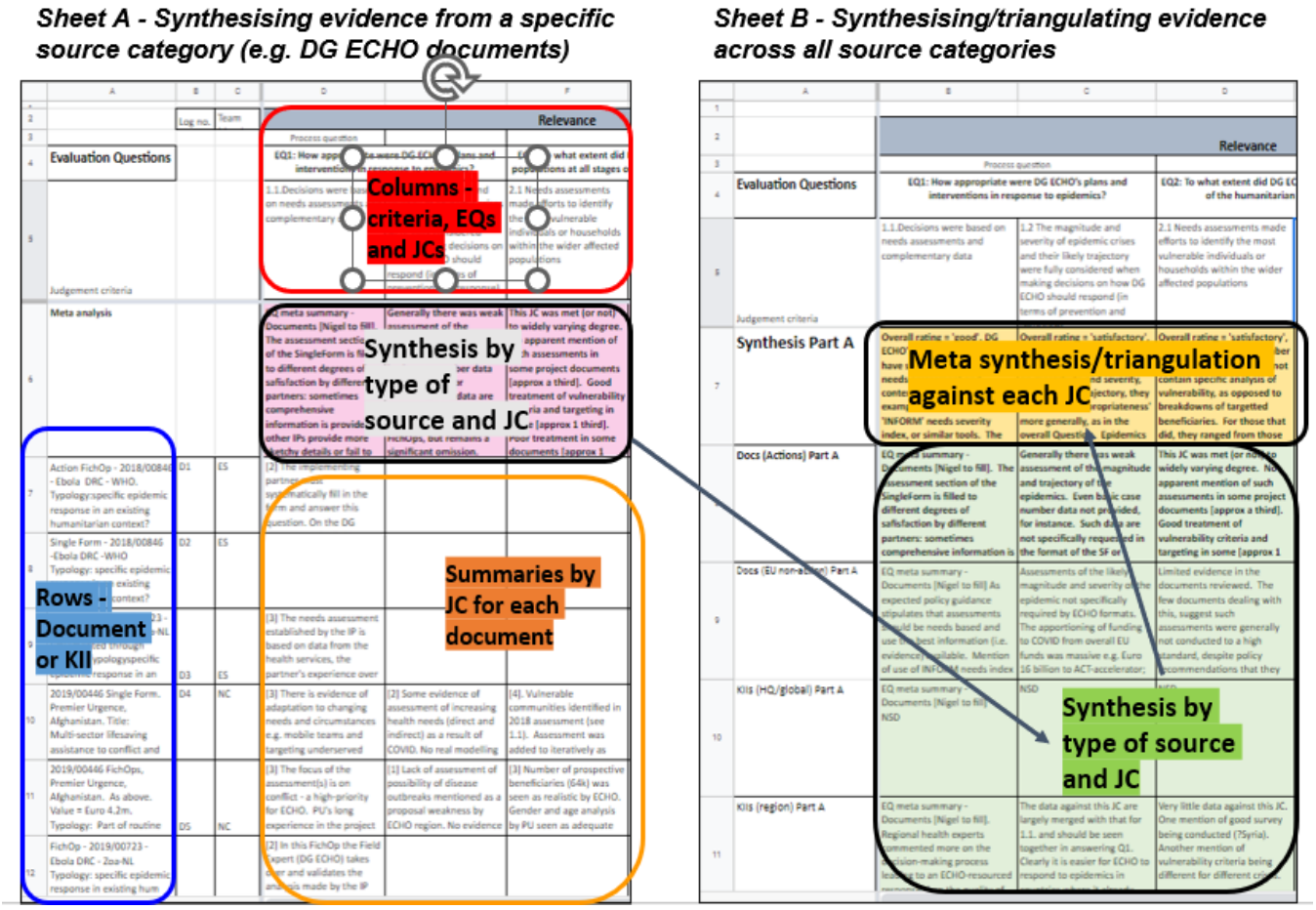
In total, 95 responses were received (70 from direct invitation and 25 through the Health Cluster) from a combined total of 459 individuals who were sent the survey (255 informants were directly invited to participate and 204 via the DRC Health Cluster). Respondents who were directly invited to participate in the survey represented a 27% response rate.

2.4. Data processing and reporting

All relevant data, regardless of its source, were recorded in summary form in an evidence matrix designed by the ET. This matrix was an expanded version of the Evaluation Matrix, but included several Excel sheets wherein data from every single source could be plotted against each relevant EQ and JC. This allowed for a relatively straightforward synthesis of all data relating to an EQ, for analysis by certain strata (e.g., by country, type of informant etc), and provided a clear 'line of sight' between the eventual findings and the evidence contributing to those findings. Since much of the evidence in this matrix was provided on a confidential basis and relates to individual informants, it is not provided as an annexe of this report.

[5] Some key informants were equally relevant for both Parts A & B of the evaluation. To protect the time of these individuals some were interviewed by multiple members of the ET to cover both parts. In these instances, interviews have been counted as two separate interviews. In addition, some interviews were follow-up interviews with the same individual, and these are also counted as separate interviews.

Figure 3 A snapshot of the 'Evidence Matrix' used by the Evaluation Team to cross tabulate data points against judgement criteria



2.4.1. Strength of evidence

Overall, plentiful evidence was collected by the ET during the Desk and Field phases. From KIIs, reviewed documents and FGDs there were over 1,300 separate data items recorded against 26 individual JCs, and this is not factoring in the data recorded by the online survey.

Strength of evidence was calculated as the number of evidence points/sources (KIIs, documents, etc.) - that provided relevant data towards specific JC – against the total number of sources for both Part A and Part B of the evaluation. This resulted with a "heat map" which enabled the ET to easily identify the level to which each EQ and JC was supported by associated data.

2.5. Limitations of the data

The scope of the evaluation in the TOR was very broad, and whilst the Inception Report sought to refine the scope, there remained various limitations which were navigated by the evaluation team to the best of their ability.

Restrictions on movement and data collection

There were various restrictions on movement, even for the countries deemed feasible to be visited by international experts (DRC and Venezuela), for reasons including the COVID-19 pandemic and general security considerations. The safety of both Senior and Local Experts and of those with whom they interacted was of paramount importance, and therefore their movement in-country was undertaken with caution.

Direct observation was not a method of this evaluation and, broadly speaking, evaluators did not travel outside of capital cities or major secondary hubs, with the exception of Venezuela where the Local Expert

collected data in the state of Sucre. The principal reason for this was practical constraints (often security related) to their work, including the ability to conduct FGDs.

In Afghanistan, IPs were often unable to support the ET in arranging data collection activities due to having busy schedules, an issue compounded by the devasting 5.9 magnitude earthquake which struck the Khost region of Afghanistan on June 22 and which, rightly, diverted humanitarian attention.

Sampling of Actions

The high volume of Action documents in the scope and the respective length of the SFs and FichOps meant that the ET could only analyse a limited sample in depth.

Participation of affected persons

Due to its global and strategic policy aims, the evaluation did not seek a truly bottom-up approach to evidence gathering. This being said, a concerted effort was made by the ET to include the voices of affected persons, as evidenced through the FGDs and interviews with local personnel on Risk, Communication and Community Engagement (RCCE) activities in the relevant countries.

Diversity

The TOR did not require the evaluation to focus specifically on gender or disability or other socio-economic factors, as a means of analysing disparities in access to resources and meaningful participation. Nonetheless, the ET also acknowledges its own limitations in terms of diversity. Genuine attempts, however, were made to include analysis of DG ECHO's consideration of disparities of wealth and power in its decision making and activities, especially through the ET's approach to country level KIIs and FGDs.

As such, a concerted effort was made, where possible, to ensure a gender-balanced team of local experts in each country that was subjected to a more in-depth analysis. In some scenarios, especially when dealing with vulnerable persons or when tackling sensitive issues, affected persons can be more comfortable communicating with interviewers/facilitators who are the same ethnicity or gender as them, thus creating an environment where responses to questions are often more detailed and reliable.

In total six local experts were hired, three of whom were men and three were women.

Involvement of WHO

WHO was not actively involved in the evaluation until after the Inception Phase and well into the Desk Phase. This created some challenges and delays with regards to accessing key informants and WHO resources, particularly during the Desk Phase.

WHO HQ requested that the ET liaise with both WHO HQ and regional offices before reaching out to WHO staff for interviews at all levels. While this was very useful for successfully connecting with WHO staff in HQ and most of the regional and country offices, this was not the case for the African regional office (AFRO), which was unresponsive and did not assist the ET to connect with country level staff in the African region. For this reason, there are fewer inputs from WHO AFRO, especially for Part B.

During the commenting periods for each significant evaluation deliverable (i.e., inception report, desk report and field report), DG ECHO shared drafts with WHO, but WHO responses were often delayed, and in some instances – notably at the inception and desk phases - WHO were unable to provide their feedback at all.

Selection of countries for field phase

Through diligent purposive sampling, which involved a comprehensive analysis of DG ECHO's global epidemics-related Actions, the ET placed a great emphasis on representativeness. Initially The ET proposed countries that covered the full range of different types of epidemic, of types of Epidemics Tools used, as well as a variety of humanitarian situation (large/small, sudden/protracted) and geographic coverage. However,

the ESG insisted that the ET focus on countries that were of more current and strategic importance for DG ECHO, even though they had relatively limited epidemics programming, and for two of which international visits were impossible.

Furthermore, in South Sudan, the nature of the ECHO-funded Actions meant that community-level engagement was unlikely to yield meaningful data, and economic sanctions in Syria impeded the contracting of Local Experts to support with in-country data collection activities.

DG ECHO and IP staff turnover

Staff turnover meant that it was difficult to find respondents that could speak to Actions before 2020 in most cases. This was particularly true in Afghanistan, whereby none of the current health focal points had worked on epidemic response between 2017-2021.

2.6. Ethical standards and principles

The ET members abided by and upheld the European Consensus on Humanitarian Aid as well as internationally recognised ethical practices and codes of conduct for evaluations. The whole evaluation was guided by Active Learning Network for Accountability and Performance in Humanitarian Action's (ALNAP) Evaluation of Humanitarian Action Guide, the Sphere Handbook (SPHERE) and Standards for Monitoring and Evaluation, and Ethical Research Involving Children. In addition, the team ensured the highest quality standards in terms of comprehensiveness (OECD-DAC evaluation criteria); proportionality (tailoring the scope of the evaluation to the maturity of the intervention being assessed and data available); independence and objectivity (robustness and reliability of results; conducting the evaluation without influence or pressure from any organisation; and full autonomy of the team in conducting and reporting their findings); transparency of judgement (based on data available and previously agreed judgement criteria); and evidence-based (collected and triangulated from different sources, with clear limitations addressed).

In addition to more general considerations required to maintain an ethical evaluation design, the ET took particular care to mitigate against the elevated risks to vulnerable populations during the current global COVID-19 pandemic. Landell Mills takes the protection of vulnerable populations extremely seriously and this design was grounded in an understanding that vulnerable groups should not be exposed to contact with persons with whom they would not ordinarily cross paths, unless it is possible to ensure the environment is COVID-19 negative (i.e., prior testing has taken place). In many ways, the pandemic is a reminder that Do No Harm is a principle that must be upheld through active efforts to minimise risk particularly for those who are already experiencing trauma and/or humanitarian need. As such, this methodology was tailored to ensuring remote consultation was carried out where possible and beneficiary views were incorporated into the evaluation findings through locally-led (either through local beneficiary representatives or local evaluation experts) data collection activities.

2.6.1. Statement of validity

The evaluation team considers that the review of documents, interviews conducted, online survey and field observations provided sufficient data and triangulation for the evaluation findings to be valid.

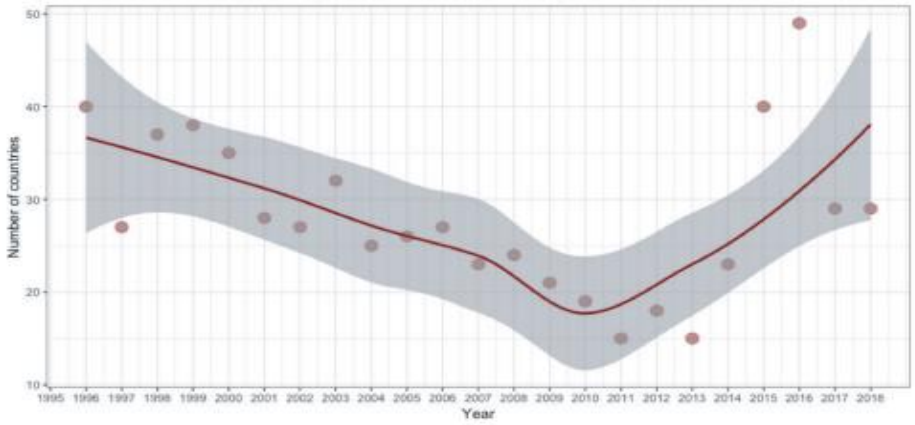
3. Context and portfolio analysis

This section describes the context of DG ECHO's response to epidemics during the period 2017-2021. It outlines the resurgence in recent years of infectious disease as a major global health concern, and how the international community, including the EU, DG ECHO and the WHO have responded, through new health security architecture and partnerships. It also sets health emergencies within the wider context of unprecedented challenges for humanitarian action as a whole.

3.1. The resurgence of infectious disease epidemics

Accurate measurement of the growth of epidemics is challenging due to variations in levels of disease surveillance and communications, as well as the likely bias resulting from the exponential growth of internet use since 1990. Nonetheless, analysis of WHO Disease Outbreak news between 1995 and 2018 by (Harvard Global Health Institute and the World Economic Forum) suggests that the number of countries experiencing significant outbreaks has been increasing since 2010.[6]

Figure 4 Number of countries experiencing significant disease outbreaks, 1995-2018



Source: Harvard Global Health Institute/World Economic Forum analysis of data from WHO Disease Outbreak News (http://www.who.int/csr/don/en/)

Even before the COVID-19 pandemic it was observed that novel zoonotic diseases were mainly responsible for this increase[7]. Whereas human-specific diseases have been declining in their range and impact (in terms of cases per capita), the same cannot be observed for zoonoses[8]. Various modelling exercises have predicted that this trend of increasing zoonosis will continue[9].

This increase in outbreaks and projected trajectory, from both known and new diseases, has been characterised by the US Centres for Disease Control and Prevention (CDC) as "emerging infectious diseases" and this terminology has been adopted by the TOR for this evaluation. This term encompasses:

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognised infections appearing in areas undergoing ecologic transformation

[6] https://www3.weforum.org/docs/WEF%20HGHI_Outbreak_Readiness_Business_Impact.pdf

[7] Significant outbreaks of zoonotic infectious diseases in recent years include Nipah virus (1999), SARS (2002), Avian Flu (2003), MERS (2012), Ebola (2013-15 and 2018-2021), Zika fever (2015) and COVID-19 (2019).

[8] Smith, Katherine F et al. "Global rise in human infectious disease outbreaks." Journal of the Royal Society, Interface vol. 11,101 (2014): 20140950. doi:10.1098/rsif.2014.0950. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4223919/

[9] https://www.cgdev.org/blog/the-next-pandemic-could-come-soon-and-be-deadlier. Metabiota estimates the annual probability of a pandemic on the scale of COVID-19 in any given year to be between 2.5-3.3 percent, which means a 47-57 percent chance of another global pandemic as deadly as COVID in the next 25 years.

- Old infections re-emerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.[10]

This trend is highly relevant to both parts (A and B) of this evaluation. Firstly, "emerging infectious diseases'' can be considered more likely to occur in low-income countries, including contexts where there are existing humanitarian needs. When outbreaks occur in humanitarian settings, they are also likely to have a greater impact than in non-humanitarian settings. Secondly, major epidemics have the potential to reverse recent progress in meeting Sustainable Development Goals, to increase humanitarian needs and place more pressure on fragile health systems. Epidemic causes, frequency and severity overlap and intertwine considerably with prevailing environmental, social and economic conditions in humanitarian and low-income country contexts. Responding to epidemics is likely to continue – and possibly even grow – as a subset of humanitarian action. DG ECHO responds to outbreaks in humanitarian contexts, and, to a lesser degree, works to control and prevent them in both humanitarian contexts and potential humanitarian contexts.

3.2. Epidemics and global health security

In the 21st century there is increasing recognition among global health actors and policy makers that epidemics and health security are linked closely to other policy areas. Between 2007 and 2010, this manifested in the emergence of the "One Health" concept. It summarises what has long been known, that "animal health, human health, and environmental health are intrinsically intertwined and interdependent"[11] and that the management of global health risks (particularly zoonoses) requires cooperation between human, animal and environmental health sectors.

Global focus on "health security" has accelerated following criticism of global preparedness for - and response to - the 2014 Ebola and 2016 Zika outbreaks, and has naturally captured the attention of global actors and leaders during the COVID-19 pandemic. There is a growing awareness among global health policy makers that health system strengthening (in pursuit of Universal Health Coverage), and health security efforts for prevention and response, need to be pursued in tandem as part of a mutually reinforcing approach to enhancing resilience to infectious disease outbreaks. This new understanding can be seen, to varying extents, in the policies of the WHO, major donors, and groupings such as the G7 and G20.[12]

A collection of countries, international organisations, non-governmental organisations (NGOs) and companies established the Global Health Security Agenda (GHSA) in 2014. To date, the GHSA has 70 members, of which 64 are countries and the rest are non-governmental members, including WHO and Food and Agriculture Organisation (FAO) (which perform the role of "permanent advisors"). Neither the EU nor the Commission is a member; however, eight EU Member States have joined. The vision of this partnership is the prevention of, early detection of, and effective response to, infectious disease threats[13]. Implicit in the creation of the GHSA is the recognition that diseases do not respect international borders or national sovereignty and that too much reliance has, in the past, been placed on the International Health Regulations (IHR) which are implemented with varying degrees of effectiveness by different countries. More international collaboration is therefore needed across a range of initiatives. The GHSA aims to support the implementation of the IHR, but also emphasises the importance of national leader-level (i.e., political) commitment to the issues; collaboration among the health, security, environmental and agricultural sectors; and the importance of global networks/mechanisms in addition to national government capacities.[14]

Other intergovernmental and multilateral organisations have initiated a significant amount of policy discussion on global health security, particularly since the start of the COVID-19 pandemic. This has generated numerous calls for new multilateral financing mechanisms on global health security and pandemic

[10] https://wwwnc.cdc.gov/eid/about/background
[11] https://www.oie.int/en/what-we-do/global-initiatives/one-health/
[12] https://gh.bmj.com/content/3/Suppl_1/e000656
[13] https://ghsagenda.org/about-the-ghsa/
[14] https://ghsagenda.org/

preparedness (or prevention)[15]. The G20 commissioned a "High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response"[16] which has called for a Global Health Threats Fund amongst a range of other recommendations. The World Bank has established the Intermediary Fund for Pandemic Prevention, Preparedness and Response in September 2022. The United Nations (UN), through WHO, established the "Independent Panel for Pandemic Preparedness and Response" (IPPPR), which had a comparable scope. The Biden administration has passed legislation for US participation in a new "Global Fund" for global health security and pandemic preparedness[17]. The need for enhanced multilateral action and financing for health security and epidemics has been discussed at the UN General Assembly[18], the UN Security Council[19] and in communiques issued by the G7[20] and G20[21].

Beyond the GHSA (described above) a number of multilateral partnerships and programmes focussed on epidemic prevention/response and global health security have emerged in the last two decades. Prominent among these are:

- The Global Outbreak Alert and Response Network (GOARN), a partnership of over 250 institutions designed to efficiently pool available expertise and capacity for outbreak response and to effectively mobilise it when needed
- The Global Preparedness Monitoring Board, a high-level political/advocacy body tasked with providing an independent and comprehensive appraisal for policy makers in relation to disease outbreaks and other emergencies with health consequences
- GAVI**,** the Vaccine Alliance, a public-private partnership with a goal of increasing access to immunisation in low and middle-income countries
- The Measles and Rubella Initiative (MRI), a global partnership, founded by the American Red Cross, CDC, UNICEF, the United Nations Foundation and WHO, which leads efforts to control and eradicate both diseases.[22]
- The Global Fund to Fight AIDS, Tuberculosis and Malaria which pools donations from governments and the private sector, making grants totalling more than USD 4 billion each year, and aims to strengthen health systems in ways which will also make them more resilient
- Coalition for Epidemic Preparedness Innovations (CEPI), a global partnership of public, private, philanthropic, and civil society organisations working to accelerate the development of vaccines against emerging infectious diseases and to enable equitable access to these vaccines during outbreaks

Added to these there have been a variety of partnerships, programmes and funding appeals launched by international organisations and multilateral actors since the onset of the COVID-19 pandemic. They include:

- The UN's Strategic Preparedness and Response Plan, a combined plan and appeal prepared by WHO and launched in response to the pandemic
- The Access to COVID-19 Tools (ACT) Accelerator, a multi-agency global collaboration to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines. This includes COVAX – its vaccines arm – which by January 2022 had shipped over one billion vaccine doses to 144 countries and territories.[23]

[15] https://pandemicactionnetwork.org/wp-content/uploads/2021/08/A-New-Multilateral-Financing-Mechanism-for-Global-Health-Security-and-Pandemic-Preparedness.pdf
[16] https://pandemic-financing.org/report/high-level-summary/
[17] https://gjia.georgetown.edu/2021/12/08/measurability-and-inclusivity-challenges-for-the-new-global-health-security-fund/
[18] https://media.un.org/en/asset/k19/k19mtwb7cu
[19] https://www.state.gov/secretary-antony-j-blinken-remarks-to-the-un-security-council-briefing-on-COVID-19-and-vaccine-access/
[20] https://www.g7uk.org/wp-content/uploads/2021/06/G7-Carbis-Bay-Health-Declaration-PDF-389KB-4-Pages.pdf
[21] https://global-health-summit.europa.eu/rome-declaration_en
[22] https://www.unicef.org/supply/media/14281/file/Measles-Measles-Rubella-Combination-Vaccines-Market-and-Supply-Note-Oct-2022.pdf
[23] https://www.gavi.org/covax-vaccine-roll-out

However, the unprecedented global response to COVID-19, a pandemic which had caused at least 6.5 million deaths by October 2022,[24] masks some old truths: that health threats have a disproportionate impact on the poorest and most vulnerable populations, and that high-income countries prioritise the protection of their own citizens rather than sharing precious resources equitably with lower-income nations. In early 2022 over 70% of citizens of most EU member countries had received at least two vaccine doses against COVID-19 whereas only 10.2% of people in low-income countries had received a single dose. The calls for global health equity and ''building back better'' have never been stronger.[25] [26]

3.3. The response of the EU and DG ECHO to infectious disease outbreaks

The *Communication of the EU Role in Global Health* [2010] provides broad policy guidance on international collaboration in pursuit of better global health outcomes, but touches only lightly on the subject of epidemics: "the EU should contribute to global and third countries' national capacities of early prediction, detection and response to global health threats, under the International Health Regulations''[27]. Arguably, the European Commission institutions have not been as prominent as other national or transnational bodies (e.g., United States of America (USA), G7, some EU Member States) in leading the development of global health security policies.

However, the Member States and the Commission are strong defenders of multilateralism in this field and remain committed to strengthening the role of WHO. The EU has observer status at the WHO and its Governing Bodies, and has become increasingly active in sessions of the World Health Assembly and the Executive Board. This is reflected in the growing numbers of EU-sponsored and co-sponsored Decisions and Resolutions, as well as joint statements on behalf of the EU and its Member States in governing body meetings. The 2019 WHA saw a historic first joint statement with the Africa group, while in 2020 the EU tabled and negotiated the "Resolution on COVID-19 response", which was adopted by consensus. The overall EC contributions to WHO rose from USD 105 million in 2012–2013 to USD 412 million in 2020–2021, making the EC the 6th largest contributor to WHO's budget.[28]

The Commission's DG SANTE is a member of the Global Health Security Initiative (GHSI) which has a relatively narrow membership of just eight countries plus the EC and WHO[29]. The GHSI mandate overlaps with that of the GHSA, but it was established earlier in 2001, and focussed initially on chemical, biological, and radio-nuclear terrorism (CBRN) threats to public health.

In 2020, the Council of the EU considered the role of the EU in strengthening the WHO. The conclusions of the Council and of the Representatives of the Governments of the Member States were approved on 6th November 2020, thereby reaffirming the EU's commitment to WHO's leadership, in particular in relation to capacity for preparedness and response in health emergencies, including the following suggestions:

- consideration for revision of the Public Health Emergency of International Concern (PHEIC) system to include differentiated levels of alerts
- distinction between travel and trade restrictions by the IHR
- independent epidemiological assessments on-site in high-risk zones
- increased transparency on national compliance with the IHR[30]

[24] https://covid19.who.int/

[25] Health inequality during the COVID-19 pandemic: a cry for ethical global leadership, Chiriboga et al [2020] https://doi.org/10.1016/S0140-6736(20)31145-4

[26] https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th-session-of-the-executive-board

[27] https://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX:52010DC0128

[28] https://open.who.int/2020-21/contributors/contributor?name=European%20Commission

[29] http://ghsi.ca/

[30] https://www.consilium.europa.eu/en/press/press-releases/2020/11/06/strengthening-the-world-health-organization-the-eu-is-ready-to-take-the-leading-role/

This position translated into EU leadership of the process for the successful adoption of the "Resolution on strengthening WHO preparedness for and response to health emergencies" at the WHA in 2021.

Since 2020, and largely in response to COVID-19, the EU has announced a raft of new initiatives under "Building a European Health Union: Reinforcing the EU's resilience for cross-border health threats" aimed at enhancing its capacity to respond quickly and effectively to emerging health threats. These include:

- transforming the Commission Decision on serious cross border health threats into a Regulation, strengthening coordination at EU level when facing cross-border health threats
- strengthening the mandate of ECDC
- creating a 'EU Health Task Force' coordinated by ECDC to support countries with emergency preparedness and to rapidly intervene in health crises[31]
- an EU4Health funding programme addressing health systems' resilience
- the decision to forge an EU Global Health Security Strategy[32]
- establishing DG HERA to ''strengthen Europe's ability to prevent, detect, and rapidly respond to cross-border health emergencies, by ensuring the development, manufacturing, procurement, and equitable distribution of key medical countermeasures''.[33]
- the cross-border health threats communication.[34]

DG ECHO has played a significant role in the EU's response to global health threats through its response to outbreaks. As a humanitarian aid donor, DG ECHO is a major contributor to the funding of humanitarian health programmes. Health accounted for on average 16.2% of DG ECHO's overall expenditure in the period 2017-2021. This represents € 1.5 billion (or USD 1.72 billion) spent on emergency health programmes in the same timeframe.[35] More specifically with regards to epidemics, DG ECHO can 'tag' Actions it funds to various different attributes using its HOPE database. This includes an identifier for all Actions which responded to epidemics in some way. Over the five-year period in the scope of this evaluation (2017-21), DG ECHO disbursed € 526M in funding towards epidemics, from three different instruments: the Epidemics Tool, Geographical HIPs and 'Commission Decisions'. This represented 4.7% of DG ECHO's overall humanitarian aid disbursements over the same period, which amounted to € 11,076M. Funding from the Epidemics Tool represented 11.5% of overall epidemic funding, as opposed to 85.5% coming from Geographical HIPs and just 3% coming from Commission Decisions.

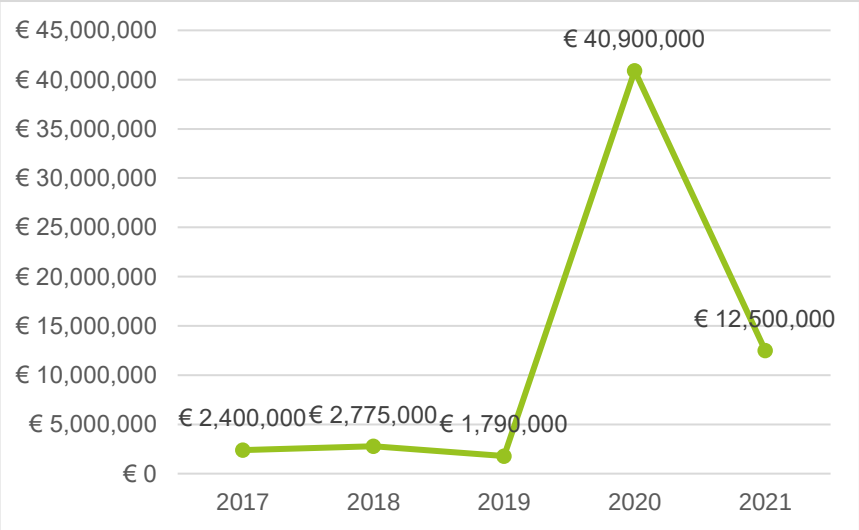
[31] https://ec.europa.eu/info/sites/default/files/proposal-mandate-european-centre-disease-prevention-control_en.pdf
[32] https://ec.europa.eu/commission/presscorner/detail/en/statement_22_3128
[33] https://ec.europa.eu/commission/presscorner/detail/en/ip_21_4672
[34] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52020DC0724
[35] https://fts.unocha.org/

Table 4 DG ECHO funding disbursements for epidemics by year and instrument compared to overall humanitarian disbursements (2017-2021)

Year	Epidemics Tool	Geographic HIPs (Actions including sub-sector of epidemics)[36]	Commission decision on financing a special measure/ humanitarian action	All epidemics funding	All DG ECHO humanitarian funding
2017	€ 2,400,000	€ 83,228,082	€ 1,500,000	€ 87,128,082	€ 3,221,790,466
2018	€ 2,775,000	€ 102,005,803		€104,780,803	€ 1,671,729,716
2019	€ 1,790,000	€ 86,068,000		€87,858,000	€ 2,481,601,610
2020	€ 40,900,000	€ 64,252,097	€ 14,450,000	€119,602,097	€ 1,226,770,937
2021	€ 12,500,000	€ 114,176,200		€126,676,200	€ 2,474,684,138
Total	**€ 60,365,000**	**€ 449,730,182**	**€ 15,950,000**	**€526,045,182**	**€ 11,076,576,867**

Historically, the contribution of the Epidemics Tool to overall humanitarian funding has been very small (averaging around € 2.5M per year in years 2017 to 2019), but the situation changed in response to COVID-19 (see Findings under EQ 5 How effective have DG ECHO's tools and instruments been in addressing epidemics?). The amount disbursed through this funding instrument rose to € 40.9M in 2020, before falling again in 2021.

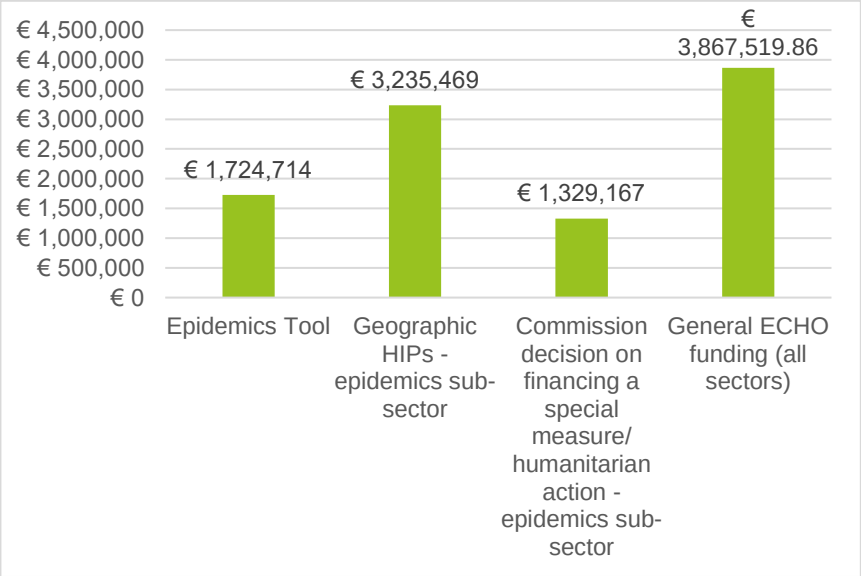
Figure 5 Total disbursements from Epidemics Tool (2017-2021)



Excluding 2020's exceptional COVID contribution (€ 30M), which was managed through the Epidemics Tool more for administrative convenience than because it was a classic Epidemics Tool activity, disbursements through the Epidemics Tool were 5% of disbursements for HIP Actions that included epidemic response. The average size of grant disbursed from the Epidemics Tool (€ 1.7M) was also considerably smaller than those provided under Geographical HIPs (€ 3.2M) (see Figure 6).

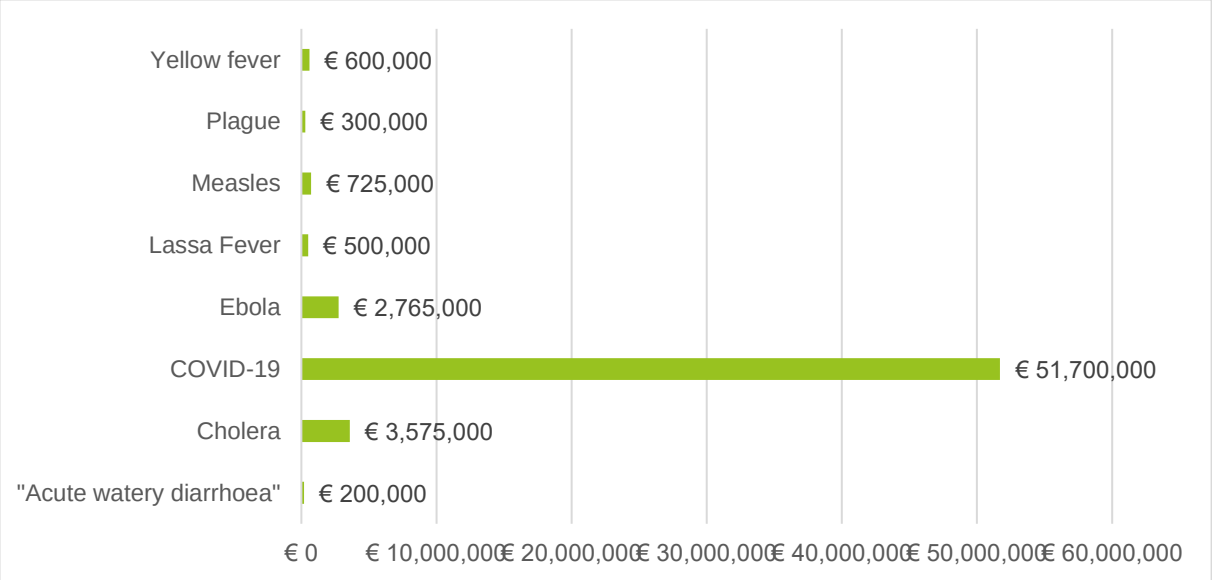
[36] Note to Geographic HIP data – includes total ECHO contract amounts to actions which include (but are not limited to) the sub-sector of epidemic, as tagged in the HOPE database. Contracted amounts for these actions are aggregated at the level of sector but are not registered at the level of sub-sectors. Therefore the proportion of funding that went to epidemic related activities within these actions is likely to be less than the total contracted amounts presented.

Figure 6 Average size of DG ECHO Action budgets by funding decision type (2017-2021)



In terms of which types of epidemic received Epidemics Tool funding, and how total funding was apportioned between them, it can be seen from Figure 7 (below), that by far the largest amount (€ 51.7M) went to Actions addressing COVID-19. This was 86% of the total disbursements, with the remaining 14% being divided between six other types of epidemic, among which Cholera and Ebola were the most notable.

Figure 7 Funding disbursed from the Epidemics Tool by epidemic type (2017-2021)



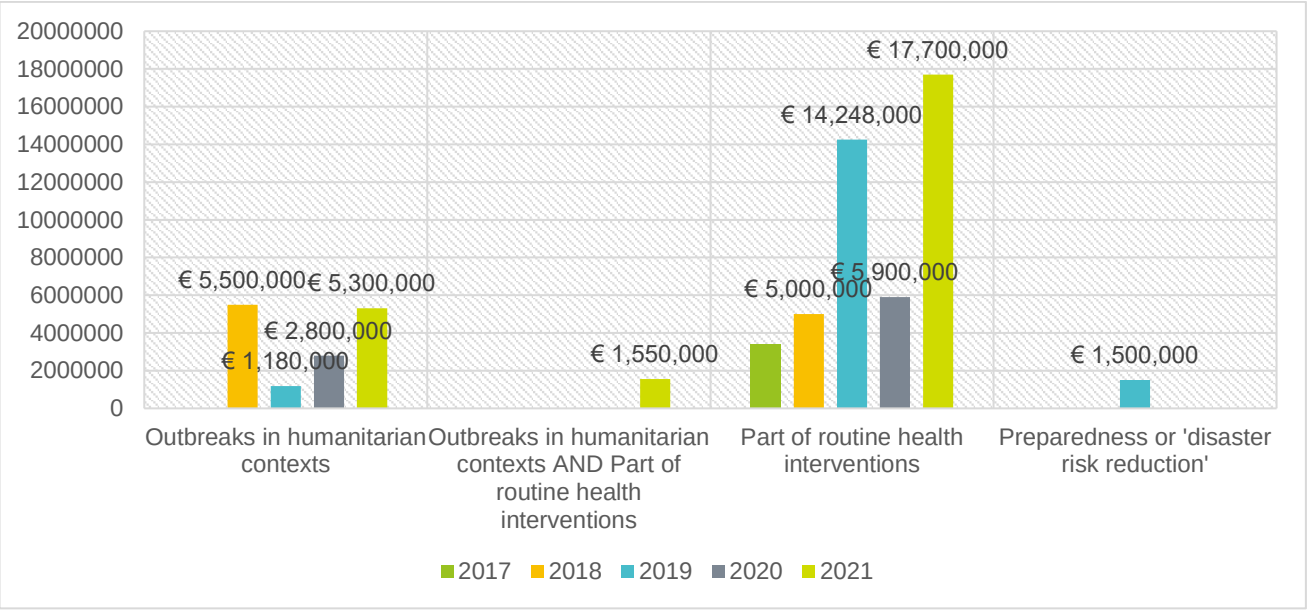
Using a sample of 23 ECHO-funded actions within the scope of the evaluation (see annexe 4 for details of this sample), the ET applied a typology of four categories: actions which were a component of routine health interventions, actions responding to outbreaks in humanitarian contexts, actions responding to outbreaks in non-humanitarian contexts, and actions focusing on preparedness or 'disaster risk reduction'. As shown in Table 5 and Figure 5, by far the most common typology within the sampled actions were actions which were part of routine health interventions, followed by actions responding to outbreaks in humanitarian contexts. DG ECHO funded actions which were classified by the ET as 'preparedness or 'disaster risk reduction' typology occurred to a lesser degree, representing just 2% of the sampled funding.37 Actions responding to outbreaks in non-humanitarian contexts did not arise in the sample.

37 In using this typology the evaluation team regarded 'preparedness' actions as those that focused exclusively on preparedess. A number of actions included elements of preparedness as part of response.

Table 5: Number and total DG ECHO funding of sampled actions (n=23) by typology

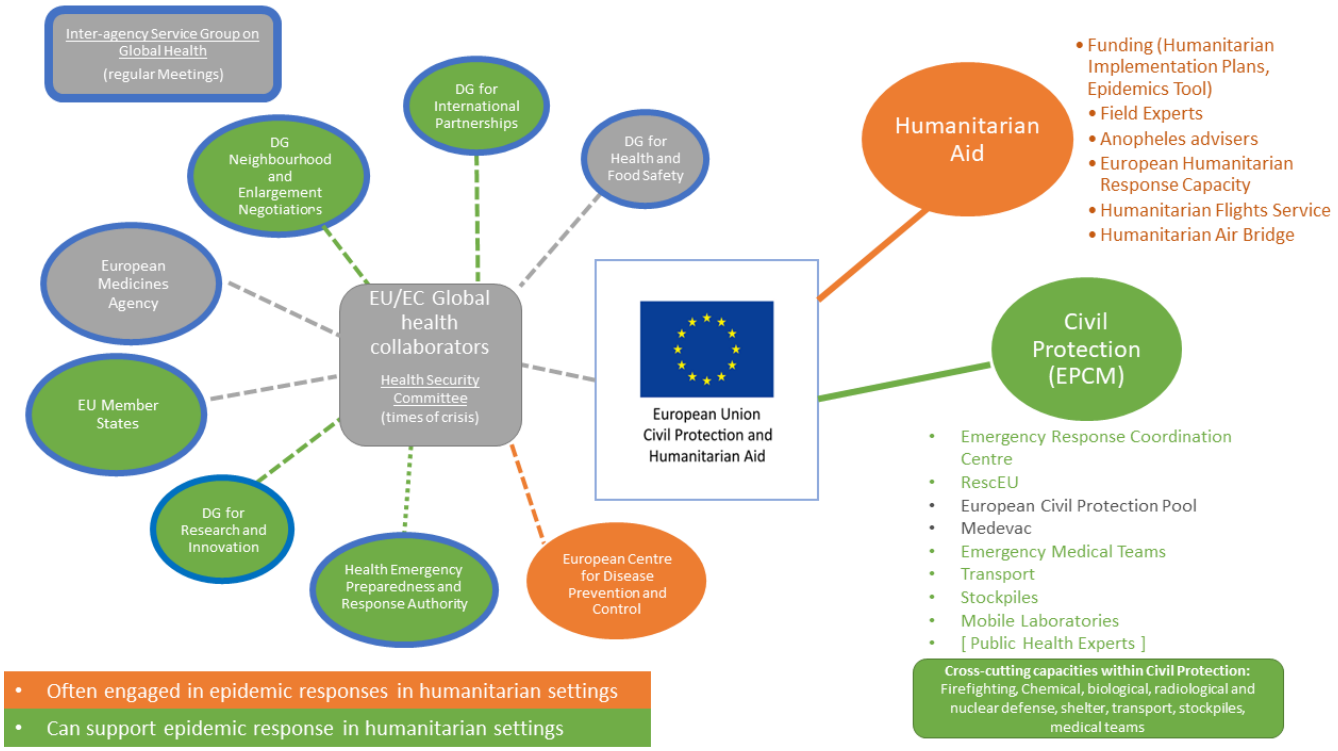
Typology of action	Number of actions	Total DG ECHO Funding
Outbreaks in humanitarian contexts	8	€ 14,780,000
Outbreaks in humanitarian contexts AND Part of routine health interventions	1	€ 1,550,000
Part of routine health interventions	12	€ 46,268,000
Preparedness or 'disaster risk reduction'	2	€ 1,500,000
Total	**23**	**€ 64,098,000**

Figure 8: DG ECHO funding of sampled actions (n=23) by typology and year



Aside from humanitarian funding, DG ECHO maintains other important capacities for responding to global health threats. In 2001, it established a civil protection arm in the form of the UCPM which incorporates the Emergency Response Coordination Centre (ERCC). This centre ensures the rapid deployment of emergency support and acts as a coordination hub between all EU Member States, seven additional participating states, the affected country, UN agencies, Red Cross/Crescent movement and civil protection and humanitarian experts. The European Medical Corps (EMC), established in 2016 under the UCPM, enables quick deployment of teams and equipment from EU Member States and can provide medical assistance and public health expertise in response to emergencies inside and outside the EU (for example, past deployments to Samoa (measles) and Mozambique (cyclone). The EMC is composed of public health teams, mobile biosafety laboratories, medical evacuation capacities, medical assessment and coordination experts and Emergency Medical Teams (EMT). On the latter, WHO collaborates with DG ECHO on the accreditation and preparation of these teams.

Figure 9 DG ECHO wiring diagram for epidemics network



The EU Humanitarian Aid Flight provides passenger (and some cargo) flights in around a dozen countries where the lack of safe and reliable commercial flights would otherwise hamper humanitarian operations. In 2020, in response to COVID-19, DG ECHO added a companion service, the EU Humanitarian Air Bridge, to help meet the logistical challenge of moving large quantities of personal protective equipment (PPE) and other critical supplies to where they were needed most.

Furthermore, as part of the evolution of EU structures in response to the COVID-19 pandemic, a new tool, the European Humanitarian Response Capacity (EHRC), was announced in the *Communication on the EU's Humanitarian Action* (March 2021). This tool will operate within DG ECHO and enable the EU to intervene directly to fill gaps in the rapid delivery of humanitarian assistance. The main components of the EHRC are emergency stockpiles, logistical support and medical emergencies[38].

Finally, a Service-Level Agreement (SLA) was signed between ECHO and ECDC under the terms of which ECDC could support the response in the field during the 2018 - 2020 Ebola epidemic in the DRC. The task was twofold, 1) surveillance to support contact tracing and active surveillance, and 2) support the Analysis cell by analysing the Ebola outbreak to explain the dynamics, analyse the trends and predict what might happen next.

As outlined above, the 'architecture' of the EU's capacity to respond to major health threats is evolving very rapidly, and it may take time for the new and existing structures to establish effective ways of collaborating with each other, as well as with relevant non-EU bodies and EU Member States.

[38] https://civil-protection-humanitarian-aid.ec.europa.eu/what/humanitarian-aid/european-humanitarian-response-capacity-ehrc_en

3.4. The WHO response to humanitarian health emergencies and humanitarian emergencies with health impacts

3.4.1. What is WHO?

As the specialised lead health agency of the United Nations, the WHO deems itself to be the "guardian of global health"[39]. According to its constitution, WHO's mandate is "*to act as the directing and coordinating authority on international health work,*" and it works through its HQ, six regional and 150 country offices[40]. The WHA, comprised of 194 Member States, sets WHO policy, approves and supervises its budget for two-year periods, and elects a Director-General to lead WHO for five-year terms.

WHO's funding comes from two main sources - member states' assessed contributions, which comprise less than 20% of WHO's budget, and voluntary contributions from member states, other UN organisations, philanthropic foundations, the private sector and other sources[41].

Historically, WHO has primarily played a normative role, by establishing global standards in public health, coordinating global health research, and providing technical assistance to countries, including for health emergencies. It is important to note that first, WHO was not traditionally provided with an operational capacity to respond to major health emergencies, and second, as WHO is governed by its member states, it does not have the legal authority to oblige countries to follow its guidelines and technical advice, including those related to the prevention, detection and response of health emergencies.

3.4.2. The legal framework for health emergencies - International Health Regulations

The IHR, first adopted by the WHA in 1969 and most recently revised in 2005 following the 2002–2004 SARS outbreak, are a legally binding instrument of international law that lay out countries' rights and obligations in managing public health events and emergencies that have the potential to cross borders and threaten people worldwide.[42] The 2005 IHR came into force in 2007, with 196 binding countries agreeing to strengthen their capacity to detect, assess, report, and respond to public health events. There are currently 13 core capacities covering disease detection, reporting and response which countries must self-evaluate and report on an annual basis. In addition, since 2016, a Joint External Evaluation has been conducted on a periodic basis as a voluntary and multisectoral process to assess countries' IHR core capacities.

In addition to state requirements to report public health events, the 2005 IHR outlines the criteria to determine whether a particular event constitutes a PHEIC. The PHEIC designation is an important official alert that triggers an international response including funding allocations and surge responses. Once a PHEIC is declared, WHO is also responsible for developing and recommending the critical health measures that member states should implement. Since the 2005 IHR has been in effect, there have been seven PHEIC declarations: the 2009 H1N1 (or swine flu), the 2014 polio declaration, the 2014 outbreak of Ebola in West Africa, the 2015–16 Zika virus epidemic, the 2018–20 Kivu Ebola epidemic, the ongoing COVID-19 pandemic, and most recently the global outbreak of monkeypox[43].

The revised 2005 IHR was meant to address gaps and lead to improved global health security and cooperation. However, numerous published assessments commissioned by high-level panels found that the IHR have been poorly implemented in most countries (particularly in the global south), with incomplete compliance in the case of epidemics, and the process for declaration of a PHEIC by WHO deemed as

[39] https://www.who.int/about/what-we-do/global-guardian-of-public-health.pdf?ua=1

[40] https://www.who.int/governance/eb/who_constitution_en.pdf. Technically PAHO is a regional office, but it also has its own standing as the specialized health agency of the Inter-American System

[41] https://www.who.int/about/funding

[42] https://www.who.int/health-topics/international-health-regulations#tab=tab_1

[43] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00540-0/fulltext

inconsistent and political by many public health and international law experts[44]. These shortcomings of the IHR were revealed during the 2014 West African Ebola and later during the COVID-19 pandemic[45].

3.4.3. Debate surrounding WHO's role in health emergencies

The fact that WHO primarily has a normative role, as opposed to having a more operational role, has been surrounded by debate and controversy, and the organisation has undergone multiple reforms to revise its mandate and strategic priorities in an attempt to be more effective in its response to health emergencies. WHO has been the Global Health Cluster (GHC) lead agency since the cluster system was created in 2004, but had a relatively limited role in humanitarian operations at that time.

The 2014 Ebola outbreak in West Africa brought to the forefront the mismatch between the global community's demands and expectations of WHO to lead the emergency health response versus WHO's mandate per its constitution and other frameworks, as well as its resource and organisational restraints, to have a stronger operational role[46]. The hard-learned lessons from the 2014 Ebola outbreak forced WHO to re-examine its role, organisational structure and governance, relationships with member states, operational efficiency, and its ability to provide timely, responsive and high-quality technical normative guidance.[47] [48] Following this review, in 2015, WHO established the triple billion targets, an ambitious initiative to improve the health of billions by 2023, with one target focused on the protection of one billion more people from health emergencies as an organisational priority. As the foundation of WHO's Thirteenth General Programme of Work, under the goal of protecting a billion people from health emergencies, WHO is responsible to[49]:

- prepare for emergencies by identifying, mitigating and managing risks;
- prevent emergencies and support development of tools necessary during outbreaks;
- detect and respond to acute health emergencies; and
- support delivery of essential health services in fragile settings.

In May 2016, at WHA's 69th Session, WHO Member States agreed to one of the most profound transformations in the Organisation's history - establishing a new WHO Health Emergencies Programme (WHE) with the mandate to improve operational capacities and capabilities of the organisation so that WHO can effectively and efficiently respond to outbreaks and other health emergencies.[50]. This reform was a critical step to transforming WHO into an operational agency, to complement its technical and normative role[51].

3.4.4. The WHO Health Emergencies Programme

The WHE programme works with countries and partners to help build/establish the capacities required to rapidly detect, respond to and recover from any emergency health threat, including disasters, disease outbreaks and conflicts. The WHE was designed to bring all of WHO's emergency work into a single programme with "one clear line of authority, one workforce, one budget, one set of rules and processes, and one set of standard performance metrics", and a common structure at HQ and regional levels[52]. This also served to reinforce WHO's role as GHC lead agency. The WHE's aims, work areas, and activities to achieve the protection of one billion people from health emergencies are described in Annexe 5.

The WHE program aims to minimise the consequences of health emergencies through the following:

[44] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5394645/
[45] https://academic.oup.com/ia/article-lookup/doi/10.1111/1468-2346.12454
[46] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5055771/
[47] Moon et al., "Will Ebola Change the Game?"
[48] Gostin and Friedman, "A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic."
[49] https://www.who.int/about/what-we-do
[50] https://apps.who.int/iris/bitstream/handle/10665/252688/A69_30-en.pdf?sequence=1&isAllowed=y
[51] "WHO | Renewed Partnerships Build Momentum for WHO's New Health Emergencies Programme."
[52] https://www.cfr.org/backgrounder/what-does-world-health-organization-do#chapter-title-0-9

- Ensuring preparedness: by strengthening countries' capacities to detect, prevent and respond to health emergencies
- Surveillance: monitoring of new and ongoing public health events to assess, communicate and recommend action for public health risks
- Response: rapidly and effectively respond to health emergencies under a coordinated incident management system

In 2021, the WHO established the Hub for Pandemic and Epidemic Intelligence to detect new events with pandemic potential, to monitor disease control measures on a real-time basis, and support countries with the tools needed to forecast, detect and assess epidemic and pandemic risks so they can take rapid decisions to prevent and respond to future public health emergencies.

Financing WHE's work requires a combination of core financing for WHO's normative work, a contingency fund for rapidly initiating and scaling up emergency response operations - WHO's Contingency Fund for Emergencies (CFE) - and ongoing appeals for voluntary funding to support operations and response to crises.[53] Historically, the programme has faced chronic budget and human resources shortages, relying heavily on appeals and voluntary contributions to supplement available funds.

3.5. Partnership between DG ECHO and WHO

3.5.1. Twenty years to a strategic partnership

Almost two decades ago (December 2002), even before the EC and WHO had established a formal partnership, DG ECHO and WHO had pursued a collaborative relationship through the Strategic Programming Dialogue (SPD 2002) to consider "the appropriate framework for cooperation in the field of humanitarian affairs".[54,55] This SPD, along with EC's communications to the European Council and Parliament on building an effective partnership with the UN, and the Exchange of Letters between EC and WHO, led to two important umbrella framework agreements. The first was the Financial and Administrative Framework Agreement between the United Nations and the European Union (FAFA). Signed in 2003, the FAFA is the ruling document governing the cooperation between the EC and its DGs and the UN and its multiple agencies, establishing an overall legal framework, and defining the objectives, principles and the modality of cooperation between the two entities.

The second was the 2004 Memorandum of Understanding (MoU) which established a framework for a strategic partnership between the EC and WHO.[56] The aim of the 2004 MoU was to enhance the effectiveness of WHO and the EC, along with its DGs, including DG ECHO, in pursuit of their health development goals. The MoU delineates the partnership's goals, priority objectives, scope, areas for policy dialogue and financial cooperation. It also defines the administrative, operational and financial arrangements, including the establishment of annual high-level Senior Official Meetings (SOMs) to review partnership progress, issues and future directions in priority areas.

It was under these agreements that DG ECHO and WHO collaborated. However, while WHO and DG ECHO worked together in humanitarian health settings, historically, DG ECHO did not view WHO as a natural humanitarian partner due to its primarily normative role and limited operational capacity to respond to health in emergencies and humanitarian settings. As such, since early in their partnership, WHO was not on an even playing field with the more traditional humanitarian agency partners like World Food Program (WFP) and the United Nations High Commissioner for Refugees.

53 DG ECHO does not contribute funding to WHO's CFE

54 Memorandum of Understanding concerning the establishment of a strategic partnership between the World Health Organization and the Commission of the European Communities in the field of development. 2004

55 The Evaluation Team has not been able to track this document and based on the inability for DG ECHO to locate it, seems it is not part of the organization's institutional memory, and this document is mentioned in the 2004 MoU between EC and WHO.

56 Memorandum of Understanding concerning the establishment of a strategic partnership between the World Health Organization and the Commission of the European Communities in the field of development. 2004

Two milestones changed this. The first was the establishment of WHE, mandating WHO as an operational agency in health emergencies. The second was the 15th SOM in 2018 that established health emergencies as one of three shared priority areas for collaboration between EC and WHO, bringing the WHE into the forefront of the EC – WHO relationship.[57] The subsequent 2019 SOM further elaborated the following focus areas relevant to health emergencies and humanitarian settings[58]:

- Partnership framework: using the IHR framework as the basis on which to build a more structured partnership to collaborate on health emergencies; and
- Collaboration: working together to
  - scale up activities to strengthen preparedness and response to health emergencies such as in the Ebola crisis in the DRC;
  - better integrate chronic care, mental health and psychosocial support in health emergency response; and
  - develop tailored solutions for strengthening health systems resilience in fragile states.

An action point stemming from the 2019 SOM was a strategic dialogue meeting between DG ECHO and WHO to discuss collaboration in fragile states.

3.5.2. Officialising the partnership as strategic

> *"In 2019, our then Director General decided that WHO should become a strategic partner because of the importance of the organisation as a partner for the EU humanitarian response"* [DG ECHO HQ]

In late 2019, DG ECHO officially designated WHO as a mandated strategic humanitarian partner. DG ECHO has eight strategic partnerships with agencies considered major humanitarian responders. As there is no specific Memorandum of Agreement to formalise these partnerships, what makes them officially strategic, according to DG ECHO, are the annual high-level dialogues that take place between DG ECHO and these partners.[59]

The first High-level Strategic Dialogue (HSD) between DG ECHO and WHO took place in January 2020. The goal of the HSD was to agree on the most important overall humanitarian and civil protection priorities. The HSD addressed three broad technical areas: emergency response and civil protection, improving basic health care in humanitarian settings and preparedness for high impact events - as well as the overall strategic partnership itself. The HSD also identified follow-up actions centred around more dialogue opportunities and joint actions between DG ECHO and WHO.[60] These actions were collated into a Monitoring Table which is reviewed at regular partnership meetings between the DG ECHO and WHO partnership focal points and updated as milestones are met. Up to the end of 2021, two additional HSD's took place in October 2020 and November 2021.

Prior to the officialisation of the DG ECHO/WHO partnership as a strategic one, the C1 Policy Unit managed the relationship with WHO. In 2019, the D1 Unit (Strategic Partnerships with Humanitarian Organisations) was created to establish and manage strategic partnerships, including the one with WHO.

[57] Outcome of the SOM WHO-EC, Geneva, 29 June 2018
[58] Outcomes of the Senior Officials Meeting between the Commission services and the World Health Organization, Brussels, 12 July 2019
[59] Communication with DG ECHO staff in Unit D1
[60] DG ECHO - WHO Strategic Dialogue of 15 January 2020 Monitoring Table, updated 5 February 2020.

3.5.3. DG ECHO's investments in WHO/PAHO

Between 2017 and 2021, DG ECHO awarded WHO and PAHO € 251.1M to implement 70 Actions (Table 6). WHO received 91% of these funds (€ 228.4M) with PAHO receiving the remaining € 22.7M. Figure 10 shows the funding by year, with total funding rising from € 32M in 2017 to € 71.4M in 2021. This trend parallels that of EC"s investments in WHO, which rose substantially from USD 169M in 2016, to USD 412M in 2018, to USD 466M in 2020/2021, making EC the 8th, 6th and 5th largest donor to WHO respectively. Whilst funding for PAHO marginally increased until 2019 and subsequently levelled out in 2020 and 2021, funding for WHO increased year on year, witnessing a substantial funding increase (70%) from 2019-2021. This coincided with the "officialising" of the strategic partnership with DG ECHO at the HSD in December 2019, but also with the advent of the COVID-19 pandemic.

Figure 10 DG ECHO funding to WHO/PAHO by year (2017-2021)

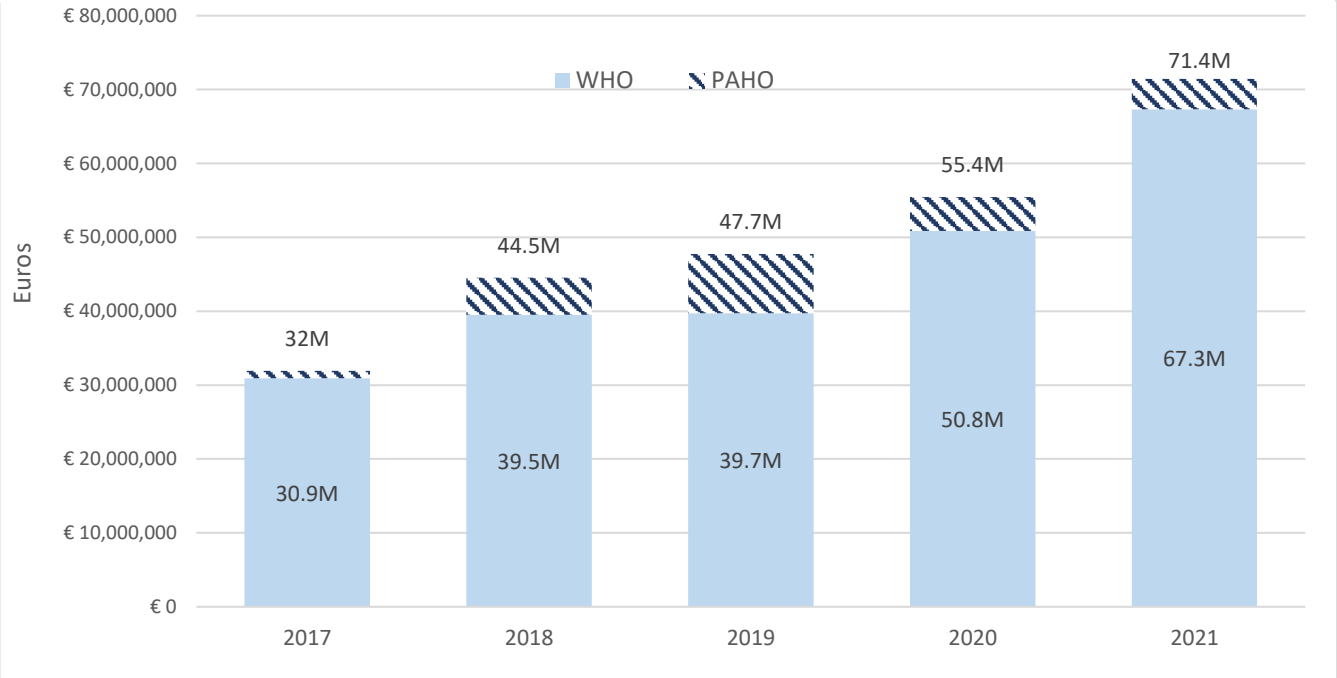


Table 6 Funding awarded to WHO/PAHO by DG ECHO between 2017-2021

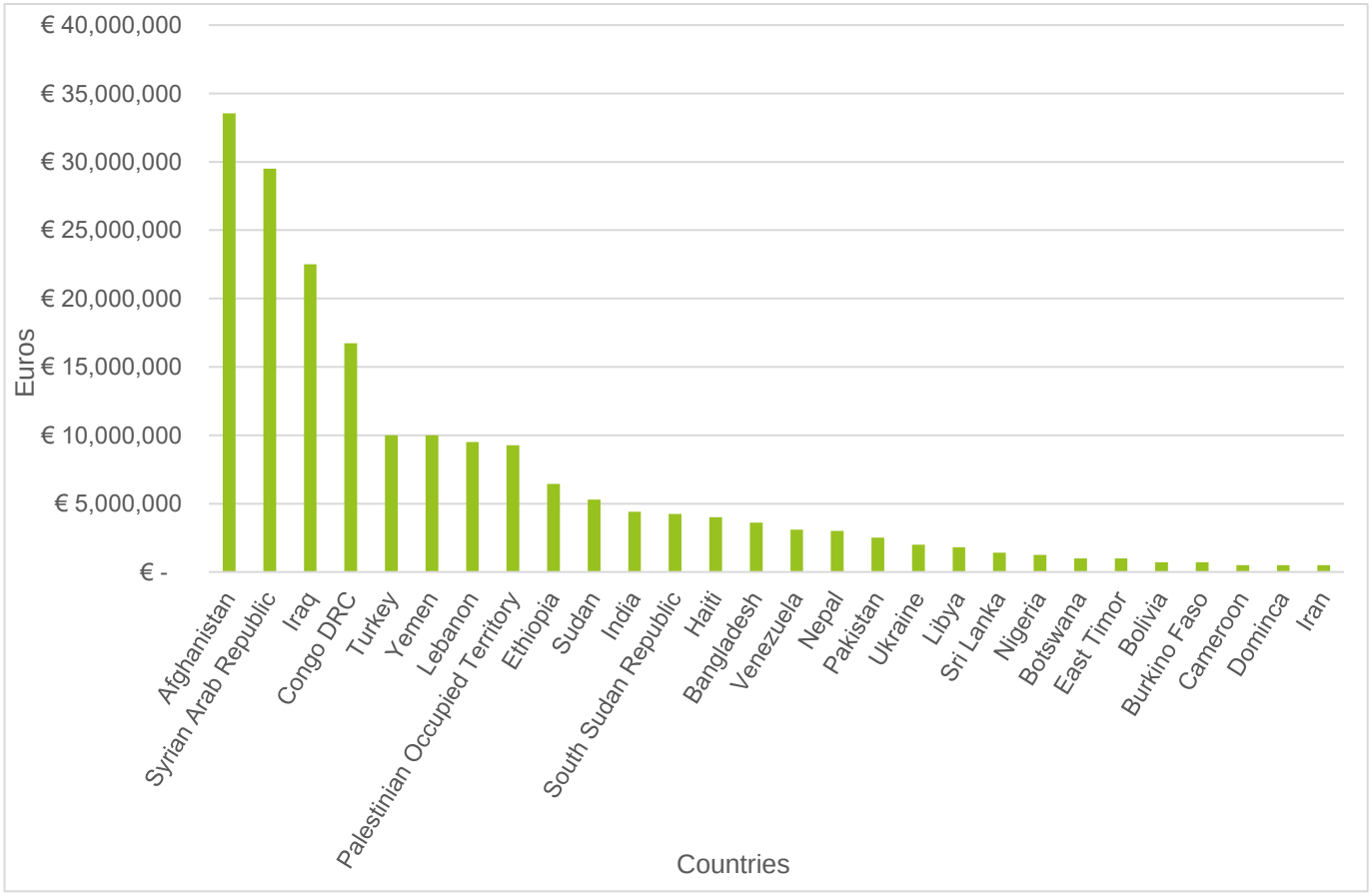
	DG ECHO funding	# Actions
Total	€ 251M	70
Organisation		
WHO	€ 228.4M	61
PAHO	€ 22.7M	9
Type of grant		
Single country	€ 189.4M	62
Multi-country	€ 61.7M	8

Most of the funding (75%) was disbursed as single country grants to cover 62 Actions in 29 countries.[61] Figure 11 shows the distribution by country of these single country grants between 2017 and 2021. The majority of funding went to countries in the Middle East, although Afghanistan received the highest amount of funding at € 33.5M, amounting to 17% of all funding to WHO/PAHO within this period. Afghanistan was also the recipient of the largest grant for a single Action - € 16.3M in 2019. WHO Syria ranked second in awarded funds, receiving € 29.5M, and also implemented the greatest number of Actions (8). Iraq and DRC follow, having received € 22.5M and € 15.7M respectively. In addition to single country Actions, 25% of DG ECHO funding to WHO/PAHO was for eight regional/multi-country Actions. The two Actions which received the largest amount of funding were both COVID-19 related.

[61] Each grant funds one Action, so there were 62 grants funding 62 Actions

In terms of decision envelope, WHO/PAHO funding was primarily sourced through the Geographic HIPs (66%), with one third sourced through the Emergency Toolbox HIP (Epidemics Tool). However, the bulk of the Epidemics Tool funded the two COVID-19 multi-country Actions of € 30 million (2020) and € 16 million (2021). Excluding these two Actions changes the distribution to 92% sourced through the Geographic HIPs and 8% sourced through the Emergency Toolbox.

Figure 11 Distribution of single country grants (by country) between 2017-2021



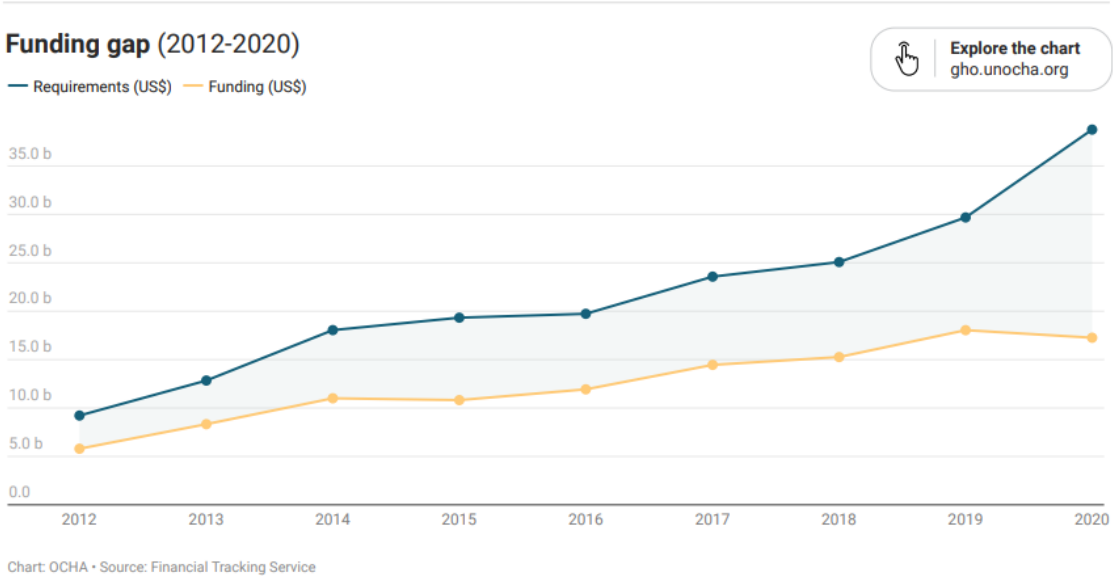
3.6. Epidemic response in the wider context of humanitarian action

In 2021 the European Commission set out the range and scale of challenges facing global humanitarian action in its *Communication on the EU's Humanitarian Action*[62]. Even before the COVID-19 pandemic, humanitarian agencies and donors were struggling to meet rising humanitarian needs driven mainly by the resurgence in state-based conflicts (resulting in unprecedented numbers of forcibly displaced people). Globally, the gap between needs (as expressed in appeals) and funding is widening[63].

[62] Ibid

[63] https://www.unocha.org/global-humanitarian-overview-2021

Figure 12 Funding gap (2012-2020)



COVID-19 has caused this gap to accelerate. The World Bank has estimated that 97 million additional people were thrown into extreme poverty by the pandemic in 2020.[64] Although the impact of COVID-19 is expected to be gradually reversed, it could take several years, especially as it has since been exacerbated by the consequences of Russia's war in Ukraine and global inflation. COVID-19 has impacted most heavily on the livelihoods of the poorest and on the services provided in low-income countries, and together with the impacts of the war in Ukraine, this has limited the ability of high-income countries to fund development and humanitarian aid programmes.

Emergency health appeal requirements have been growing as a percentage of overall humanitarian appeals between 2017 and 2021. However, health funding as a percentage of actual humanitarian donations has been steady at 7% (with a dip to 5% in 2019)[65]. The implication is that health services are not given high enough priority by humanitarian donors as a group.

Table 7 Health sector requirements/funding

Year	% of Total requirements	% of Total Funding
2017	8%	7%
2018	9%	7%
2019	9%	5%
2020	11%	7%
2021	10%	7%

DG ECHO's own record on support to humanitarian health is more encouraging (see Section 3.3: from 2017-2021 health has represented 16% of DG ECHO's humanitarian spending), but the pandemic has underscored that basic services funded through humanitarian programmes cannot be seen as a long-term substitute for development investments underpinned by stabilisation and peace-making initiatives.

[64] Updated estimates of the impact of COVID-19 on global poverty: Turning the corner on the pandemic in 2021? Mahler et al [2021]. World Bank Blogs: https://blogs.worldbank.org/opendata/updated-estimates-impact-COVID-19-global-poverty-turning-corner-pandemic-2021#:~:text=We%20find%20that%20the%20pandemic,the%20course%20of%20the%20pandemic).

[65] https://fts.unocha.org/

Another lesson from epidemics in humanitarian or fragile contexts is that the indirect effects of disease outbreaks, even on health outcomes, can be as bad for some groups as the direct effects of epidemic morbidity and mortality. This was seen in the West Africa Ebola outbreak (2013-15), where research conducted during the recovery phase showed a significant decrease in the utilisation of routine but potentially life-saving services, such as malaria treatment, as health facilities closed under pressure or fear changed people's health-seeking behaviour[66]. This effect has been even more stark in relation to COVID-19, where children and young women, who were at relatively low risk from the virus, either felt they needed to avoid health facilities or witnessed access to services diminish in critical areas like mother and child health.[67] Further to this immediate health impact, epidemics of a significant magnitude can also have severe economic and social consequences. Reduced or reversed economic growth has been recorded both as a result of Ebola in West Africa and COVID-19 globally, and months if not years of crucial education can be lost. In an existing humanitarian setting, the need to mount a response to an epidemic can divert attention and resources from other critical needs.

COVID-19 has challenged humanitarian organisations in new ways and has forced them to adapt. Humanitarian procurement systems and supply chains for medicines, equipment, PPE and other goods and commodities faced an extremely challenging market and logistics situation, increasing risks to staff and patients in healthcare settings. Furthermore, the safe deployment (and rotation) of personnel, always a challenge, became even more acute in 2020-2021 as countries closed their borders, flights were cancelled, and humanitarian workers with underlying health conditions were deemed too much at risk to travel internationally. This placed more reliance on national staff, government-led services and local organisations – developments which major donors and agencies had previously signed up to under the Grand Bargain commitments to localisation – but which had hitherto often faced passive resistance and foot-dragging by senior decision-makers.[68]

[66] Effects of the West Africa Ebola Virus Disease on Health-Care Utilization – A Systematic Review, Ribacke et al [2016] https://doi.org/10.3389/fpubh.2016.00222

[67] Impact of COVID-19 on reproductive health and maternity services in low resource countries, Abdelbadee et al [2021] DOI: 10.1080/13625187.2020.1768527

[68] COVID-19 and Humanitarian Access: How the pandemic should provoke systemic change in the global humanitarian system, United Nations University [2021]. https://reliefweb.int/report/world/COVID-19-and-humanitarian-access-how-pandemic-should-provoke-systemic-change-global

4. Findings

4.1. Findings – Part A

EQ 1 How appropriate were DG ECHO's plans and interventions in response to epidemics?	**RELEVANCE**
JC 1.1 Decisions were based on needs assessments and complementary data JC 1.2 The magnitude and severity of epidemic crises and their likely trajectory were fully considered when making decisions on how DG ECHO should respond (in terms of prevention and response)	
Key findings	
• Overall, DG ECHO-funded interventions were appropriate and based on the triangulation of data from a range of sources • Considerable reliance was placed on the knowledge and understanding of DG ECHO's experts to compensate for the poor quality of assessment data in the Action documents • Epidemiological data, including projections of epidemic scale and trajectory, were generally lacking in the Action documents • Although the Actions were appropriate, they may not always have been the most appropriate. It is possible that some interventions fitted what IPs felt comfortable in offering, rather than what would have had the most impact	

The use of specific assessments by implementing partners

The European Consensus on Humanitarian Aid (2008) demands a "*rigorous approach to needs assessments*" [69] and DG ECHO's Health Guidelines (2014) state that "*the assessment of health-related needs will be conducted as quickly as possible and interventions will be designed and implemented in accordance with the findings. As health-related needs can change rapidly….. needs assessments should be repeated frequently and programmes modified accordingly".*[70]

The primary source of evidence on needs assessments was DG ECHO's Action documents. The eSingleForm (SF) is a combined proposal and reporting tool that contains a dedicated section on 'Assessment Dates and Methodology' to be provided by the IP. The accompanying FicheOp[71] provides an opportunity for DG ECHO experts to comment on the quality of the assessment information provided. DG ECHO's SF Guidelines (2021) say "*a good needs assessment and risk analysis is vital for the success of the Action".*[72] But the assessment section of the SF received surprisingly light treatment by IPs – ranging from a single sentence[73] to half a page.[74, 75] Among 23 sample Actions reviewed by the ET, there were few references to field assessments focused specifically on epidemics.[76] Detailed analysis of a representative sub-sample of 16 Actions showed that just 25% were based on major new field assessments, although a further 25% involved minor new assessments, usually to explore aspects of a pre-determined intervention

[69] Article 32, The European Consensus on Humanitarian Aid (2008)
[70] DG ECHO Thematic Policy Guidelines No.7: Health General Guidelines (2014)
[71] Project management record internal to DG ECHO
[72] DG ECHO SF Guidelines (2021). P.14
[73] E.g., Action 2019/00680. ALIMA, measles, DRC
[74] E.g., Action 2021/00214. WHO, Public Health Surveillance and Response, S Sudan
[75] SF submissions by IPs are often accompanied by separate attachments (which can include assessment documents), but these were rarely available to the evaluators, who therefore relied on relevant information being summarised or referenced in the SF and commented on in the FicheOp
[76] Actions whose documents were downloaded from the database and reviewed by the ET

e.g., an infection prevention and control (IPC) assessment of targeted health facilities. The ET found that NGO partners were more likely to base their proposals on recent field assessments than UN partners – a finding that was confirmed in interviews with Anopheles experts (DG ECHO's regionally-based health experts).

The lack of field assessments focused on epidemics is most likely because most (87.5%) of the Actions reviewed were responding to country-level HIPs, as opposed to the (more specific) Epidemics Tool[77] (12.5%). The majority of Actions in the evaluation sample were broader health projects containing some element of epidemic preparedness, or were adaptations to existing humanitarian projects (e.g., in health, Water, Sanitation and Hygiene (WASH) or protection) that introduced an element of epidemic response because of a new outbreak. These adapted projects were in contexts where DG ECHO had an ongoing partnership with an IP, sometimes of several years' duration, which benefitted from the serial renewal of funding. Often the original funding application had been based on a thorough needs assessment conducted by the IP, but not focused on epidemics. Thus, existing Actions which were modified to address new disease outbreaks were justified on the basis of older general needs assessments (44% of the sub-sample), the IP's experience of working with particular communities (75%), and secondary data about the epidemic e.g., from WHO or the national health authorities (75%). Most Action documents referred to a blend of these approaches to assessment, and used the assessment more often to justify the Action than to actually guide/plan the Action.

A minority of sampled SFs included relevant information about the magnitude of outbreaks e.g., by providing data on case numbers over time,[78] but the majority lacked inclusion of such data in the SF itself or made only vague references, for example to the overwhelming scale of the COVID-19 pandemic. None provided any mathematical treatment of possible trajectories, such as modelling data conducted by epidemiologists. The lack of specific epidemiological data in the Action documents themselves, such as incidence graphs or modelling of trajectories, represents a possible weakness. Resourcing decisions should consider scenarios about the possible scale and duration of a new threat, and the magnitude and severity of resulting needs. Epidemic modelling could have helped provide more specific information on possible needs (e.g., case management beds, vaccines, oxygen concentrators etc.). A recent DG ECHO evaluation of its response in Yemen noted that DG ECHO and its partners were not well prepared with appropriate assessment methodologies for measuring the scale and severity of COVID-19. [79] [80]

Triangulation of information (including secondary sources)

There was convincing evidence (from the FicheOp and KIIs with DG ECHO experts) that DG ECHO based its funding decisions on the triangulation of a range of information sources, and not just the information provided by the IP in the SF. In the FicheOp, data from other IPs, interaction with other donors, and participation in coordination fora were often used by DG ECHO experts to augment the assessment information provided by IPs, and to build a more comprehensive case to fund an Action.[81] Equally, it is clear that the overall technical knowledge and experience of the Anopheles experts was a strong factor in decision-making, as was the field experts' understanding of local context and of the potential of each partner based on past performance. There is a sense that DG ECHO experts can often see the 'bigger picture,' and can see beyond the relatively sparse information provided by IPs in the SF. The weight given to the opinion of the Anopheles experts is even more pronounced in the case of Actions funded under the Epidemics Tool, for which an additional (internal) assessment document, the Assessment Template for Epidemic Threat is filled by the relevant Anopheles

[77] Part of the Emergency Toolkit (outlined annually in a dedicated global HIP)

[78] E.g., Action 2019/00680. ALIMA, measles, DRC.

[79] For example, live open-source epidemic modelling for lower and middle-income countries was available from respected authorities from an early stage of the COVID-19 pandemic and funded in part by the UK's Foreign, Commonwealth and Development Office (or DFID, as it was in early 2020). The modelling from Imperial College London was available here: https://mrc-ide.github.io/global-lmic-reports/ Similar modelling by the Centre for Mathematical Modelling of Infectious Diseases (part of the London School of Hygiene and Tropical Medicine) was available online until March 2022.

[80] Evaluation of the European Union's Humanitarian Interventions in Yemen and Humanitarian Access 2015-2020.

[81] E.g., Action 2020/00956. WHO, COVID-19, Syria

expert, and subsequently sent out for comments to the rest of the Anopheles group for the sake of peer review and consistency.

"*When the disease is endemic, DG ECHO tries to address it through normal health programming: we try to look for the added value we can bring. There are some epidemics we tend not to respond to e.g., Dengue Fever, as they need more of a systems-building approach. And the bar is quite high to respond to epidemics in new countries".* [DG ECHO expert]

When asked about the rationale for epidemic interventions, the Anopheles experts themselves spoke less about assessments, and more about how the different funding instruments and project modifications addressed different types of epidemic situation, with minor outbreaks in endemic areas being dealt with through the geographic HIPs and Crisis Modifiers (CM),[82] whereas the Epidemics Tool was used for larger or less-anticipated outbreaks. As these experts are involved in all epidemic-related decisions, they helped ensure the appropriateness of each response, based on their rich knowledge and understanding.

The use of assessment data for decision making

The findings show that DG ECHO placed as much weight on overall situation analysis (leaning heavily on its experts) as it did on the quality of the assessment data coming from its IPs. On the whole, based on documentary evidence found in FicheOps, DG ECHO experts did not question the lack of assessment information in the SF (perhaps suggesting the availability of complementary data on which they could make decisions), although there were some examples of DG ECHO experts requesting more details. The ET was also made aware of an example of an Anopheles expert recommending a proposal be rejected, based on a consideration of information from complementary sources.

In response to the online survey, stakeholders indicated a high degree of confidence that DG ECHO makes appropriate decisions in relation to epidemics.[83] And FGDs in the DRC felt that interventions were relevant to their needs and priorities, appreciating the impact that infectious diseases can have on communities. FGD participants said that sometimes they were not convinced at first, but changed their minds when they appreciated that epidemics are 'real' and not false information.

While there is evidence that DG ECHO's decisions were broadly appropriate, the ET found that assessments were often used passively to provide context and justification for proposed Actions, rather than to actively shape interventions to meet the specific needs of the epidemic. IPs often relied on older, more general, field assessments and there was a general lack of any information about epidemic trajectory. Although DG ECHO experts sometimes questioned the lack of assessment data in the SFs, on the whole there was insufficient evidence of IPs being challenged to explain their intervention logic with reference to perceived gaps and priorities. The suggestion was also made during KIIs that the interventions selected by the IPs were not always the most appropriate ones, considering the need to rapidly bring an epidemic under control. It was observed that sometimes the proposed interventions (e.g., small-scale risk education) might have a marginal effect (e.g., compared to strengthening surveillance or rapid response teams), and that the process of selecting appropriate Actions might need more rigor. Another observation (from a country-based DG ECHO expert) was that the technical advice of field staff, based on local evidence, was sometimes overridden by 'top management' in HQ, especially in relation to the COVID-19 response. Added together, these observations provide some challenge to whether DG ECHO-funded interventions were always the most appropriate. In some cases, the information in the SF may have been used by DG ECHO merely to justify the proposed intervention, whereas it could have challenged itself and its IPs to fill gaps or weaknesses in the epidemic response, even if that meant encouraging some partners to move out of their comfort zones and work in different places or on different epidemic response pillars.

Summary

DG ECHO-funded interventions in response to epidemics were appropriate, in the sense that they were broadly relevant and made valid contributions to overall response efforts. On the whole, there was weak

[82] See under EQ 8 for more on Crisis Modifiers

[83] E-survey question 8. 72% thought DG ECHO's 'appropriateness' was excellent or good in relation to epidemics.

inclusion of fresh and specific epidemic assessment data in the SF. IPs emphasised their presence 'on the ground' and often adapted their existing humanitarian programmes to address epidemic response through 'add on' activities. It was rare for IPs to provide holistic contextual analysis or to justify why the chosen interventions were a priority i.e., by identifying critical gaps which needed to be plugged. There was virtually no treatment of epidemic magnitude or trajectory. The lack of overt assessment data in the SFs was compensated to some extent by the rich understanding of context endowed in DG ECHO's field experts and the technical expertise of the Anopheles experts. The ET was confident in the ability of these experts to filter out inappropriate interventions through their role in project appraisal (although a few projects were approved despite doubts being expressed). But to be sure that the interventions selected were the most appropriate (and not just 'appropriate') the ET would have valued seeing evidence in the Action documents of more rounded problem analysis and consideration of the various intervention options and pros and cons – both by the IPs and by the DG ECHO experts.

EQ 2 To what extent did DG ECHO's Actions seek the participation of affected populations at all stages of the humanitarian project cycle, and seek to address their needs and priorities?	**RELEVANCE**
JC 2.1 Needs assessments made efforts to identify the most vulnerable individuals or households within the wider affected populations JC 2.2 Response plans demonstrated a 'do no harm' approach and were sensitive to cultural factors JC 2.3 Project implementation involved - and demonstrated accountability to - the affected populations	
Key findings	
• Despite some examples of good practice, vulnerability targeting, Do No Harm (DNH) and Accountability to Affected Populations (AAP) were relatively neglected areas of project design and management • DG ECHO's Anopheles and field experts tended to assign low priority to these aspects in the context of epidemic response • Affected people themselves expected to participate in decisions which affected them, and valued the integrity of projects which put people at their centre	

Reaching the most vulnerable

Vulnerability, according to DG ECHO's Health Guidelines, "*comprises the characteristics of population groups that make them more or less susceptible to experiencing stress, harm or damage when exposed to particular hazards*."[84] There are several sections of the SF where IPs can describe the impact of epidemics on affected persons, which groups will be targeted, and how vulnerabilities will be considered in the project design, the most relevant being a section headed *'Does the Action specifically target certain groups or vulnerabilities?'*

A review of Action documents revealed that this vulnerability section of the SF was not consistently completed. Roughly one third of Actions provided a substantive analysis of vulnerabilities and how these would be addressed; another quarter made some reference to vulnerabilities or referred to vulnerability assessment but without providing many details; and almost half of the sampled Actions stated that vulnerable groups were not being targeted, or provided no information on the subject. Some of the best examples were Actions in Afghanistan where COVID-19 interventions were integrated into ongoing health and protection projects, and vulnerability was central to project design. Beyond identifying vulnerabilities, several Afghanistan Actions sought to address vulnerability in meaningful ways. For instance, the International Rescue Committee, recognising that women and children were at risk of being marginalised, ensured that its RCCE activities were age- and gender-specific, and employed additional female workers to provide outreach to women (most of whom were caregivers, but who might have been isolated within their households or

[84] ibid. p.34

communities).[85] Intersos provided disaggregated data for intended beneficiaries, specified the vulnerabilities being addressed, and also adapted its response accordingly e.g., by ensuring that female psycho-social support teams were available to help women coping with sickness or bereavement.[86] In contrast, a measles response by an international NGO in DRC (funded under the Epidemics Tool) did not mention vulnerability at all in the SF and barely even mentioned 'children,' despite young children being the group obviously at risk from measles.

The differing approaches may be due to the experience of the IPs: there was some evidence that IPs who also worked in protection were accustomed to considering social vulnerabilities and more confident in addressing them in the SF, while IPs traditionally more focused on emergency medical care were more universal in their approach. By speaking to the community when monitoring the measles intervention above, DG ECHO experts realised that parents were not being given clear and consistent messages about where to seek help for children suspected to have measles. An IP more adept at engaging the community might have realised that weakness early on.

The data from KIIs confirmed that vulnerability was not accorded a high priority by most stakeholders. Many IPs noted that some assessment of vulnerability is now a requirement in DG ECHO's project documentation and is therefore 'addressed', but provided few details of their own approach to vulnerability or examples of how they incorporated this into project design. Again, Afghanistan was the country where the strongest approaches were evidenced and IP respondents were able to speak with passion and conviction about vulnerability. There were good examples from Venezuela as well. Some DG ECHO experts stated that addressing vulnerability was not the highest priority in the design phase of an epidemic response if a rapid response was required – arguing that vulnerability could be addressed during implementation.[87] Again, a notable exception was Afghanistan, where DG ECHO was seen as providing real leadership on the systematic incorporation of vulnerability from the beginning of the project cycle. IPs in Afghanistan appreciated the inclusion of women staff in DG ECHO's field teams, and their role in championing gender-sensitive programming in particular (i.e., recognising imbalances in access to participation and resources and seeking to address this). Afghanistan is noteworthy as an example of the DG ECHO policy on vulnerability being respected in practice, even though the bulk of the evidence is that assessment of the differential vulnerability of population groups is regarded as less relevant when designing epidemic response.

The ET had some sympathy with the view that in-depth analysis of vulnerability can be difficult to incorporate in the early stages of designing epidemic interventions, but, overall, was not convinced that sufficient weight and consideration was given to vulnerability. The Action documents deliberately provide space for an appraisal of vulnerability, but this opportunity was passed over too often. At the very least, some initial desk-based analysis could have been included with more regularity and more thoughtful consideration of different populations groups, how they might be differently impacted, and how their specific needs might be addressed through project design.

Cultural sensitivity and the 'Do No Harm' approach

DG ECHO does not have its own policy guidelines on Do No Harm, but the Consensus on Humanitarian Aid (2008) says policies in *'humanitarian aid intervention … must be adapted to context and …. The 'do no harm principle' is the minimum requirement underlying such policies and aid approaches,'* and this is reinforced in the Humanitarian Aid Communication (2021).[88] [89] Humanitarian literature stresses that DNH is not strongly defined, is often vaguely understood and loosely interpreted. The basic concept is that humanitarian interventions should not – directly or indirectly – cause additional harm to affected populations, and that humanitarian practitioners should take such risks into consideration before they act. Stemming from analysis

[85] Action 2020/00466

[86] Action 2020/00481

[87] A number of IPs notes that DG ECHO experts look at vulnerability during their field monitoring visits – thus ensuring that vulnerability is not neglected during implementation

[88] Ibid. Article 42.

[89] Ibid. p.4

in the 1990s of the interplay between conflict and humanitarian action, the concept of DNH broadened into conflict sensitivity, and then expanded further in recent years to include the consideration of environmental impact.[90]

The SF does not call for a specific DNH analysis, although it does include relevant sections on 'assumptions and risks' and 'contingency measures taken to mitigate the risks' which could incorporate DNH. It is therefore left to each applicant for DG ECHO funds to decide whether DNH is relevant enough as a planning principle to be described in the application. DG ECHO field experts and desk officers must make similar judgements when completing the FicheOp. One third of the Action documents reviewed contained data relevant to DNH, and this general lack of reference to DNH suggests that low priority was placed on this dimension of humanitarian action by most IPs.

Where DNH was addressed in SFs, there were good examples of the DNH principles being applied. Three Actions (two in Afghanistan; one in Syria)[91] described measures to ensure cultural and conflict sensitivity such as maintaining a gender balance in field teams, transparent processes for staff recruitment, and frequent consultation with community leaders (who could also help preserve humanitarian access in the event of a change in local political authority). Other Actions demonstrated a resolve not to undermine existing local or national capacity[92] and to ensure the safety of staff and service users during peak COVID-19 waves, through adapted intervention protocols and good hygiene measures.[93]

The overall picture emerging from the KIIs was more positive with regard to the practice of DNH. The best examples came again from Afghanistan, likely reflecting the many years' experience built up by humanitarian agencies of working in a conflict situation where there is widespread distrust of international agencies. IPs in Afghanistan explained the constant need for cultural sensitivity and for mitigation of risks associated with misperceptions of how humanitarian assistance is provided. A DG ECHO field expert explained the constant need to justify targeting criteria and decisions in a society where fairness is generally seen as providing equal shares for all, rather than equity for the most vulnerable. DG ECHO also emphasised the importance of resisting calls to impose conditionality on aid after the Taliban takeover in 2021, and instead encouraged IPs to continue dialogue on humanitarian access without compromising humanitarian principles. Regarding DNH measures associated more directly with epidemics, interlocutors most often spoke of protecting people from COVID-19 infection when delivering services. In DRC, the work of the Integrated Analytics Cell was praised for incorporating a DNH approach, and providing actionable insights into communities' experiences of coping with epidemics by merging and analysing epidemiological and anthropological data in real time.[94]

During FGDs, community members in Venezuela spoke of their sense of trust in the IPs, appreciating IP efforts to assist their (remote) populations and noting the impact this can have on people's lives. In DRC, local people also spoke of the importance of trust, contrasting the top-down and bottom-up approaches of different project implementation teams during the COVID-19 response, and emphasising the need to negotiate priorities with the local population.

Accountability to Affected Populations

EU humanitarian aid policy encourages the participation of people affected by humanitarian crises in decisions which affect them, and accepts that it is accountable to them, just as much as it is to EU citizens.[95] Like DNH, the principles and practical application of AAP are open to wide interpretation. During this evaluation, some respondents tended to interpret any interaction with affected populations or attempts at

[90] https://www.alnap.org/system/files/content/resource/files/main/donoharm_pe07_synthesis.pdf

[91] Actions 2017/00355, 2019/00446 and 2021/00139 – where was this number taken from?

[92] Actions 2019/00723 and 2020/1056

[93] Action 2020/00481

[94] https://www.unicef.org/drcongo/en/integrated-analytics-cell

[95] See Consensus on Humanitarian Aid (2008), article 45 and Humanitarian Aid Communication (2021), p.4.

differential targeting of vulnerable groups as examples of AAP, whereas others had a more sophisticated understanding, closer to the 'participation revolution' called for in the Grand Bargain and endorsed by the EU.[96] The ET considers the more specific definition of the Grand Bargain to be more applicable.

DG ECHO's Action documents still use the term 'beneficiaries' to cover populations affected by humanitarian emergencies. While the term is still widely used in the humanitarian sector, it is increasingly regarded as paternalistic because it does not confer agency upon the affected population – it encourages a view that affected populations are passive recipients, and somewhat contradicts a rights-based approach.[97] The SF has a section 'beneficiary involvement in [the] Action' which is also open to interpretation: 'involvement' could be interpreted as local people being surveyed, or contributing time and resources to the Action, or being employed by the IP etc. 'Participation' might be a more progressive term, in keeping with emerging humanitarian thinking.

Favourable AAP approaches in epidemics-related interventions would seek to facilitate dialogue and trust with communities over time. Ideally they would demonstrate how communities are consulted in the design of interventions, and propose multiple techniques and channels for ensuring continuous community participation and opportunities for actionable feedback e.g., through community meetings, FGDs, KIIs, surveys, suggestion boxes and helplines.[98] Of the sampled Action documents around 40% had evidence of an acceptable AAP approach, a further 20% had some references to AAP that were found to be inadequate, and 40% contained no reference to AAP at all. Striking features of best practice were that the leading IPs clearly saw AAP not as a burden but as enhancing the quality of their work, and that AAP measures were routine – an integral and continuous part of project implementation - rather than intermittent. Further analysis shows these leading examples were all Actions where routine humanitarian health and protection projects had been adapted for epidemic response. None of the Actions which were specifically designed for epidemic response were strong on AAP.

During KIIs, the different approaches to emergency epidemic response and routine humanitarian programming were highlighted by several DG ECHO experts, who were adamant that beneficiary engagement was not a priority when designing an epidemic response, because epidemics need a very fast response and a scientific approach, using well-practiced technical interventions. This view is supported to some degree by the DG ECHO Health Guidelines (2014): "*community participation may be more appropriate when deciding how to implement interventions than for deciding what interventions to implement"*[99], although the ET found this contention overly emphatic and too dismissive of the potential merits of early engagement with affected people (see below).

"I do not think it is appropriate to seek the participation of affected populations at all stages of the humanitarian project, because it is a scientific, evidence-based response that will help set a programmatic approach". [DG ECHO field expert]

Some DG ECHO field staff were more persuaded of the importance of AAP. In Venezuela it was noted that AAP practices among IPs had become more systematised in recent years, and this positive development could be observed during field monitoring visits. In DRC it was felt that 'in-depth work with the population' could pay off. Epidemic response insights from the Integrated Analytics Cell (CAI), a real-time research cell incorporating field anthropologists (see Figure 13 below), were included in the Ebola HIP document for 2018, and a rumour-monitoring service conducted by International Federation of Red Cross and Red Crescent Societies (IFRC) to enhance the Ebola response was also valued.

[96] https://interagencystandingcommittee.org/system/files/grand_bargain_final_22_may_final-2_0.pdf

[97] JCs 2.2 and 6.2 are relevant to the issue of those who may not have benefitted from DG ECHO's interventions

[98] E.g., Actions 2019/00446, 2020/00466 and 2020/00481

[99] Ibid. p.15

In Afghanistan DG ECHO encouraged all its partners to use the nationwide 'Awaaz' telephone complaints and feedback mechanism.[100] When reflecting on DG ECHO's stance on AAP, IPs had mixed views. Many praised DG ECHO for its willingness to travel frequently to the field for monitoring purposes and noted that DG ECHO made efforts to engage with communities during the visits. Several noted that AAP is now a 'requirement' when seeking DG ECHO funds. However, a few IPs felt that DG ECHO was itself lukewarm about AAP and that IPs took their cue from this attitude.

Figure 13 An example from DRC of the use of social science to combat epidemics

Using social science to combat epidemics in the DRC. In the DRC the work of health anthropologists is becoming increasingly important to donors and implementing partners to inform thinking and response to epidemics. During the 10th Ebola outbreak in DRC (2018-2020) a Social Sciences Cell and Epidemiological Cell worked together to provide an integrated understanding of local factors affecting the outbreak, to better understand and suggest ways of adapting the response in real time. The first Integrated Analytics Cell (CAI) was set up. During the outbreak, many analyses were conducted and recommendations co-developed and used by civil society, MoH, UN and NGOs. The CAI applies an Integrated Outbreak Analytics approach by bringing together multiple types and sources of data (new and existing) to fully understand the factors that might be causing a particular trend in an outbreak or health situation and the impact of the situation and its response on communities.

The CAI also addressed cholera in 2021. It developed an integrated household survey tool to complement existing entomological and epidemiological data through a better understanding potential risk factors (including access to and use of essential services, hygiene needs, health behaviours, etc.) among households and communities where cholera outbreaks were recurrent. The tool was developed together with partners working on other aspects of cholera research and response, to have one harmonized data tool that could be used by all actors. A finding from the survey was that women were largely responsible for cholera prevention activities and an additional qualitative study was conducted to better understand this issue. It found that women are more responsible for receiving information, and for collecting and treating water, however they do not have the decision-making or ability to influence household spending on prevention needs such as soap and water treatment. Key recommendations in 2022 have since focused on identifying opportunities to work with men on understanding the importance of investing and spending on cholera prevention (soap, water treatment), which can improve health in the household and reduce overall expenditure on health needs resulting from poor hygiene.

On the whole the non-DG ECHO stakeholders endorsed the principles of AAP with more conviction. Field interviews revealed strong examples of practice from each of the five countries, with a notable emphasis on AAP at each phase of the project cycle, and the use of a wide range of engagement techniques. The practice of one IP in DRC – using the 'People First Impact Method' - was so persuasive that it was showcased at the World Health Summit.[101] But the exemplary responses of a minority of IPs did not outweigh the more numerous examples of stakeholders who could only point to passive AAP approaches like complaints boxes, or confessed that their agencies still had a lot to learn about AAP.

The affected populations themselves leave no doubt as to the value of AAP. Strong evidence came from the FGDs in DRC and Venezuela of the importance of the affected people themselves participating in decisions and feedback sessions about humanitarian action, including epidemic response. In DRC, the FGDs emphasised that community interventions in RCCE (for COVID-19) were better received and more effective when 'bottom-up' approaches were used, i.e., when communities were engaged from the beginning on how interventions would be rolled out. In Venezuela, six FGDs underscored the importance of building trust, and appreciated that the interventions matched the priorities of the community.

[100] Operated by UNOPS on behalf of the humanitarian community

[101] https://www.malteser-international.org/en/our-work/africa/dr-congo/p-fim-in-the-context-of-ebola-and-covid-19.html

In the view of the ET, the contention of some DG ECHO experts that AAP is not a priority in the design phase of an emergency epidemic response deserves to be challenged. There is strong evidence in humanitarian literature that community trust, understanding and active participation are essential for successful epidemic response.[102] Even if full community consultation and input are not practical or necessary during the design phase of interventions, the ET expected to find evidence of attempts to approximate the views of affected populations through rapid engagement with community leaders, analyses of possible pathways for RCCE activities (teachers, social media, religious leaders, radio broadcasts etc.), or desk-based analyses of AAP lessons learned from previous epidemics in the same countries. Rather than dismiss the need for any form of early engagement with affected people, DG ECHO and its IPs could have been more open to the potential offered by AAP, and more creative in seeking meaningful solutions which were not at odds with the need for expediency.

Summary

Overall, Actions funded by DG ECHO did not always seek the participation of affected populations at all stages of the project cycle, and DG ECHO's implementation of this policy was uneven. Indeed, several DG ECHO experts were quite candid in their view that community engagement was definitely not a priority in the design phase of an epidemic response intervention. Accordingly, the ET found that DG ECHO is largely comfortable with epidemic needs and priorities being decided by humanitarian health experts without overt involvement of local populations. Supporting this, there was little evidence of meaningful consideration of AAP mechanisms by DG ECHO experts in the Action documents, although some of DG ECHO's IPs did exemplify good practice in respect of community engagement in initiative design (e.g., the People First Impact method mentioned above and implemented by Malteser), and sought ways of being accountable to the populations they served. It was often these same agencies that sought to identify persons with particular needs or vulnerabilities, and targeted them for assistance. Speaking with affected persons themselves, the ET found that they regarded interventions which engaged them early on as being more genuine and effective.

EQ 3 How coherent was DG ECHO's response with that of relevant external actors?	**COHERENCE**
JC 3.1. DG ECHO decisions and actions were aligned with national public health policies, priorities and plans for epidemic response JC 3.2. DG ECHO decisions and actions were coherent with those of other international actors and WHO JC 3.3. DG ECHO actively participated in multi-agency coordination mechanisms (including in advocacy), at global and national levels JC 3.4. DG ECHO's interventions enhanced - and added value to - the overall response	
Key findings	
• Often operating in situations where government-led planning is weak, DG ECHO mainly sought coherence through donor coordination, where DG ECHO was frequently seen as providing leadership • DG ECHO actively supported humanitarian coordination for epidemic response, and expected and encouraged its IPs to coordinate with relevant stakeholders • There was strong and consistent evidence that DG ECHO added value in a number of ways. Dominant among these were a strong understanding of context, and relationships of trust with competent and responsive agencies	

[102] For example: (1) Bedson J. et al. Community engagement in outbreak response: lessons from the 2014-2016 Ebola outbreak in Sierra Leone. BMJ Glob Health. 2020; (2) Gilmore B, Ndejjo R, Tchetchia A, et al. Community engagement for COVID-19 prevention and control: a rapid evidence synthesis. BMJ Global Health 2020; (3) Kathryn M Barker et al. Community engagement for health system resilience: evidence from Liberia's Ebola epidemic. Health Policy and Planning 35, 2020.

Coordination with other actors

EU policy documents recognise the primary responsibility of national authorities for the protection of their citizens when disaster strikes, while also asserting EU support for coordinated international humanitarian action and the lead role of UN agencies, especially UN Office for the Coordination of Humanitarian Affairs (OCHA) when OCHA is present.[103] The ET considered DG ECHO's own role in coordination, as well as that of its IPs, by examining the alignment of response plans with those of other actors, as well as participation in country-level coordination mechanisms.

Among the 23 Actions reviewed, 46% of the SFs elaborated on coherence with national plans and authorities, and 66% discussed coordination with international actors. Overall, the ET found that this was a high overall level of coherence. Practical coordination with national authorities was often conducted at district or provincial levels, but there were also several references to country-level plans, some of which were UN-led e.g., Humanitarian Response Plans (HRP). The relatively frequent and rich commentary on coordination by the DG ECHO experts in the FicheOp demonstrated the value they placed on this area of practice. In some cases, more information was requested from the IPs, usually to ensure there was no duplication of effort.

During interviews, IPs underscored that they referred to national or sub-national plans such as the HRP or COVID-19 Response Plan when available, although it was also observed that government-led planning was sometimes weak. IPs tried to have regular dialogue with authorities when possible, and said this was encouraged by DG ECHO. However, given the nature of the countries sampled for the evaluation, relations with national health authorities were sometimes difficult (Venezuela) or impossible (e.g., no Ministry of Health (MoH) presence in North-West Syria) or extremely limited (Afghanistan). In Venezuela, an international NGO partner said that DG ECHO's field experts had helped negotiate humanitarian access and 'opened doors' for its IPs.

DG ECHO personnel said they had relatively limited relationship with national authorities in most places where they worked, although this depended on context, the nature of the epidemic, and whether DG ECHO had a health expert in-country. The link with national authorities was more through DG ECHO's IPs, especially WHO and the United Nations Children Fund (UNICEF), which were expected to work closely with relevant ministries. DG ECHO also encouraged its NGO partners to collaborate with existing local structures, but accepted that the degree of collaboration could vary accordingly to the situation. In high-impact epidemics, the Incident Management System set up to manage and coordinate the response might be nationally led, but supported by WHO.

In terms of coherence with the plans of other humanitarian donors, there was strong evidence of DG ECHO's participation and even leadership in donor coordination fora. This included a health donors' forum in DRC, and a humanitarian donor group in South Sudan. In Syria, DG ECHO was described as playing a role in convening actors to discuss key topics, including the COVID-19 response, being "at the forefront of discussions" and "ensuring coherence through bilateral and multilateral discussions". In Venezuela, DG ECHO was seen as "very collaborative and inclusive in all its work". In South Sudan, one stakeholder observed that there could have been better coordination between donors in terms of the funding they were providing to WHO. This weak coordination had led to WHO supporting the capacity development of different national systems for health information and disease surveillance, whereas these efforts could have been streamlined to better effect.

Aside from seeking coherence over funding decisions, DG ECHO was widely seen as active in humanitarian coordination, including the coordination of disease outbreak response. DG ECHO supports the UN-led system and expects its IPs to engage in the cluster system where present. This was confirmed by the partners themselves, some of whom held cluster leadership roles. In Afghanistan, DG ECHO was an observer on the Humanitarian Country Team and on the Advisory Board for the Humanitarian Pooled Fund. In DRC, DG

[103] E.g., Consensus on Humanitarian Aid (2008), articles 4 & 25

ECHO collaborated in a range of groupings for epidemic response (donor-led, UN-led and government-led), for instance DG ECHO had a position in the Advisory Council for COVID-19 response. But one respondent from a prominent medical NGO in DRC felt that DG ECHO should have pushed WHO (which DG ECHO funded) to better coordinate the response to measles and Ebola outbreaks. In South Sudan, DG ECHO sat on the national steering committee for COVID-19 response, and in Venezuela DG ECHO was seen as the 'focal donor' in relation to the health cluster. Although the evidence strongly confirmed that DG ECHO implements its policy of support for coordination through practical engagement, its experts admitted that this depended to some extent on the number of experts available in any situation, and their personal inclination to engage in one grouping or another.

Despite urging its IPs to engage with the cluster system, DG ECHO's Anopheles experts felt that the quality of the WHO-led health cluster was 'questionable' at the country level, and not particularly relevant when coordination is needed for an epidemic response. In Afghanistan, it was said that the health cluster had been totally dormant for several months during the height of the COVID-19 response. Elsewhere it was felt that health cluster leadership was not always strong, and some of the member agencies were mainly looking to enhance their profile or stay abreast of funding opportunities.

DG ECHO's added value in outbreaks

The ET considered DG ECHO's added value among other key humanitarian actors, including other donors, by examining what were the particular qualities associated with DG ECHO that 'made a difference' to epidemic response.[104] In addition to DG ECHO adding value through its coordination activity, which included linking its IPs to coordination structures, there was substantial evidence from both documents and interviews that DG ECHO added value in two important ways.

Firstly, the value-added of DG ECHO's field presence. Most of the evidence on this came from non-EU stakeholders, who praised DG ECHO for the knowledge, experience and network of relationships it builds up in each country. DG ECHO's experts were seen as knowledgeable about the context - and not just at the national level, but also at sub-national levels. This was based on their dialogue with IPs in the field, and their frequent monitoring visits. A field expert claimed that DG ECHO was the 'eyes of other donors,' and this was corroborated by donor representatives in two countries who each said that DG ECHO's knowledge of local context complemented the capacities of other donors (who might have more funding and technical resources).

The second dominant quality was DG ECHO's close and often lasting relationship with highly capable IPs, a relationship based on long-standing mutual respect and trust. This was seen as providing solidity and authenticity to DG ECHO's portfolio of interventions: DG ECHO is admired as a donor by virtue of the high-quality work it supports, and by the way it works with its partners to maintain high standards.

"DG ECHO goes regularly to the field to monitor IP activities and make sure, among other things, they are consistent". [Humanitarian worker for DG ECHO implementing partner].

Beyond DG ECHO's support for coordination, its field presence and strong IP relationships, several further dimensions of value-added were identified. Third, DG ECHO's support for epidemic preparedness in the form of surveillance systems was valued in Afghanistan, South Sudan, Venezuela and Syria. A specific example was DG ECHO's ongoing support to WHO in South Sudan over several years to build an Early Warning and Response System (EWARS) and Integrated Disease Surveillance and Response (IDSR) capacity.

Fourth, the technical expertise of DG ECHO's country and regionally-based staff, including the Anopheles (health) experts, was much admired. IPs appreciated the technical dialogue and advice they were able to receive in designing and implementing their projects. Interviewees with UN and donor agencies valued the knowledge that DG ECHO colleagues could bring to coordination meetings.

[104] JC 6.1 will look more specifically at the outcomes associated with DG ECHO's interventions

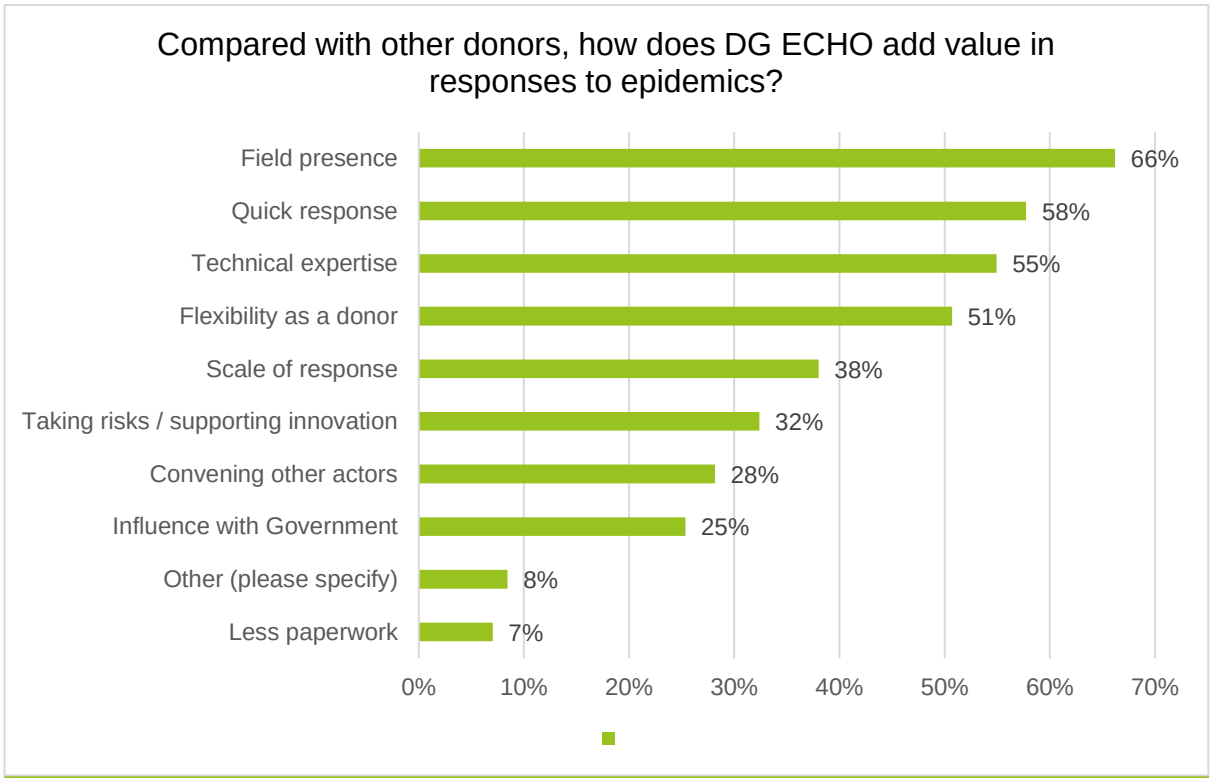
Fifth, stakeholders in Afghanistan and Venezuela highlighted the advocacy support DG ECHO provides, especially to its NGO partners. In Afghanistan, DG ECHO's advocacy had helped stave off the implementation of a restrictive new NGO law which had been proposed by the government (before the Taliban take-over). In Venezuela, IPs felt that DG ECHO had successfully mediated with the government to provide a less politically-hostile environment for NGO activities, including epidemic response.

Sixth, flexibility – a quality which will also be examined under EQ 8 To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses? – was also felt to be a strength for DG ECHO. Flexibility goes hand in hand with local understanding and strong collaborative relationships with IPs. Several partners perceived DG ECHO as more understanding of the operating context than some other donors, and as having a practical approach to project adjustments if these could be justified. DG ECHO was also perceived as sharing risks with its IPs – perhaps having a more collaborative approach than other donors.

Finally, several further observations were made regarding DG ECHO's value-added, including its willingness to fund interventions in 'hard to reach' locations and to 'stay the course' in difficult contexts, providing much-needed services to marginalised communities; its support for 'enabling' types of logistical infrastructure, including ECHO Flights; its willingness to support experienced local organisations (through international partners) in Venezuela; and its ability to support rapid response to epidemics (see EQ 8 for more analysis of 'timeliness').

Confirming the positive assessment of added value, the respondents to the e-Survey ranked 'added value' as second (of eight) DG ECHO qualities in relation to epidemic response. Here, added value was described as 'the unique strengths/contribution of DG ECHO over other donors'. When asked directly about DG ECHO's added value compared to other donors 'field presence' was the most popular choice (of ten possible options); and 'less paperwork' was the weakest quality (possibly implying DG ECHO is more bureaucratically demanding than other donors in the eyes of some respondents).

Figure 14 e-Survey results on DG ECHO's added value compared to other donors



Summary

DG ECHO not only sought coherence with other actors, but showed leadership by actively promoting and encouraging response coordination efforts, especially among donors and international humanitarian actors. It supported and participated in UN-led coordination mechanisms and encouraged its IPs to engage with the coordination mechanisms (Information Management Systems, Health Cluster), and ensured their interventions were coherent with those of other actors at the local level. There was less direct evidence of government-led plans guiding DG ECHO's response, although broad coherence with such plans was assured through the UN-led (or UN-facilitated) coordination structures and through regular dialogue between IPs and local health officials. In Venezuela, DG ECHO played a catalytic role in promoting dialogue on epidemic response between government, UN and NGO actors. There was strong evidence of DG ECHO adding value to overall epidemic response efforts in multiple ways, including its technical understanding, backed by knowledge of local context; its ability to work flexibly with experienced long-term partners; and its role in humanitarian advocacy.

EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security?
JC 4.1. DG ECHO's coordination with other EU/EC services ensured that its interventions were complementary to – and added value to - epidemic preparedness/response work conducted by the EU/EC as a whole, including that of Member States JC 4.2. DG ECHO's mandate, capacities and potential are being considered strategically in light of ongoing developments in the EC's epidemic response capacity (e.g., EHRC, DG HERA)
Key findings
• Most EU institutions relevant to health security are focused internally, within the EU's borders. Examples of DG ECHO adding value to EU and member state epidemic response in humanitarian settings were relatively few, although they increased in response to COVID-19 • Coordination across EU institutions was weak. Few stakeholders had an overview of the plethora of relevant institutions and initiatives; most initiatives were the result of bilateral collaboration • Overarching policy on epidemic preparedness is lacking in EU external action (but reportedly will soon be addressed). There is uncertainty about mandates and leadership, especially at a time when new institutions, services and initiatives are being created • As a 'front-line' institution, DG ECHO has the potential to do more and play a leading role in establishing the EU's future strategy for epidemic preparedness in humanitarian contexts, but it is currently taking a back seat

Evidence against EQ4 mainly came from interviews. Unsurprisingly, no significant data on EU coherence came from Action documents, so the limited documentary evidence available to the ET came from other EU documents provided by the EU, most of which were policy or planning documents that offered limited information about actual activities.

Collaboration with other EU/EC bodies

It was a challenge for the ET to synthesise the data on internal EU collaboration. The observations from interviews were quite tentative, partial in nature, and scattered across the web of EU entities and connections which had some bearing on collaboration in epidemics (see

Figure 9).

Very few stakeholders, many of whom were staff from DG ECHO or other EC services or Member States, were able to speak with certainty about collaboration between EU institutions on health security outside of the EU's borders, or described DG ECHO as playing a significant role in EU coordination. The ET found that few interviewees had a good overview of what all the different actors did, and so most comments were limited to the interlocutor's narrow and partial field of view. This confused overall picture was reinforced by the only observation that was common to most interviewees: that coordination between the different bodies was quite weak. Only one oblique mention was made of the ERCC, a DG ECHO unit.

"Overall, the growing number of [EU] initiatives and agencies involved in health security is hard to keep up with. There's need for more coordination". [DG ECHO policy officer]

There was a consensus among interviewees that the EC's main focus regarding health security is internal. DG INTPA and DG NEAR are perhaps the only other services with an exclusively external focus. Even within DG ECHO, a large number of initiatives and programmes which have the potential to respond externally to epidemics fall under its civil protection architecture, the essential function of which is to respond to emergencies, including health emergencies, inside the EU (although the UCPM also responds to requests from third countries). In times of international crisis (especially one that might threaten the EU or its citizens living abroad) some of this capacity can – and has been – deployed externally. This often requires agreement from Member States who have contributed directly to this capacity: an example being the West Africa Ebola crisis of 2014-16 (which falls outside the scope of this evaluation). The COVID-19 pandemic provided further opportunities for heightened cooperation on external assistance across the EU and its Member States, of which prominent examples were the Team Europe initiative (mainly finance), and the launch of the Humanitarian Air Bridge (logistical response). The European Humanitarian Response Capacity, a new (2021) tool under DG ECHO, seeks to build on experience gained through the COVID-19 response by deploying in-kind humanitarian support quickly to third countries.

Broad internal EU coordination on global health security is attempted through an Inter-Service Group on Global Health (ISGGH) and the Health Security Committee (HSC). The former was a regular, but informal, discussion forum between EC services which was put onto a formal footing under the chairmanship of the EU Secretariat early in the COVID-19 response; the latter meets every two to three months (or more frequently depending on the urgency and importance of health security issues), and is composed of representatives of EU Member States at senior and technical levels, depending the topics discussed.

There were a few positive observations from interviewees in relation to collaboration on epidemic response – examples of EU entities adding value to each other's efforts. Anopheles experts from DG ECHO and epidemiologists working for ECDC had a high regard for each other's technical competence. Occasional short-term deployments of ECDC officials to humanitarian contexts had been appreciated, and there was an appetite to collaborate more in the future on real-time epidemiological investigations and studies, bringing in other actors as needed. Experts from DG ECHO and DG INTPA spoke of similarly positive experiences of collaboration on epidemic response, including instances where development funds had been channelled to support humanitarian interventions in DRC (Ebola) and COVID-19 (Afghanistan).[105] DG ECHO was described as the EU's 'eyes and ears' in humanitarian contexts, able to provide situation reports and briefings to member state embassies and to other EU bodies with little or no presence in the affected countries - something particularly appreciated in the DRC. DG ECHO personnel appreciated the efforts of EU Delegation staff (EEAS) who provided support with humanitarian advocacy and helped overcome bureaucratic hurdles e.g., over the importation of supplies for COVID-19 response. However, the ET's overall sense is that these successes of collaboration were the ad hoc results of the personalities and professionalism of EU staff, and not due to mandates and systems.

[105] The collaboration between DG ECHO and DG INTPA is explored in more detail under EQ9.

Beyond the generally negative views on the lack of internal coordination, there were a number of observations which, without being negative, amounted to a sense of anticipation - or maybe unfulfilled promise. The potential of Emergency Medical Teams (part of the UCPM) to deploy externally was mentioned, but with the caveat that few teams are available and that they have been little used so far. Likewise, medical stockpiles under the RescEU facility established in 2019, have been deployed outside the EU, but mainly to neighbouring countries in accordance with their limited mandate. DG HERA is a new EC service, announced in 2021, but only starting to be functional in 2022. Although focused on increasing the EU's internal resilience to global health threats, DG HERA is intended to contribute to '*global surveillance … and …reinforced international cooperation and support for crisis-relevant medical countermeasures with global actors'.*[106]

Some interlocutors, especially those based at regional or country levels, were critical of some aspects of EU epidemic response, especially in relation to COVID-19, which they regarded as sometimes motivated by the political need to be seen to be doing something, rather than based on evidence of what was actually needed, although this shortcoming is perhaps more prominent with hindsight. These observations related to certain vaccination initiatives and deliveries of medical supplies and equipment, which they saw as driven by the desire for visibility. The ET found some basis for these observations: it was official EU policy to increase the visibility of its COVID-19 response[107], and a KII with senior DG ECHO management confirmed that there were political pressures to ensure some humanitarian aid during the pandemic could be earmarked for particular countries - rather than assigned to pooled response funds and dispersed according to priorities decided by the implementing partner e.g., WHO.

Epidemics: DG ECHO's role among other EU actors

Whereas all other evaluation questions require retrospective analysis, EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security? invites consideration of DG ECHO's current and future positioning within the EU, in relation to epidemics. As concern over infectious diseases has dominated discussion about global health security (GHS) in recent years, the concepts of epidemic preparedness and GHS have become merged.[108]

At the time of writing this evaluation report, there is no single policy document that describes how the various EU institutions will work together on epidemic preparedness. The Communication on Global Health sets out the EU's priorities for global health, but was very focused at the time of its publication (2010) on health development, and access to affordable services in lower and middle-income countries (the only reference to epidemics being in relation to AIDS). This underscores the extent to which epidemics have re-emerged as a global health concern in the last decade. Perhaps mindful of this policy gap, the European Commission announced in May 2022 that it would develop an EU Global Health Strategy. The official statement makes it clear this will be focused on infectious diseases and their potential to cause pandemics.[109] The previous absence of an epidemics preparedness policy suggests that the several EU institutions with relevant responsibilities, including DG ECHO, have, until now, had to forge coherence through inter-service dialogue, but may not have enjoyed a very structured approach to this.

By far the most information on DG ECHO's role among other EU actors came from EC employees based in Brussels. Their observations fell broadly into two categories. Many interlocutors spoke of the lack of clarity about institutional mandates in relation to epidemics. The emergence of DG HERA and the EHRC had

[106] Communication… Introducing HERA, the European Health Emergency preparedness and Response Authority, the next step towards completing the European Health Union, [COM(2021) 576] European Commission, 2021

[107] See, for example, The Rise of the Team Europe Approach in EU Development Cooperation (2021). Niels Kaijzer et al. German Development Institute.

[108] For instance, the Global Health Security Agenda was specifically established in 2014 'to achieve the vision of a world safe and secure from global health threats posed by infectious diseases' and the EU's new HERA service has been founded in response to the COVID-19 pandemic with a mandate to 'reinforce global health emergency preparedness'.

[109] EC statement 22/3128, 19 May 2022.

created a sense of anticipation, but also a degree of uncertainty about roles and the boundaries between roles, including who would lead on which aspects of GHS. Potential overlaps were seen, in particular between DG HERA, DG SANTE, ECDC and the ERCC, which were yet to be resolved. It was acknowledged that this was a process, that roles were still being clarified, and that existing bodies would need to yield some space for DG HERA. At the same time, it was noted that the mandate of each of these entities was largely focused internally within the EU, albeit with a need to monitor disease threats outside its borders and collaborate with international partners. Similar uncertainty was expressed about how the EHRC would work; two field-based experts even confused it with DG HERA.

The second category of comments related to DG ECHO's potential to play a greater role in GHS, through developing its own capacities and working more closely with other EU institutions. The interplay of underdevelopment, conflict, displacement, climate change and environmental degradation mean that humanitarian contexts are high-risk areas for infectious disease outbreaks, for which DG ECHO is 'on the front line'. It is the only EC body with a direct mandate to respond to acute health emergencies outside the EU, and has an existing range of mechanisms for disease surveillance, epidemic preparedness and response, including the Epidemics Tool, which some interlocutors thought should be used more often and with more emphasis in appropriate situations. On the other hand, it was noted that DG ECHO has not sought to emphasise its humanitarian health work in the past: its desire to be a 'reference' donor (i.e., to encourage innovation and provide policy leadership) has been focused on other humanitarian sectors.[110] Some interlocutors were excited about the potential of the civil protection 'side' of DG ECHO to break free of its focus within EU borders and add new dimensions to the humanitarian assistance work – 'moving from donor to doer'. But others were more cautious or sceptical, fearing the 'politicisation' of aid (see discussion above) or noting that potentially useful capacities, such as the deployment of EMTs, were underdeveloped at present. More generally, a few respondents spoke of a lack of coherence between the civil protection and humanitarian aid sides of DG ECHO, with some units appearing to work in silos and staff not engaging enough with colleagues in different sections. The perceived rapport between DG ECHO and ECDC, and potential for more frequent future collaboration was reiterated. A service-level agreement exists between them, governing the deployment of ECDC experts to support DG ECHO. DG HERA was also seeking to develop MoUs with several sister institutions, including ECDC and DG ECHO.

Amidst the general optimism about DG ECHO's opportunities to collaborate more with other EU bodies on epidemic preparedness and response, a serious note of caution was sounded by some stakeholders who felt that DG ECHO was too passive and reticent in its participation in GHS discussions, noting for instance that it is DG SANTE and DG INTPA which are leading on the Global Health Security Strategy, and that DG ECHO only provided one participant (out of 57) in the inter-service meeting where discussions were launched. In offering reasons as to why this might be the case, the ET was informed that DG ECHO valued its independence and feared being dragged into 'political' discussions, but it was also remarked that there is a critical lack of DG ECHO health expertise in Brussels (see EQ 5 How effective have DG ECHO's tools and instruments been in addressing epidemics? below for more on this finding). When asked the open question in the e-Survey 'what are the opportunities and constraints to DG ECHO playing a greater role in global health security within the EC', most responses about opportunities concerned *better coordination with other EU entities/ linking other EU capacities to DG ECHO responses or preparatory actions.* In terms of constraints, most responses mentioned the *lack of resources and competencies to fulfil a bigger role in GHS.*

When asked about the role foreseen for DG ECHO in the Global Health Strategy, a senior DG ECHO leader confirmed the desire to be part of strategy formation, drawing upon recent experience of coordinating cross-EU response efforts in the West Africa Ebola crisis and the COVID-19 pandemic, and deploying new capacities such as the Humanitarian Air Bridge. It was accepted that there were too few health experts (as well as experts in other technical disciplines) in Brussels to achieve what was described as DG ECHO's 'ambition' to strengthen its engagement in policy and strategy, thereby complementing its status as a 'doer' agency.

[110] Particularly humanitarian cash transfers, food aid and nutrition

Summary

There is a growing number of EU bodies and initiatives which have a bearing on epidemic preparedness and response, but most are focused inwardly (within the EU's borders). In respect of external humanitarian response to outbreaks the ET found that they were not sufficiently tied together by coordination mechanisms or policy direction, leading to some incoherence. In humanitarian settings, DG ECHO has the potential to play a bigger role in the coordination of epidemic preparedness and response, as well as in the EU's related global health security dispositions. DG ECHO has privileged information and expertise, and could use this more within the EU to emphasise the associations between humanitarian crises and epidemics, and to champion the need for prevention, preparedness and early response. At present, however, DG ECHO appears to be diffident about coordination with other EC services, and lacking sufficient policy capacity to lead on those aspects of the EU Global Health Strategy that relate to international humanitarian action. Nor does it have a strong history or inclination to work collaboratively with other EC services, and above all it does not have a clear policy direction to guide it on this matter.[111]

EQ 5 How effective have DG ECHO's tools and instruments been in addressing epidemics?	**EFFECTIVENESS**
JC 5.1. The size of DG ECHO's epidemic/pandemic response architecture was appropriate to the scale of the needs JC 5.2. DG ECHO's tools and instruments were well designed, 'fit for purpose' and do not leave unreasonable gaps in response capacity	
Key findings	
• Recognising that humanitarian funding levels rarely match all the needs and that COVID-19 was especially 'overwhelming', DG ECHO's funding for epidemic response was generally seen as appropriate, although many thought the highly-rated Epidemics Tool should be a bigger element of the funding portfolio • There is potential for civil protection instruments to play a greater role in epidemic response in certain humanitarian contexts. At present, however, this ambition is not matched by capacity and is hampered by poor internal coordination • Appropriate selection of interventions is grounded in DG ECHO's strong field presence. Nonetheless, its decision-makers tended to be guided by what IPs proposed, rather than challenging them to prioritise, based on a strategic overview of needs and gaps • The network of Anopheles experts is the cornerstone of DG ECHO's reputation in epidemic response, but the severe shortage of corresponding health experts at HQ weakens the organisation's potential to be a more significant actor in this area	

This EQ examines the mechanisms for DG ECHO's response, and whether they had utility in their own right (rather than whether they produced results - which is considered under EQ 6 What results were achieved by DG ECHO's epidemics response?). In the evaluation's TOR, tools and instruments are defined as 'all activities that DG ECHO does in response to epidemics.' They include funding mechanisms as well as other assistance mechanisms, such as interventions under the UCPM. A consideration of DG ECHO's architecture - or ways of delivering assistance - is also suggested by the question, although a detailed review of all DG ECHO's organisational and management structures with a bearing on epidemics was judged beyond the scope of the evaluation.

[111] This general picture was fully borne out by the e-Survey, which for this set of questions was directed only to EC staff

Scale of response

According to the funding data displayed in Table 4 [section 3.3], DG ECHO provided € 526M to Actions tagged 'epidemics' in the HOPE funding database in the period 2017-2021, although many of these Actions would have only included an element of epidemic preparedness or response among a range of other interventions. This sum represents 4.7% of total DG ECHO humanitarian disbursements (all sectors) over the same period (€ 11,076M).

As might be expected, most stakeholders believe that humanitarian funding, as a whole, is rarely enough to cover perceived needs: for instance, the most recent humanitarian appeal for Venezuela was only 50% funded, according to one UN staff member. Furthermore, there was recognition that compared to some other donors, notably United States Agency for International Development's (USAID) Bureau for Humanitarian Assistance, DG ECHO's resources were more modest, although this was offset by the perception that DG ECHO added value in other ways, for example by being quick and flexible. In terms of epidemics more specifically, funding levels were generally considered appropriate, although it was acknowledged that the scale of the COVID-19 pandemic was 'overwhelming', despite some sizable responses by DG ECHO. However, several stakeholders considered the funding amounts available through the Epidemics Tool to be insufficient. Some thought the average size of each grant through this tool was too modest, with one employee of an IP feeling it hardly warranted the effort spent on the application. Before the COVID-19 pandemic (years 2011-2019) the average size of an Action funded from the Epidemics Tool was € 464k, which might be considered a small grant from a major institutional donor. By comparison, the average Action funded under the Geographical HIPs during the same period was € 3.6M.

Table 8 Comparison of funding disbursements under the Epidemics Tool and Geographical HIPs, 2017-2021[112]

Year	Epidemics Tool			Geographic HIPs* (Actions including sub-sector of epidemics)		
	Total Contracted Amounts	Number of Actions	Average size	Total Contracted Amounts	Number of Actions	Average size
2017	€ 2,400,000	6	€ 400,000	€ 83,228,082	26	€ 3,201,080
2018	€ 2,775,000	5	€ 555,000	€ 102,005,803	27	€ 3,777,993
2019	€ 1,790,000	4	€ 447,500	€ 86,068,000	22	€ 3,912,182
2020	€ 40,900,000	5	€ 8,180,000	€ 64,252,097	25	€ 2,570,084
2021	€ 12,500,000	15	€ 833,333	€ 114,176,200	39	€ 2,927,595
Grand Total	**€ 60,365,000**	**35**	**€ 1,724,714**	**€ 449,730,182**	**139**	**€ 3,235,469**

The overall amount allocated each year to the Epidemics Tool (as part of the Emergency Toolkit) is around € 5M, although this can usually be topped-up if needed. Recognising the additional demands on this tool created by the COVID-19 pandemic, it was allocated € 15.8M at the beginning of 2021. Additional modifications during the year saw this amount rise to an unprecedented € 125.8M, representing 87% of the Emergency Toolkit allocation for 2021. The reason for this jump was a decision made at the highest levels of the EU to channel € 110M in support of COVID-19 vaccination in low-income countries, including: € 25m in support to national vaccination campaigns in Africa and reinforcement of national health systems' resilience to epidemics, € 75m targeted humanitarian operations to prepare, facilitate and conduct in-country vaccination campaigns (€ 25m for multi-country operations and € 50m for country-specific operations), and € 10m for support to the delivery of vaccines under the COVAX Humanitarian Buffer. The Epidemics Tool was judged to be the best available vehicle to facilitate the quick disbursement of funds to multiple countries and partners, but this decision was controversial in some quarters of DG ECHO. Technical experts questioned whether this expenditure was based on best evidence or the need for the EU to make an eye-catching 'statement' about its support for COVAX. Furthermore, it was noted that DG ECHO is not set up to run large multi-country, multi-

[112] Sources: ET analysis of a) Epidemics Tool data provided directly by ECHO, and b) data sourced from HOPE database for actions tagged to the subsector of epidemics, under Geographic HIPs

partner programmes (as opposed to projects), and there was a concern that this intervention would stretch the organisation's management and accountability systems.

Stakeholders had fewer comments regarding the in-kind interventions. The Humanitarian Air Bridge (HAB) was highly appreciated in Afghanistan, which received around 15 large cargo flights for COVID-19 response during the period 2020-21. Interviewees in Afghanistan said that the HAB was flexible and effective compared to a similar UN air cargo system in the country. In contrast, it was reported from Syria that the HAB had benefited the Middle East very little (although there may have been operational reasons for this). As noted, also under EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security?, there were doubts about the capacity of the UCPM to make a difference through the deployment of EMTs. A 2019 assessment found that the EC had no level-3 (field hospital) teams available.[113] An internal report on Medical Capacities in the UCPM (2020), noted that no medevac teams or mobile labs had been deployed (at that time) in response to COVID-19 and that "*EMTs were overwhelmingly involved in national [i.e., internal EU] response.*"

In the judgement of the ET, there are good reasons to augment traditional humanitarian aid with the civil protection capacities which are integrated within DG ECHO. The HAB was clearly effective during the height of the COVID-19 response. It added value to traditional capacity (e.g., to the UN-led Logistics Cluster) rather than seeking to duplicate or displace it. On the other hand, there are signs that DG ECHO is over-estimating and over-emphasising the potential for civil protection capabilities to play a major role in future humanitarian crises, possibly driven by considerations for visibility. The term 'moving from donor to doer' is circulating within DG ECHO and could provide the wrong signals internally and externally: DG ECHO's donorship will always be its most important contribution to humanitarian response. And some of the capacities mentioned as part of the EHRC, for example the short-term deployment of EMTs and the use of volunteers, are likely to be of marginal value in practice, and only in very specific situations.[114]

Choosing appropriate interventions

DG ECHO's system for selecting what Actions to support depends a lot on its network of field-based experts, whose understanding of context is seen as one of the institution's key strengths. This knowledge gets fed into the annual HIP for each country (or region), which provides a framework for prioritising which interventions to fund, and is the basis for IPs to submit proposals. If countries are at high risk of epidemics, this should be noted in the HIP, and the HIP would be the normal source of epidemic response funding. The Epidemics Tool provides a safety net for outbreak response in situations where an outbreak was unforeseen, or outstrips the available resources, or in a country without a HIP. The Epidemics Tool can also be used proactively for epidemic preparedness work.

In terms of selecting specific interventions, partners submit proposals through the eSingleForm, and the FicheOp is the project management tool used by DG ECHO staff to track each Action, comment on its performance, and record internal discussions on implementation problems and recommended solutions. For epidemic response, the team managing an Action typically consists of a country-based field expert, a regionally-based Anopheles expert, and the Brussels-based desk officer. The FicheOp is designed to allow rounded and collective decision-making, although in reviewing the Action documents the ET could not always see how the technical observations of the Anopheles expert were considered in the final decision, a point also made by Anopheles experts (see also findings under EQ 1 How appropriate were DG ECHO's plans and interventions in response to epidemics?). However, on the whole, the FicheOp provided evidence of reasoned decision making, based on evidence, compatibility with the relevant HIP, an understanding of context and the track-record of the IP.

[113] Evaluation Study of Definitions, Gaps and Costs of Response Capacities for the Union Civil Protection Mechanism (2019), Centre for Strategy and Evaluation Services.

[114] See Humanitarian Action Communication (2021), section 3.2

Nonetheless, the mechanism is not flawless. Often missing from the Action documents was a strategic understanding of the particular challenges and needs of epidemic response (as opposed to the overall humanitarian situation which is covered in the HIP). The ET was disappointed that the Action documents did not situate the planned intervention in a broader analysis of what the overall needs were, and of what response gaps needed to be prioritised. The fact that epidemic response tends to be structured around a number of classic 'pillars' (which would normally also be set out in the country's epidemic response plan), should make this straightforward. However, it seems from interviews with Anopheles experts that DG ECHO is very dependent on what its IPs are offering in terms of a response, and furthermore that 'the bar is high' for responding to epidemics in countries where DG ECHO lacks an existing presence. One evaluation finding therefore is that DG ECHO looks to the SF for explanation and justification of what an IP proposes, rather than looking to the SF for analysis of how the proposed Action meets the priority needs of the epidemic. Neither the HIP, nor the SF, shapes a response by encouraging potential partners to fill the most critical response gaps. In short, the decision-making described in the FicheOp tends to say 'yes, this intervention is relevant', rather than 'yes, this is the most relevant intervention'.

Although the Action documents did not specifically situate the planned interventions within epidemic response 'pillars', the ET conducted a mapping exercise of 23 sampled actions to ten epidemic response 'pillars',[115] to seek a snapshot into the alignment and weighting of DG ECHO funded actions with these pillars. The result of this analysis is shown in 9. Several actions covered two or more pillars. Surveillance, infection prevention and control, and case management were amongst the most frequently occurring pillars in the sample.

Table 9: Sampled actions by epidemic response pillars

Pillar	Frequency of occurrence within sampled actions	Percentage of sampled actions including pillar (n=23)
Surveillance	11	48%
Infection prevention and control	9	39%
Case management	9	39%
Risk communication and community engagement	8	35%
Psychosocial support	8	35%
Continuity of Healthcare Services	6	26%
Laboratory	4	17%
Coordination	3	13%
Logistics	2	9%
Vaccination	1	4%

Source: ET analysis of 23 sampled actions (see annexe 4)

The Anopheles experts have more control over the Epidemics Tool. This incorporates a special internal form[116] which is filled in by the relevant expert and then sent for peer review and comment by the rest of the Anopheles group. Tight deadlines are imposed on this, and the whole decision process can take just a few days in theory. Whilst the format of the form is kept deliberately simple, it does cover the basic elements of a situation analysis and, importantly, allows Anopheles experts the opportunity to say what actions they recommend, rather than just recording what actions are being proposed by potential partners. In this sense, the Epidemics Tool improves on the HIP process. Generally, the Epidemics Tool was highly valued and appreciated by stakeholders. It is unique in being a funding instrument focused on a particular technical

[115] The pillars covered were continuity of health services, infection prevention and control, vaccination, laboratory, surveillance/case detection, case management, risk communication and community engagement (RCCE)/ hygiene promotion, coordination, logistics and Mental Health and Psycho-social needs (MHPSS)

[116] The Assessment Template for Epidemic Threat

sector. While the amount of available funding is not large, funds are generally disbursed quite quickly (see EQ 8 To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?), and were valued for their potential to kick-start a response in advance of other funds coming onstream, perhaps from other donors. Thus, the Epidemics Tool was seen as being quick, focused, and catalytic.

One aspect of 'appropriateness' is the balance of interventions focused on preparedness, as opposed to response. This question will be explored under EQ 9 To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?, as prevention and preparedness often require sustained investments over time and are part of a focus on resilience.

Making the tools work

As mentioned earlier, the knowledge and experience of DG ECHO's field network is key to its success as a humanitarian donor. For this, it uses seasoned humanitarian professionals. Other major donors might have fewer personnel in the field, or their field teams might comprise a greater proportion of administrators and generic civil servants. In the context of epidemics, the Anopheles experts are highly respected within the EU and among external agencies. Some respondents felt that more such experts were needed, whereas others pointed to other perceived gaps, notably the need for more field generalists capable of providing strategic analysis and advice on governance issues. Some EU staff suggested that additional health expertise could come from closer collaboration with ECDC or appropriate experts in other organisations or institutions, such as academics who could engage in real-time operational research during disease outbreaks. Looking at all relevant data, including some responding to other EQs, the ET would support the idea that some health expertise in the field can be surged in when required, through building links with other institutions (EU and non-EU), but that there is a strong argument to boost in-house capacity to grapple with certain strategic policy issues (see also EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security? and EQ 9 To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?, for instance).

The fact that some UCPM interventions had taken place without recourse to the advice of the Anopheles experts was highlighted as a concern, and closer coordination with UCPM was recommended in future. A related point was that too few actors were aware of the possibilities for UCPM interventions or how to request them. Evidence of a general lack of coordination and collaboration between the humanitarian aid and civil protection sides of DG ECHO, in relation to the deployment of tools and instruments, adds weight to the similar finding under EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security?. On the other hand, the much-admired Epidemics Tool is administered by a unit generally considered as belonging to the civil protection side, but with strong technical input from the Anopheles group, demonstrating that this kind of collaboration can work effectively.

A strong finding, for which evidence was also collected under several EQs, was that DG ECHO has inadequate levels of technical and policy expertise in Brussels. Throughout most of the five years under evaluation (including two years of COVID-19 pandemic) there was a single contractor occupying this role, a situation that colleagues in other EU services found bizarre and which would contrast strongly with comparable donor organisations. A healthy dialogue between field and HQ levels is important in terms of strategic overview, staying abreast of emerging trends, institutional learning, ensuring consistency of approach etc. Subject matter experts operating at the global level will bring a different perspective to colleagues working in the field, but can also provide an important bridge between the two levels, as well as a node of communication on relevant technical and policy issues for senior management, with other EU institutions, donors, and UN agencies. The weak policy engagement from HQ was underscored by comments

from field-based Anopheles experts who explained that, perhaps understandably in view of their locations and workload, they were reluctant to engage in global-level discussions.

"Of course more money would be good, but DG ECHO needs more technical [health] expertise. This could raise the quality of interventions (e.g., civil protection support), through being evidence-based." [EU official, Brussels].

Despite widespread praise for the relative rapidity with which DG ECHO could process funding proposals (see EQ 8 To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?), several IPs also commented that project paperwork was hard for field staff, in particular, to get to grips with, and complained of 'fussy' rules on the use of funds. This was a particular concern from some UN agencies that already have their own (lengthy) internal processes of financial planning and due diligence. E-survey respondents also saw DG ECHO's paperwork as more burdensome than other donors. Further analysis of the survey results showed that most of the negative comments regarding process came from UN agencies or IFRC, suggesting that International NGOs are either more adept at dealing with DG ECHO's systems and requirements – or more willing to invest time in applying for relatively modest amounts of funding. The process burden was also noted to be lighter when DG ECHO consulted with IPs during the annual HIP development period, and when DG ECHO field experts supported IPs with navigating through DG ECHO's paperwork and application process.

Summary

The scale of DG ECHO's response to epidemics was generally considered appropriate in relative terms, given that aid is 'never enough' and that the needs arising from COVID-19 were particularly overwhelming. By deploying resources quickly, DG ECHO can sometimes plug important gaps before donors with bigger resources are able to respond. The Epidemics Tool is a very specific and highly-valued instrument at DG ECHO's disposal, but stakeholders thought it could be used more often, especially to support preparedness work, and would be more effective if the grants were larger on average. The Humanitarian Air Bridge provided effective logistical support to the COVID-19 response. Some civil protection capacities were available to support the humanitarian response to epidemics, but had not been deployed at scale within the evaluation timeframe. DG ECHO's system of managing Actions through the SF and FicheOp documentation system may have led to efficiencies, but at the cost of richer analysis of needs and explanation about how the interventions have been prioritised. A lot of trust and responsibility is therefore placed on DG ECHO's highly-appreciated network of field experts to ensure that the selected interventions are the most appropriate ones and not just those which IPs feel comfortable in offering. Good technical expertise and field knowledge needs to be balanced by additional capacity for policy development and strategic thinking, especially at Brussels level.

EQ 6 What results were achieved by DG ECHO's epidemics response?	**EFFECTIVENESS**
JC 6.1 DG ECHO-funded actions and advocacy in response to epidemics mitigated the spread and impact of those epidemics JC 6.2 Unintended negative consequences of DG ECHO-funded actions were minimal and effectively mitigated when identified	
Key Findings	
• Overall, the epidemic interventions made valid contributions to control and mitigation, considering the modest (funding) size of many projects • Results were most impressive in projects focused specifically on epidemic response. Where epidemic interventions were embedded in projects focused on other things, some of these interventions helped maintain the continuity of important services, but others lacked ambition, incorporating elements that were relevant, but not necessarily the most relevant	

- Many epidemic response interventions had lasting positive effects beyond the end of the projects, especially where communities had been fully involved
- The data on unintended consequences was too scant to provide strong findings. There was no evidence of unintended negative consequences, and some data did show that DG ECHO and its IPs managed risks in order to avoid such consequences

Epidemic control and mitigation

As discussed in EQ5 and illustrated in Table 9, the 23 sampled Actions covered ten epidemic response 'pillars',[117] with several covering two or three different pillars. The majority of Actions were where epidemic response components were integrated into broader projects covering health or protection, and in these cases the epidemic element was often relatively subordinate (e.g., assigned one result in the logical framework out of four or five). Analysis of a subset of Actions using the FicheOp revealed that 63% of Specific Objectives were achieved or exceeded. As the results of DG ECHO-funded Actions are self-reported, their accuracy depends to a large degree on trust and the quality of the IPs' monitoring, evaluation and learning functions. DG ECHO field experts are diligent in visiting and monitoring the projects, but cannot be expected to evaluate them formally, and few Actions include a budget for independent evaluation. Nonetheless, the FicheOp documents provided evidence of due diligence on the part of the field experts and desk officers when it comes to reporting. They provided commentary on the overall project performance, often demanded additional information from IPs, and discussed variations between planned results and those actually achieved, for example explaining unforeseen challenges.

As is to be expected in short-term humanitarian interventions, the Actions only aimed to effect change at the level of outcomes (e.g., improved service provision) and to contribute to epidemic preparedness and response, rather than claiming responsibility for overall impact. Often DG ECHO was just one donor among several, and their IPs were just some among many humanitarian response agencies. The evaluators therefore needed to make judgements about the significance of the Actions in mitigating outbreaks (attribution). Some of the sampled Actions were concerned with preparedness, rather than response. As 60% of the Actions sampled were not specifically focused on epidemics, it follows that those 60% could only have limited impact on outbreak trajectory. To illustrate the challenge of attributing results, let us consider an NGO that DG ECHO funded to provide 'Multi-sector lifesaving assistance to conflict and COVID-19 affected populations in Eastern Afghanistan'.[118] Two of the four results in the logical framework were related to COVID-19: one focused on maintaining continuity of health services, the other was an intervention 'Strengthening IPC measures at community and health facility levels.' Maintaining access to routine health services during an epidemic was a very important mitigation measure covering 1.2m people, but targets for the IPC work were relatively modest, covering around 21,000 people. Such an intervention, by itself, could be judged to have modest impact on epidemic trajectory at a local level, and negligible impact at the national level. The value of many of the Actions that were not epidemic-specific could be seen in the same way: they were examples of IPs incorporating adaptations to epidemics into their existing activities, rather than addressing epidemics head-on. These were valid contributions to epidemic response, but not more than that, and the finding under EQ 5 that DG ECHO is strongly influenced by what its IPs can offer is also relevant here.

Generally, the Actions that focused more specifically on epidemics, including those funded under the Epidemics Tool, could be expected to have more significant outcomes in terms of disease control and mitigation. A good example was a measles outbreak response conducted by a single DG ECHO partner in the DRC[119]. Supporting the local health services, this NGO treated double its targeted number of cases, helped

[117] The pillars covered were continuity of health services, infection prevention and control, vaccination, laboratory, surveillance/case detection, case management, risk communication and community engagement (RCCE)/ hygiene promotion, coordination, logistics and Mental Health and Psycho-social needs (MHPSS)

[118] Action 2019/00446

[119] Action 2019/00680

bring the outbreak under control, and reduced the case fatality rate from 1.4 to 0.1. This success was recognised by the DG ECHO desk officer:

"…the project had a significant impact in the health zone where it was implemented … contributing to the control of the epidemic in the area (by the end of the project, the number of new cases was very low, mainly thanks to the vaccination campaign that was also supported by the project". [DG ECHO Desk Officer]

Similarly, an evaluation of DG ECHO's work in Yemen found that it contributed to controlling a cholera epidemic in 2018 that had affected one million people, partly through its "impressive'' results in the WASH sector, especially by increasing access to drinking water and promoting hygiene awareness.[120] In contrast, a large Ebola response project by a UN partner in DRC (originally funded by the Epidemics Tool before being extended through the Geographic HIP) had mixed results, and the overall tone of the final comments in the FicheOp is one of disappointment and underachievement. The field expert noted the low quality of the final report (*''not … [sufficiently] comprehensive to allow a sound assessment of the response''*), the IP's weak leadership of the IPC pillar, and its lack of operational expertise in humanitarian contexts.[121]

The majority of interviews discussing effectiveness and results were with representatives of DG ECHO's partners who were associated with the projects that were reviewed through their documents during the desk phase. Few were inclined to criticise their own interventions, so most IPs spoke in positive terms while adding some detail they felt relevant. Several IPs made the point that aspects of the projects had continued to have impact beyond their official end dates. They observed, for instance, that improvements in hygiene awareness (e.g., handwashing) had led to lower incidence of diarrhoeal disease, or noted that training and systems building during epidemic response had led to sustained improvement in the functioning of local health services. Speaking of DG ECHO's long-running support for epidemic surveillance and preparedness in South Sudan, several respondents affirmed that disease detection and reporting (e.g., for measles, meningitis and cholera) had improved over time, although they doubted how sustainable this would be without ongoing external support.

Some IP representatives made the point that reporting tended to be too descriptive to elicit clear findings about outcomes and impact, and that the short project timespans and modest funding typically available from DG ECHO reduced the potential for large-scale outcomes.

Concerning advocacy, in addition to the discussion on this topic under EQ 3 How coherent was DG ECHO's response with that of relevant external actors? (see above), it was noted that in Syria there was praise for the DG ECHO country team for being *"very vocal in various coordination platforms to promote adequate response to epidemics, and specifically the COVID-19 pandemic, by advocating for and funding IPC, and enhancing case management capacity, and surveillance".*

FGDs in DRC and Venezuela were broadly positive about the effects of DG ECHO-funded interventions in their communities. They saw the biggest change in terms of the knowledge and behaviour of community members, including vaccine acceptance, following various risk communication and hygiene education sessions conducted by DG ECHO's partners. In DRC these changes were associated with reductions in cases numbers (incidence) for cholera, COVID-19, typhoid and simple diarrhoeas. In both countries, FGDs felt that some of the effects would last beyond the life of the projects, thus echoing the views of some of the key informants. Two FGDs in Venezuela further thought community collaboration and solidarity had increased as a result of recent epidemics (e.g., yellow fever and COVID-19), and in DRC the FGDs spoke of increased general demand for vaccination services, handwashing points in restaurants, people keeping water points clean, and better awareness of food hygiene. On the other hand, two FGDs in Venezuela thought the RCCE interventions had been too modest in scope – not reaching enough parts of the community, and with the visits

[120] Evaluation of the European Union's Humanitarian Interventions in Yemen and in Humanitarian Access 2015-2020 (https://reliefweb.int/report/yemen/evaluation-european-union-s-humanitarian-interventions-yemen-and-humanitarian-access)
[121] Action 2018/00846

from the IP being too infrequent. Notwithstanding some differing opinions, on balance, FGDs were generally positive about the likelihood of lasting results.

Unintended consequences

Despite the ET's efforts to elicit information on unintended consequences from FicheOps, very little evidence was found on this. Risks were generally interpreted as risks to the successful completion of the project, rather than the risk of unintended consequences, even though such risks were relevant. For instance, in reviewing the Action documents for Venezuela, a country where the government is ill-disposed towards humanitarian organisations, the ET was surprised that the risks of further punitive restrictions being imposed as a consequence of DG ECHO-funded Actions were not assessed.

In interviews there were anecdotal observations, for example DG ECHO field experts mentioned some 'poaching' of staff by a UN partner (although this could well have been just transparent recruitment where NGO staff were attracted to move for larger salaries). Another comment in relation to the same partner in Afghanistan pointed out that the lack of gender analysis in the SF may have led to a male bias in project delivery. A positive example of an IP adjusting for possible unintended consequences was the implementation of a data protection policy in Syria, which prevented details of staff or service-users being put at risk and used by armed actors to target individuals.

Interviews also confirmed that IPs took measures to prevent unintended negative consequences: for example, where DG ECHO and its IPs were working in fraught political contexts, considerable efforts were made to ensure conflict-sensitive approaches to humanitarian work and to avoid creating any additional tensions between or within communities (see findings on 'Do No Harm' under EQ 2 To what extent did DG ECHO's Actions seek the participation of affected populations at all stages of the humanitarian project cycle, and seek to address their needs and priorities?). Furthermore, some IPs emphasised the efforts they had taken to protect their staff and service-users (e.g., patients attending clinics for routine consultations) from nosocomial infection, through adherence to operating protocols and good IPC measures .

Summary

The results of most Actions were self-reported by the IPs and not subjected to independent evaluation, although DG ECHO field experts did conduct field monitoring visits, scrutinised project reports and sought clarifications when necessary. Around 65% of project targets were achieved or exceeded and explanations were provided for missed targets. Results were most impressive in Actions focused specifically on epidemic response rather than those (the majority) where existing projects had been lightly adapted to incorporate epidemic intervention measures, which sometimes lacked ambition and probably had negligible impact on epidemic trajectory. Several stakeholders, including affected persons, thought DG ECHO-funded interventions had had a lasting effect, beyond the life of the Actions itself. Data about unintended consequences were very scant, making it hard to formulate any overall judgements, although the ET was made aware of a number of active measures taken by IPs to avoid such consequences as a result of their project implementation.

EQ 7 Have DG ECHO's Actions in response to epidemics been cost-effective?	**EFFECTIVENESS**
JC 7.1. DG ECHO-funded Actions demonstrated cost-effectiveness	
Key findings	
• DG ECHO has no framework for assessing cost-effectiveness, but it does have strong systems to ensure costs are minimised in relation to intended results • Most of the evidence points to DG ECHO-funded projects being cost-effective, although responses to other EQs suggest some areas where even greater cost-effectiveness might be achieved	

No formal guidance on cost-effectiveness

DG ECHO does not provide formal guidance on cost-effectiveness. A study of approaches to cost-effectiveness commissioned by DG ECHO in 2016[122] found that usage of the term cost-effectiveness in the EC varied, and suggested a definition which this Evaluation has adopted: '**the achievement of intended outcomes in relation to costs.**' The findings of the Study were also borne out by the Evaluation of DG ECHO of Afghanistan and NRC partnership (2018)[123] which found no systematic or standardised system of ensuring cost effectiveness (other than DG ECHO's streamlined grant management processes). The SF guidelines explain that 'cost efficiency' is one of the assessment criteria used by DG ECHO in deciding what to fund, but this is a narrower term which the SF guidelines interpret as the 'cost of a programme relative to the amount disbursed.' Given the broad thematic nature of this evaluation, spanning many Actions over a five-year period, it was not feasible to provide an audit-level analysis of cost-effectiveness, for example by comparing reported results with detailed project budgets and expenditure reports, and in any case this sort of quantification is a doubtful measure of efficiency.[124] The approach taken by the ET was to examine a sample of Action documents (especially the FicheOp) for specific commentary on cost-effectiveness; to ask key informants for their observations; and to make common-sense judgements based on the collective experience of the ET of working on epidemic response in similar contexts.

The data acquired on cost-effectiveness were quite diverse, with no single issue standing out strongly. Nonetheless it was possible to group findings into a few loose themes. Several stakeholders highlighted the lack of a formal framework for making cost-effectiveness judgements, with one observer commenting on the difficulty of making comparisons between different types of project, since the costs of operating in a hub with decent infrastructure would be less than those incurred in remote areas; and since success in responding to Ebola might look different to success in tackling measles. It was also observed that different expectations about cost structures (i.e., the acceptable proportion of indirect to direct costs in the budget) were applied to NGOs and UN partners.

The effect of DG ECHO's project management systems on cost-effectiveness was generally seen as positive. Once again, the knowledge and understanding of context among its field experts was significant. They develop a 'feel' for what is reasonable or not in terms of costs and an understanding of what IPs can reasonably achieve according to their capacity and track record. There was evidence in the FicheOp documents of DG ECHO scrutinising bills of quantity attached to funding applications, and requesting additional information from IPs on costs (although one project was approved despite a field expert questioning the cost structure). In Venezuela, where drug importation was very expensive due to the economic collapse, DG ECHO facilitated a special cargo flight for its partners in 2020. Several IPs commented that DG ECHO was strong in demanding cost efficiencies, but a few key stakeholders felt this was sometimes unreasonable – that it is hard to achieve quality 'on the cheap,' and that field experts sometimes demanded cost reductions at the same time as wanting more outputs. It was also noted that this institutional knowledge of context could not be applied as effectively in new operating contexts.

"DG ECHO-funded Actions are assessed against cost-efficiency standards e.g., cost-per-patient, cost-per-consultation etc. Usually support costs are limited to 15 -20% of the budget". [DG ECHO field expert]

The advantages of continuity in supporting cost-effectiveness were also seen where epidemic interventions were incorporated into existing project structures, meaning set-up costs could be minimised thanks to an existing platform of management staff and infrastructure which did not need duplicating. Some IPs also spoke of being able to spread such costs between different projects and donors. Other examples of cost efficiencies claimed by IPs were careful budget formation, coordination with other humanitarian actors on salary and incentives levels, rapid test kits (which reduced laboratory fees), and the co-option of community support and

[122] Study on Approaches to Assess Cost-Effectiveness of DG ECHO's Humanitarian Aid Actions (2016). ADE.

[123] Ibid (2019)

[124] See ADE report: ibid (2016)

participation, including the use of local volunteers. A DG ECHO Anopheles expert also enthused about the collaboration of epidemiologists and social scientists who could provide real-time data in DRC to help fine-tune the interventions, and make them more efficient and effective (see Figure 13).

Some observers noted inefficiencies. Delays in project implementation (for which there were various reasons) were seen as eroding cost-effectiveness. The involvement of 'downstream' implementing partners was questioned in terms of having to fund different tiers of support costs; and the difficulty of measuring the value of outputs actually reaching affected people were mentioned. However, these were all generic issues, common to most programmes and donors, and not significant examples of cost-ineffectiveness. Perhaps the most important comment on inefficiency was that DG ECHO did not support vaccination as a (more cost-effective) element of epidemic prevention and preparedness in Venezuela, where there was instead a need to mount a more expensive rapid vaccination campaign in response to an outbreak. While this observation was made in the context of epidemic management, a similar argument can be made more generally about DG ECHO's reluctance to invest in disaster risk reduction and preparedness.

Lastly, some findings provided against other EQs are important in the analysis of overall cost-effectiveness. Under EQ 6 What results were achieved by DG ECHO's epidemics response?, DG ECHO projects were found be broadly effective, often exceeding the targets, and generally impressive considering the relatively modest funding amounts provided. But the findings also suggested even greater effectiveness might have been achieved had DG ECHO challenged its IPs more in terms of the interventions they could offer in responding to epidemics. And findings under EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security? suggested that a lack of coordination among EU bodies could have led to some avoidable wastage in epidemic response.[125]

Summary

DG ECHO has no established framework for measuring cost-effectiveness, but the ET interpreted this as 'the achievement of intended outcomes in relation to costs'. By this yardstick DG ECHO's response to epidemics was broadly found to be cost-effective, achieving decent levels of results (see EQ 6 What results were achieved by DG ECHO's epidemics response? above) in return for relatively modest and proportionate amounts of funding. DG ECHO field experts were conscious of the need to achieve appropriate balance between costs and outputs, and sought cost efficiencies where they could. Findings already discussed in relation to other EQs about whether the selected epidemic response Actions were always the ones most needed (highest priority) are also relevant to the consideration of cost-effectiveness. It is possible that other interventions might have yielded even more impressive results for the same investment in some places.

EQ 8 To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?
JC 8.1 EU-funded Actions in response to epidemics were timely, demonstrating an appropriate balance between speed and quality of design JC 8.2 EU-funded Actions in response to epidemics were flexible enough to enable appropriate adaptation at field level
Key findings
• Statistical analysis of the gap between proposal submission and approval showed DG ECHO was quick to respond to epidemics. On average the Epidemics Tool is a particularly nimble instrument, although the speed of approval has slowed remarkably since 2019

[125] For example, an Anopheles expert said valuable medical equipment was 'rusting' in the government medical stores in one country because DG ECHO experts had not been consulted about in-kind donations by EU members states in relation to the COVID-19 response

- The evidence from interviews (mainly working for IPs) was more mixed on timeliness and flexibility – and likely reflected their own experience, which would have varied by year and country
- Flexibility was found to be a very strong and much appreciated aspect of DG ECHO's donorship

Timeliness

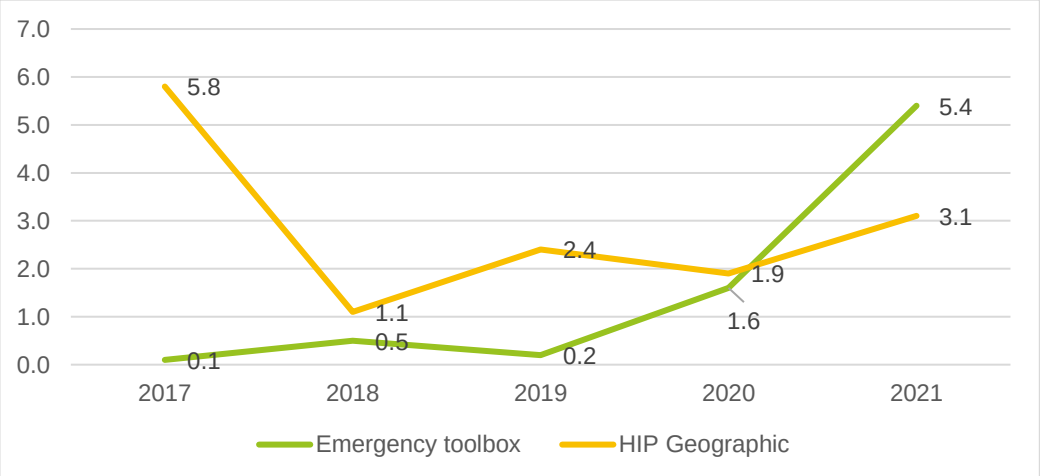
The ET carried out a statistical analysis of a sample of 39 relevant Actions covering the five focus countries (see annexe 4 for details of the sample). The FicheOp documents record information on project timings, and these were used to look at the time gap between the 'initial request' (submission date of proposal) and the approval by DG ECHO ('date signed by DG ECHO'). The team also looked at the gap between approval and the date the first tranche of funding was released. The resulting data were then analysed by type of funding instrument, year of Action and type of partner.

Table 10 Timeliness of request approval and first fund release by type of funding

Type of funding	**Median time gap (months) for request approval** *Initial request date and signed by DG ECHO date*	**Median Time 'gap' (months) for first fund release** *Signed by DG ECHO date and date 1st funds released*	**Median Time 'gap' (months) from request to fund release** *Initial request date and date 1st funds released*
Emergency toolbox	0.3	0.5	1.2
Geographic HIP	2.7	0.4	3.1
Total	**2.0**	**0.4**	**2.9**

Table 10 shows the average time elapsed between request and approval, approval and release of funds, and the overall time from request to release of funds - according to whether the Action was funded under the Epidemics Tool or the Geographic HIP. In practice, the most significant timing may be the date of signature by DG ECHO, as DG ECHO's regulations mean that DG ECHO should release initial funds ('pre-financing') within 30 days of the Specific Grant Agreement being signed,[126] and some IPs are willing to initiate an Action with their own funds in the knowledge that the payment from DG ECHO is coming. On this measure, it can be seen that funding from the Epidemics Tool was considerably quicker than funding under the Geographic HIP, although both were reasonably timely on average.[127] However, analysis over time (the five years 2017-2021), reveals an interesting trend wherein release of funds from the Epidemics Tool is getting significantly slower since 2019, while the variation over time for the Geographic HIPs is less significant.

Figure 15 Timeliness of request approval by year and type of funding (median of time gap in months)

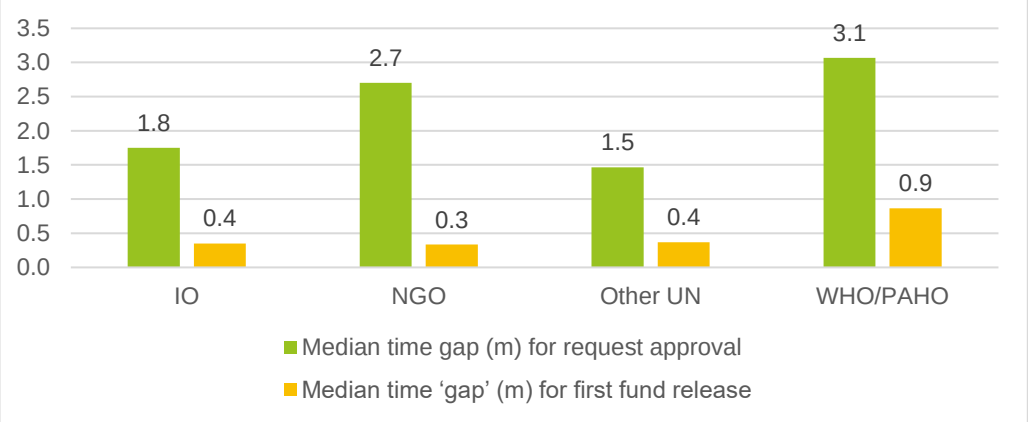


126 https://2014-2020.dgecho-partners-helpdesk.eu/ngo/specific-grant-agreement

127 The ET had no means of comparing the speed of DG ECHO's response to funding requests with that of other donors and such comparisons would be difficult given different policies, partnership frameworks, length of funding etc. Nonetheless, the timeliness of DG ECHO funding seemed at least average, and above average, according to the experience of the evaluators.

Analysis of funding timeliness by type of partner did not reveal very significant differences. Funding approval was quickest for the Red Cross (IO) and slowest for WHO/PAHO. Clearly, both DG ECHO and its IPs share some responsibility for timeliness, as the process for project application and approval is often a two-way street, with each party sometimes waiting for the other to complete paperwork and respond to comments.

Figure 16 Timeliness of request approval and first fund release by type of partner (median of time gap in months)



The review of documents and the interviews did not add much detail to what was provided through the statistical analysis. DG ECHO staff emphasised the rapidity of the Epidemics Tool, under which approval could be given 'in just a few days.' The ET did find examples of very quick approval of these funds (one approval of a multi-country action in two days, and others in four and six days, both in the DRC),[128] and the median was 0.3 months. However, the overall mean average was 1.5 months and the range was from two days to 164 days.[129] Among IPs, DG ECHO was almost equally seen as either quick or slow, depending, presumably, on their particular experience. As the reference points for most interviewees would be recent Actions,[130] their responses might be biased towards the rising year-to-year gap between funding application and approval for the Epidemics Tool. Syria seemed to have a particular challenge, as Syria's average approval time was more than double that of the other countries (average of 6.7 months, compared to 2.6 months). As found under EQ 5 How effective have DG ECHO's tools and instruments been in addressing epidemics?, a few respondents felt that DG ECHO's project application and documentation systems were not user-friendly, and would have appreciated more support with the process.

The few projects focused on preparedness were seen as the pinnacle of timeliness - i.e., supporting possible response before an outbreak had even occurred. Similarly, interventions which were launched from the platform of a pre-existing DG ECHO-funded Action – i.e., projects which were adapted to respond after an outbreak occurred – were held up as examples of particularly rapid response.

Where project implementation was delayed after approval had been received, the reasons were usually associated with factors beyond the control of the IP. The widespread impact of COVID-19 on global supply chains, passenger flights and staff recruitment, as well as local operational constraints associated with government-imposed movement restrictions, all hampered the response to the pandemic itself. Poor inter-agency coordination was another constraint mentioned by respondents, as well as procurement delays in relation to Venezuela.

The e-Survey also reflected the range of opinion about timeliness gained from the KIIs. When rating DG ECHO's performance, 'timeliness' was ranked bottom of eight qualities on a predetermined list (in terms of respondents scoring this as 'excellent' or 'good'). However, when asked open questions, 'timeliness' was

[128] Actions 2017/00976 and 2019/00680
[129] 164 days for Action 2021/01003
[130] Given the frequent turn-over of humanitarian workers in any field setting

ranked second in terms of the 'best aspects of DG ECHO's response to epidemics' and third in terms of 'what DG ECHO could do better in response to epidemics.' These are mixed and contradictory results. They may reflect that timeliness is a much-valued quality: that timeliness in practice is appreciated, but that humanitarians always want things to happen even more quickly. Or it may reflect different experiences. Further analysis showed that respondents from WHO/PAHO were least content with DG ECHO's timeliness, whereas other IPs were most likely to score this highly, with EU (including DG ECHO) respondents somewhere in the middle.

Flexibility

It is DG ECHO's policy to be flexible. The EU Consensus on Humanitarian Aid (2021) emphasises flexibility in donorship and values flexible implementing partners; and the annual HIP documents often stress the need for flexibility. Evidence from DG ECHO documents and from key informants strongly supported the finding that flexibility is a hallmark of DG ECHO's work, and the ET was unanimous in its assessment that this is central to DG ECHO's effectiveness and value-added.

"*Flexibility is seen as a strong suit for [DG] ECHO. It stems from their understanding of the context."* [Senior NGO leader, Afghanistan]

DG ECHO's field and desk staff were seen by IP representatives as universally supportive of flexibility. They felt this was a necessary quality given that DG ECHO supports work in very unpredictable contexts, but they appreciated the sympathetic support and encouragement they received, observing that DG ECHO's field staff were experienced humanitarians themselves, understood the context very well, and built trustful relationships with their partners. This flexibility had several dimensions: allowing for changes in results and project activities (often by adding additional ones); geographical scope (in some cases); and time and/or cost extensions.

The funding tools used by DG ECHO were also considered to facilitate flexibility. Modification requests could be made by simply adding information to the same SF that was used for the original funding application, thus keeping the administrative burden quite light. Although not used frequently,[131] the Crisis Modifier facility, which allows pre-approved adjustments to foreseen high-risk events, such as epidemics, was also praised by several interviewees. [See Figure 17 for more details on Crisis Modifiers]. Timeliness and flexibility were seen to go hand in hand; where partners already had a functioning project supported by DG ECHO they could adapt quickly with support from the donor. This was especially the case in relation to COVID-19, where DG ECHO supported the addition of activities, but also supported necessary changes to delivery mechanisms, such as allowing work-from-home during lockdowns or for IP staff whose co-morbidities made them especially vulnerable to COVID-19. Preparedness Actions were also seen as a good platform on which to build a flexible response, a point emphasised in DG ECHO's Guidance Note on Disaster Preparedness (2021).[132]

[131] Only 18% of the Action documents sampled incorporated a CM

[132] Disaster Preparedness: DG ECHO Guidance Note. DG ECHO (2021)

Figure 17 Crisis modifiers

Use of Crisis Modifiers

A *Crisis Modifier* (CM) allows DG ECHO partners to integrate flexibility and preparedness into actions. The aim of a CM is that it "*promotes systematic consideration of preparedness through the integration of a flexible, early action component to address, in a timely manner, immediate and life-saving needs resulting from a rapid-onset crisis or a deteriorated situation within a DG ECHO-funded Action"*. It takes the form of a dedicated result in the Logical Framework of the Action. It is a mechanism to release funds to implementing partners who are already operational on the ground and can activate early response to upcoming crises and provide a resilience cushion and, if required, a humanitarian response. The CM can be used to strengthen early response and anticipatory capacity within an intervention, shortening the time gap before other response mechanisms are activated (e.g., Emergency tool box, top-ups). It should respond to urgent lifesaving needs and it is typically designed for a limited period of time (average duration observed is generally 1-4 weeks).

Within 39 sampled actions reviewed by the evaluation, seven Actions (18%) included a CM result in their logframe. These seven Actions were between the years 2019 and 2021, with the majority concentrated in 2021. Primarily, the Actions in this sample including a CM were funded under Geographic HIPs, and one was funded under the emergency toolbox HIP. In terms of proportionality to the total budget of the sampled Actions, on average the CM allocation stood at 17% of the DG ECHO contribution to budget, and 12% of the total budget (from all funding sources).

Considering the ongoing status of the majority (five out of seven) of the Actions which included a CM, only one (closed) Action under review had activated its CM during implementation. Under this Action, the CM was triggered following the first case confirmation of COVID-19 in the project area. The CM facilitated the rapid installation and operation of a COVID-19 treatment centre covering the territory of Aru in the DRC. At final report stage, 76% of the total budget allocated to the CM result in this action had been utilised. Other sampled Actions were ongoing and therefore final reports detailing use of CM over the entire duration of the Action were not yet available.

The low, but increasing, trend in CM result inclusion in the sampled Actions, and support from interviewed DG ECHO staff, suggest that DG ECHO values CMs as a potential mechanism to provide flexible and rapid response to emerging epidemic threats. However, the incorporation and activation of CMs was not yet widespread in DG ECHO funded Actions.

Amid the overwhelmingly positive views on DG ECHO's flexibility, a small number of interviewees provided a contrary viewpoint. It was noted that, whilst there was flexibility in adding more activities to projects, DG ECHO was less flexible in terms of budgetary additions, resulting in situations where some IPs have to cover additional operational costs themselves. Other respondents felt that flexibility was mostly seen in relation to existing projects, but that DG ECHO (and sometimes its IPs) were less flexible about setting up new interventions in different parts of the same country. DG ECHO's procurement rules were also seen as inhibiting flexibility in Syria.

As with Timeliness, the e-Survey results in respect of flexibility were mixed. When selecting from a closed list of eight epidemic response qualities, flexibility was ranked 7th (respondents scoring it as 'excellent' or 'good'); and when asked an open question about what DG ECHO could do better in its response to epidemics, more respondents mentioned increased flexibility than any other quality.

However, when asked an open question about the best aspect of DG ECHO's response, in the survey there were more positive comments about flexibility than any other aspect (see Figure 18). And when asked to rate DG ECHO's comparative advantage in epidemics compared to other donors, 'flexibility as a donor' was

ranked 3rd (out of 10 positive qualities). Further analysis showed that DG ECHO's IPs were more strongly positive about DG ECHO's flexibility than any other category of respondent (see Figure 19).[133]

Figure 18 Responses to open survey questions on best aspect of DG ECHO's response to epidemics

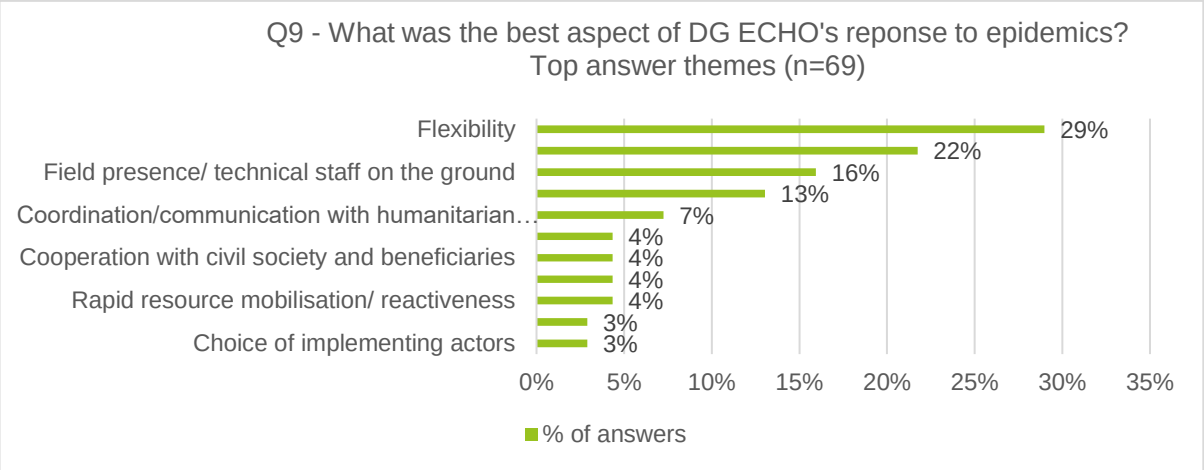
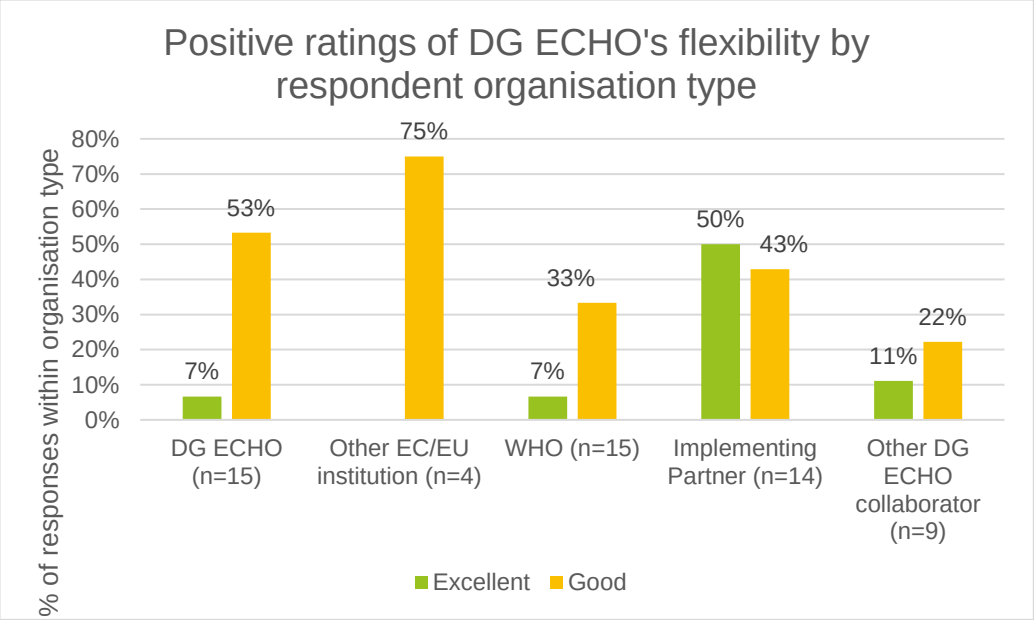


Figure 19 Positive ratings of DG ECHO's flexibility by respondent organisation type



Summary

There was very strong evidence that DG ECHO was quick in responding to epidemics and that its project management systems, combined with its close relationships with respected partners, allowed DG ECHO to be flexible in adapting its response to changing situations. Adaptation was easiest and quickest where DG ECHO had an existing project partnership and adjustments could be managed through Modification Requests. Where epidemics were a well-recognised risk, IPs had the opportunity to include a specific Crisis Modifier in their funding application, although in practice this was seldom used among the Actions reviewed in detail by the ET. The Epidemics Tool was seen as a particularly quick project instrument, especially by DG ECHO experts, although the release of funds from this tool has slowed significantly since 2019. Against the overwhelmingly positive views on timeliness and flexibility, a minority of respondents questioned how flexible DG ECHO was in responding to new emergencies in places where it did not have existing project

[133] Implementing partners (not including WHO) made up 15% of e-Survey respondents

partnerships, and that flexibility on adding intervention activities was not always matched by flexibility in providing additional funding, for example additional support costs.

EQ 9 To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?	**RESILIENCE / CONNECTEDNESS**
JC 9.1 Humanitarian actions included both immediate relief and recovery/resilience activities JC 9.2 Coordination with EC services and external actors strengthened linkages between emergency and development programming, and transition to nationally owned systems or development programmes where possible	
Key findings	
• DG ECHO contributed to public health resilience,[134] especially where partners are funded over multiple years, support basic services, and build local capacity (including epidemic preparedness) • Despite strong policy positions on working across the 'nexus', Action documents tended to gravitate towards 'business as usual' humanitarian intervention with minimal discussion of options for building linkages into more sustainable work • Stakeholders felt rather powerless in pursuing the nexus approach: they either yearned for a more strategic approach (without knowing how to achieve it), or accepted that the prerequisites for joined-up work did not exist in their locations • A lack of cross-service leadership and practical guidance hampers internal EU collaboration, despite a strong appetite to work more together on linking short and long-term work	

Linking humanitarian action with resilience and recovery

The EU has strong policy positions on linking relief with longer-term resilience, recovery and development. The Consensus on Humanitarian Aid (2008) says '*humanitarian aid and development cooperation … will be used in a coherent and complementary fashion especially in transitional contexts and situations of fragility, in order to use the full potential of short- and long-term aid and cooperation.'* This was reinforced in the Lives in Dignity Communication (2016), and reiterated in The Humanitarian Action Communication (2021) which promises that "*the EU will step up its work to link humanitarian relief with development and peacebuilding."*

Since 2014, the DG ECHO SF has incorporated a Resilience Marker (RM), thus complying with EU policy that "*All humanitarian projects funded by the European Union have to apply the Resilience Marker, which ensures that the interventions reduce risks and strengthen people's coping capacities so as to minimise humanitarian needs."*[135] The RM consists of four criteria covering different aspects of resilience. If all are met, the maximum score [=2] is applied. If only some are met, the score is one. A third option is to mark the RM as 'not applicable' (i.e., if the Action is purely intended as a short-term relief intervention). Grant applicants also have the chance to elaborate on resilience under the SF heading 'How does the Action contribute to build resilience or reduce future risk?'

Analysis of a sub-sample of 15 Actions showed the majority had RMs scored at 2, a few were scored 1, and one was marked not applicable. However, a qualitative analysis of the same RM sections by the ET concluded that only one SF provided a convincing description of linkages between humanitarian epidemic interventions and resilience. Most of the forms described some activities relevant to resilience, but lacked convincing arguments about how these would be sustainable, and several were judged to be very weak,

[134] Resilience is defined by DG ECHO as the ability of an individual, a household, a community, a country or a region to resist, adapt, and quickly recover from a disaster or crisis such as drought, violence, conflict or natural disaster (Resilience Marker Guide)

[135] https://civil-protection-humanitarian-aid.ec.europa.eu/what/humanitarian-aid/resilience-and-humanitarian-development-peace-nexus_en

barely making the case at all. Generally, these weaknesses were not identified by the field experts in the FicheOp, where they had a chance to comment. In most cases, the same weak statements on resilience are just summarised by the field experts or are barely commented on. It appears that DG ECHO staff did not make rigorous implementation of the RM their priority, at least not in the sampled Actions relating to epidemics.

More concerning, in terms of compliance with stated EU policy on resilience, were observations from a few DG ECHO personnel who seemed to challenge the entire notion of working across the nexus. Addressing resilience in the Action documents was seen as "cosmetic" by some: it was a requirement by headquarters, but reality in the field was different, and there was a lack of guidance about how to bring humanitarian and development programmes together in meaningful ways. One field expert said that epidemics were "not a focus" for DG ECHO, and another felt they were primarily WHO's responsibility and more of a development issue. These sentiments were not shared by representatives of senior leadership in Brussels, for whom the need to integrate short and long-term approaches to health - by working across the nexus – was seen as a "confirmed" lesson from the COVID-19 pandemic.

Where the Action documents did offer analysis of resilience, the overwhelming feature was some kind of capacity building (including training). This capacity building was variously directed at local government health services, local NGOs, community-based organisations, or community members themselves. Different types of capacity building included clinical skills, surveillance, WASH and IPC, rapid response teams and support with forging contingency plans. Other activities deemed to strengthen resilience were RCCE and vaccination (e.g., yellow fever vaccination in Venezuela which bestows lifetime immunity), and the integration of the CAI into the MoH in DRC. While all such activities can justifiably be said to support resilience, there was generally too little description of how they could be sustained, for example by building on previous work, by complementing other capacity building efforts, by contributing to national plans, by linking to development actors, or by promoting empowerment and a sense of local ownership.

Regardless of the poor handling of the dedicated resilience sections in the SF, evidence from elsewhere in the Action documents and from interviews was more encouraging. In contexts of protracted emergencies like Afghanistan and DRC, it can be argued that a focus on 'resilience' has superseded pure emergency response and become the norm. Some humanitarian agencies, including some funded by DG ECHO, have had a presence in such countries for 20 years or more. While remaining ready to respond to new shocks, including epidemics, most such agencies work to support the provision of basic services, often working together or alongside local structures, such as district health services, community organisations or self-help groups. Such situations are technically humanitarian and are governed by appeals, but lie in a grey area which is neither pure emergency relief nor development. By supporting such work, often with successive grants, and through its very flexible approach which allows for constant adjustments in volatile contexts, DG ECHO is clearly supporting resilience. This is underscored by the amount of training and capacity building evidenced in the body of the SF (usually under 'Logic of Intervention') as well as investments in light infrastructure (such as water sources and medical equipment). Many of the Actions examined could be considered continuations of previous projects, and there was evidence that both DG ECHO and its IPs valued the trust and experience which is built through continuity of partnership. Stakeholders also noted a DG ECHO trend towards funding longer projects[136], sometimes 24-36 months, which allow agencies more time to develop local capacity. Finally, as described under EQ 6 What results were achieved by DG ECHO's epidemics response?, community members in DRC and Venezuela observed in FGDs that several aspects of DG ECHO interventions were having lasting effects, especially those where local people had had the chance to participate in their planning and execution.

Working across the humanitarian-development nexus

Another situation which straddles the 'humanitarian-development nexus' is epidemic preparedness work. This is a type of programming in which capacity building is the main modus operandi and the main output. The DG

[136] Another Grand Bargain Workstream 7, discontinued in December 2021

ECHO Health Guidelines (2014) encourage a partnership approach to build emergency preparedness capacity, including early warning systems, in situations of protracted crisis. The latest HIP Thematic Policies Annex (providing policy guidance for all HIPs) notes that *"risk reduction and disaster preparedness are an integral part of the EU approach to resilience"* and further suggests that disaster preparedness should be mainstreamed into DG ECHO's humanitarian work.[137] On the other hand, the ET noted that specific guidance relating to the Epidemics Tool was rather equivocal on preparedness. It says *"preparedness Actions under the Epidemics Tool should be targeted at specific, imminent, localised threats"* (which suggests that IPs know in advance which epidemics will arise). Likewise the list of 'approved' examples of preparedness work provided in the same document could be considered 'response' interventions, rather than preparedness activities. This amounts to conflicting and equivocal 'guidance' on what preparedness interventions are eligible for DG ECHO funding – or not.

An interesting example of DG ECHO's support for preparedness is its funding of WHO's project on Strengthening Public Health Surveillance and Response Systems in South Sudan. With DG ECHO's support, WHO has worked on building epidemic preparedness capacity in South Sudan almost continually since at least 2017. The successive Actions have been funded by the Geographic HIP and have built incremental capacity over several years [see Figure 20 for more details].

Despite DG ECHO's contributions to resilience, the majority of stakeholders interviewed emphasised the challenges inherent to bridging the 'nexus.' Many respondents observed that responding to continual shocks in protracted crisis settings was dissatisfying, as it failed to address upstream causes. They yearned to be able to stand back, reflect on the overall pattern of events, and forge a more strategic approach, ideally one that dovetailed with nationally-owned plans. Related to these observations about the lack of humanitarian exit strategies, an equally large number of stakeholders had a more purist stance on humanitarian aid, actively resisting the move towards the 'nexus' middle ground. With the demand for humanitarian response growing globally, they felt it necessary to focus on humanitarian delivery and not get distracted by calls for emergency response to move towards filling the development gaps where development had clearly failed, and where there were (in their view) no viable pathways out of crisis. In Afghanistan, where development programmes have recently collapsed and where the number of people assessed in need of humanitarian assistance has grown from 9.3M in 2017 to 24.4M in 2021,[138] DG ECHO was seen as providing thought leadership within the humanitarian community in advocating this 'focused' approach.

"EU and DG ECHO policy documents encourage partners and ourselves to think 'Nexus', to think about possible ways to link humanitarian action to more longer-term developmental programming, and/or engage development partners more in preparedness and prevention. I see many challenges why these two approaches do not articulate themselves [in the field] as in theory they should". [DG ECHO Anopheles expert]

[137] Thematic Policies Annex: General Principles, Policies and Guidelines (2021). DG ECHO.

[138] https://www.unocha.org/afghanistan

Figure 20 DG ECHO's long-term support to South Sudan

DG ECHO has been supporting the strengthening of IDSR/EWARS through WHO-led Actions for over 10 years. The data collected on the six existing Actions since 2011 (2011, 2013, 2014, 2016, 2018 & 2021) are for a total amount of €25.8M for a DG ECHO contribution of €10.1M. DG ECHO's contribution in 2011 represented 11 per cent of the action, and 72.86 and 80 per cent respectively for the last three Actions, which suggests that other partners are withdrawing in the long-term.

Since 2011 the support proposed by WHO and financed by DG ECHO has been based on training activities, operational and technical support, the EWARS surveillance system, support to national coordination and to WHO. Over the course of the Actions in South Sudan, activities have been extended to new health centres and, since 2017, include financing of outbreak investigation kits, financing of operational costs (incentives, DSA, contingency funds) to enable the deployment of teams during alerts, as well as to support the routine surveillance and reporting from health facilities and the 10 state hubs to support prompt disease outbreak investigation.

Every 'year' the justifications for new funding are (photo) snapshots of the situation in South Sudan that show critical needs, the deteriorating humanitarian situation (increasing people in need over the years), consistent with the HIPs.

The investments provided by DG ECHO are undoubtedly necessary, as reported by a prominent Health Cluster Coordinator, among others:

"I was one of Five Public Health Officers/Epidemiologists deployed to South Sudan to start IDRS/ EWARS in 2007-2008. Deployment was part of DG ECHO support to establish IDSR/ EWARS in South Sudan. We, together with WHO and the Ministry of Health, rolled out IDSR/ EWARS in 10 states in South Sudan. We strengthened capacity of State Surveillance Officers and staff to report to the IDSR/ EWARS system on a weekly basis. From then until now, DG ECHO is playing crucial role supporting and strengthening IDSR/ EWARS in South Sudan. The country is now able to detect and manage outbreaks such as measles, cholera, meningitis and others. State surveillance officers are regularly trained, supervised and capacitated to roll out IDSR/ EWARS effectively. Weekly epidemiological reports based on IDSR data are now regularly developed and shared with partners and stakeholders. South Sudan now has well placed IDSR/ EWARS where partners are reporting on a weekly basis, weekly analysis is prepared, alerts raised and investigated, and feedback shared with stakeholders. The system is detecting alert for the outbreak (although it is not perfect). I see investment is fruitful and the system is gradually developing but requires long-term support to fully develop and [become] self-sufficient." [Health Cluster Coordinator]

Since South Sudan is young, gaining independence only in January 2011, and is currently facing a difficult situation (post conflict), the health system is weak and not supported with adequate financing. DG ECHO's long-term support is therefore needed. WHO, with support from DG ECHO, is providing technical and operational support to the Ministry of Health and partners.

Every 'year' we find more or less the same activities, which are useful, contribute to meeting the needs of the moment, and are all the more justified as the context worsens; but do not position a multi-year approach against a strategic and operational vision, or link up with the country's regular health systems. DG ECHO's, and its field partners', reflections on this issue are not represented in the Action documents and do not seem to be structured and organised in relation to HQ. The situation in South Sudan is similar to what is noted globally with an increase in the demand for humanitarian assistance, among other things due to the persistence of crises against a backdrop of insufficient political leadership and difficulties in reaching affected people.

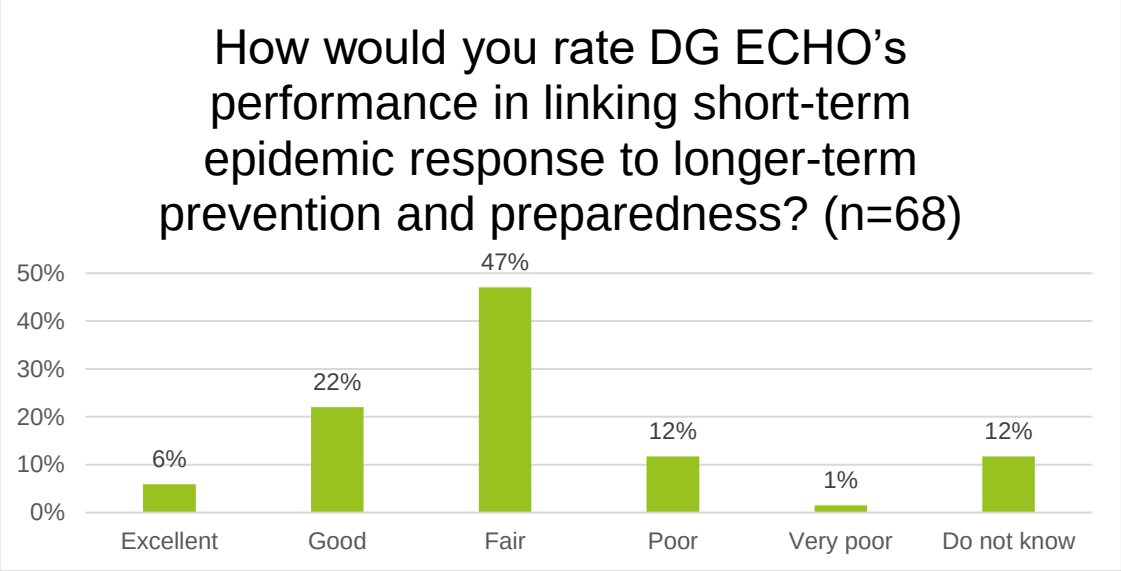
Repeated support through serial annual renewal of funding contributes to the strengthening of the health system, and therefore the question arises as to its effectiveness and efficiency in the long term. In this sense, and by way of example, the South Sudan COVID-19 Intra Action Review and the interviews contain concordant pleas for DG ECHO's stand-alone Actions carried out by WHO to be consistent with Health System Strengthening activities and the health information system.

DG ECHO's position of maintaining these activities at a minimum level is accepted by some within DG ECHO, who argue that these investments maintain a structure and a system for detecting, alerting and responding to epidemics (or even public health emergencies) in sufficient time and in sufficient proportions to avoid excessively long response times and thus to limit the spread of epidemics. But they are neither sustainable nor linked to government systems. As such, the question arises (again) of how to support long-term emergency preparedness in a humanitarian context.

In 2022, WHO conducted an evaluation of the IDSR/EWARS in South Sudan (funded by USAID). However, WHO did not inform DG ECHO that this evaluation was taking place. The resultant evaluation, whilst proffering important recommendations (i.e. increased training for community/health facility levels and the development of community feedback mechanisms), was viewed by some ECHO staff to be rather introspective and narrow in scope. Equally, it did not address the need for more strategic direction for its surveillance systems.

Survey responses in relation to linking shorter- and longer-term objectives were also mixed. 'Sustainability' was ranked 4th out of eight epidemic response qualities, but when asked how DG ECHO could strengthen its role in potential epidemics, 'more work on prevention' was the second most popular answer (out of 14 options). When asked to rate DG ECHO's performance in linking short-term epidemic response to longer-term prevention and preparedness, most respondents rated DG ECHO's performance as 'fair'.

Figure 21 Responses to e-Survey (Q21) on DG ECHO performance in linking across the nexus



As described under EQ 6 What results were achieved by DG ECHO's epidemics response?, community members in DRC and Venezuela observed in FGDs that several aspects of DG ECHO interventions were having lasting effects, especially those where local people had had the chance to participate in their planning and execution.

Collaborating and coordinating on short and long-term approaches

EU policy strongly advocates working across what is now called the 'Triple Nexus' of humanitarian, development and peace engagement:

"*Through the humanitarian-development-peace nexus, the EU will deploy all the instruments needed not only to address short-term needs but also to provide long-term solutions and, in conflicts, contribute to building lasting peace. This involves joint analysis and operational response frameworks as well as a conflict-sensitive approach so that external assistance does not inadvertently reinforce conflict*."[139]

The ET found more evidence on resilience than on collaboration across the nexus. Dealing first with collaboration which did not directly implicate other EU institutions, several stakeholders spoke of attempts to link with government-led national plans and programmes (for example the national programme on immunisation in Venezuela). There were also many examples in Action documents of IPs coordinating their capacity building in the health and WASH sectors as part of their routine project implementation. A few interviewees noted that DG ECHO had facilitated inter-agency dialogue on nexus issues. As mentioned earlier (see box), in South Sudan, long-term work with WHO had involved regular dialogue with external development partners, such as the US Centre for Disease Control who were also partnering with WHO.

As DG INTPA (formerly DG DEVCO) is the natural EU counterpart for DG ECHO in terms of development cooperation, the bulk of comments from EU staff members concerned this particular relationship within the EU/EC 'family'. Staff working in Brussels all said that relations between the two services were 'very cordial,' but also 'episodic.' There was no structured dialogue between them, so the exchanges tended to be ad hoc

[139] Humanitarian Aid Communication (2021).

and did not lead to common positions or action. Hampering the potential for sustained dialogue might be the imbalance between health experts working for the two services at headquarters level: DG ECHO normally has just one such expert, compared to around eight for DG INTPA. Another strong finding, from staff at HQ, regional and country levels, was the lack of specific policy guidelines for how the two institutions should work together. Policy in this area was considered to be 'top-line': the vision was there, but it had not been backed up with any specific tasking, for example to work on joint cooperation frameworks (although the 2021 Communication does refer to six 'EU nexus pilot countries' designated in 2017 (Chad, Iraq, Myanmar, Nigeria, Sudan, and Uganda)). This lack of guidance was seen as a failure of leadership across the two services.

At the country level, specifically, relations between DG ECHO and DG INTPA were also said to be warm, and there was some evidence of direct coordination and collaboration, for example DG INTPA switching some funding into humanitarian action in DRC and Afghanistan, where there was agreement this made sense according to the prevailing context. However, it was also noted that the two institutions sometimes funded the same IPs for different purposes, but without harmonising their approaches, and that different funding cycles and 'ways of working' (often annual and project-focused for DG ECHO; and multi-annual and programmatic for DG INTPA) were practical constraints. More generally, there was recognition at the field level that preventing epidemics needed a joined-up strategic approach, but there was a lack of EU coordination across the nexus in most countries. One senior official felt that more authority should be delegated to EU missions in third countries to make such coordination happen. An interview with senior DG ECHO leadership confirmed that policy on the nexus had been 'top down' and not widely adopted at field level, but that this was recognised by management and that guidance notes had recently been issued. Perceived blockages relating to working culture were acknowledged. It was felt that some humanitarians were resistant to new ways of working, but it was a question of 'winning hearts and minds' over time and that, ultimately, the nexus was 'common sense'.

Summary

DG ECHO contributes to resilience through its epidemic response projects and especially through those few projects which are focused on specific preparedness activities. But many of the activities contributing towards resilience could be considered as 'low-hanging fruit': they were part and parcel of humanitarian delivery in the context of chronic crises, such as training local personnel. Resilience Marker sections of Action documents received scant treatment in most cases, by IPs and DG ECHO experts alike. Typically, activities were described as contributing to resilience, rather than having resilience as a goal in its own right. Interviewees had mixed views on the humanitarian-development nexus. Some yearned for a more joined-up approach and more work on prevention and preparedness, others felt that precious humanitarian resources should be preserved for response interventions and should not be expected to address development failures. There were good examples of collaboration across the nexus with partners external to the EU, but these were few in number. Within the EU/EC family of institutions, most evidence was on the relationship between DG ECHO and DG INTPA, which was seen as very cordial, but where dialogue at all levels was seen as ad hoc, not always productive and suffering from a lack of practical guidance on how to work together.

4.2. Findings – Part B

EQ 10 Is the DG ECHO-WHO partnership strategic and synergistic, with a shared vision that leverages collaborative advantages at all levels?	**COLLABORATIVE**
JC 10.1 The DG ECHO-WHO partnership has a shared vision that is understood and valued by both partners at HQ, regional and country levels. JC 10.2 Both DG ECHO and WHO understand the collaborative advantages of the partnership and how to leverage these for value creation.	
Key findings	
• The partnership lacks shared vision and an overarching strategic framework for engagement in humanitarian settings • The partnership at the global level is marked by annual high-level strategic dialogues and a set of jointly agreed priority actions that are not widely shared or understood across partnership levels • The partnership suffers from a disconnect in that what is agreed at the global level does not necessarily trickle down to the operational level and vice versa • Conflicting opinions arise amongst DG ECHO informants, with some bearing residual impressions that WHO is not operational in humanitarian settings, and others feeling that the partnership itself would benefit from WHO having more operational capacity and resources to facilitate implementation • WHO feels that the partnership would benefit from DG ECHO attaining more technical health expertise at HQ level	

The partnership has strategic elements but lacks shared vision and a framework for engagement

Shared vision is jointly developing a well-defined ambition, the goals and outcomes for the partnership, defining each partner's responsibility, and identifying each partner's expected benefits. Shared vision leads to a deeper understanding of each organisation and how to leverage each other's strengths for mutual gain. Having a shared vision motivates the partnership and provides direction on actions.

The DG ECHO/WHO partnership has no official agreement or framework for engaging in humanitarian settings that delineates the components of a shared vision. While the partnership is governed by the 2004 EC and WHO strategic partnership MoU, the shared vision is defined for the "field of development" and does not encompass the humanitarian sphere.

According to DG ECHO HQ, the vision is understood via the HSD and its associated monitoring table (MT). However, the ET found no evidence from the HSD summary reports or MTs of any reference to or discussion of an overall vision or overarching strategy for the partnership.[140] The first HSD in January 2020 provided a forum to "*outline mutual expectations for this new strategic partnership.*"[141] DG ECHO underscored the importance it attached to strengthening its partnership with WHO and its willingness to give it more strategic support. The organisation also stated its expectations of WHO: "*As a strategic partner, we expect WHO to ensure increased efficiency, transparency, build constructive dialogue and increase EU visibility and communication activities* (see EQ 11 Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanisms to deliver on its objectives at all levels? findings for discussion)."[142] WHO also expressed a "strong" interest in strengthening the partnership, especially through regular dialogue as well as increasing EU visibility and communication. WHO was eager to pursue a programmatic

[140] Summary Report Strategic Dialogue DG ECHO- WHO (15 January 2020); Summary virtual meeting: Dialogue DG ECHO-World Health (7 October 2020); Summary DG ECHO-WHO High-level Dialogue 2021
[141] Agenda: Strategic Dialogue DG ECHO - WHO DG ECHO, Brussels
[142] Summary Report Strategic Dialogue DG ECHO - WHO (15 January 2020)

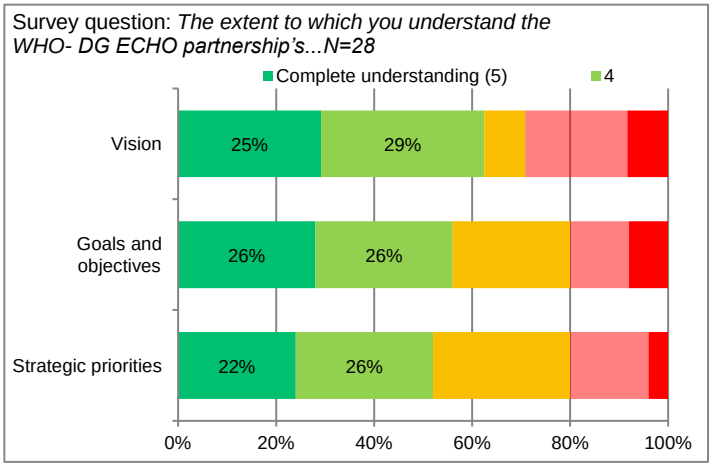
partnership, especially for high-impact events such as the Ebola outbreak, as well as exploring together with DG ECHO alternative and more innovative financing approaches (see EQ 11 Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanisms to deliver on its objectives at all levels? findings for discussion). These shared expectations are an important step for establishing mutual understanding on what the other side is wanting from the partnership, however they are transactional and do not speak to a common vision that can guide the partnership.

The HSDs also establish the partnership's priority areas for joint action which are defined and logged in the MT. However, there are divergent views on the significance of the MT. One WHO interviewee felt the MT was the fundamental document of what the partnership is doing, a view also shared by some DG ECHO interviewees at HQ. Other interviewees at DG ECHO HQ felt the MT wasn't more than a list of common interests that can enhance collaboration. The ET found the MT represents something between the two views. It is more than a list of actions to potentially collaborate as it includes fully developed initiatives such as the EMT program. However, it does not fully represent what the partnership is doing, since it reflects priority actions decided at the highest level without inputs from the operational level, nor is it formally shared beyond HQ. This is problematic considering the operational nature of health emergencies and humanitarian settings with health impacts.

Further, review of the MTs found that even for the partnership at the high-level, the MTs are not a 'stable' reflection of agreed on priorities. From the first HSD that listed four priority areas and 16 follow-up actions, one priority area that is key for epidemics and considered by both organisations as a priority to achieving resilience – preparedness for high impact events and its follow-up actions - was dropped, with no documentation of the reason or the latest status of those actions. Other follow-up actions, such as discussions on innovative financing, were also dropped without any indication as to why.

Understanding the partnership: Considering the lack of an articulated and documented shared vision, it's not surprising that among e-survey respondents, there was not a high level of understanding of the partnership's vision (54%), goals and objectives (52%), and strategic priorities (48%). What is surprising are the divergent views between the two partners, with over 86% of WHO respondents indicating they understood the partnership's vision, objectives and strategic priorities, compared to 18% or lower of DG ECHO respondents (Figure 22).[143] Despite WHO's high understanding reported in the e-survey, during interviews, not one WHO KI was able to articulate the partnership's vision when asked. In addition, WHO interviewees based in HQ indicated a shared vision/strategy was not yet formulated and wanted to see this developed along with a concordant framework to structure and guide the partnership's engagement in humanitarian settings.

Figure 22 E-survey results on DG ECHO/WHO partnership - understanding the partnership



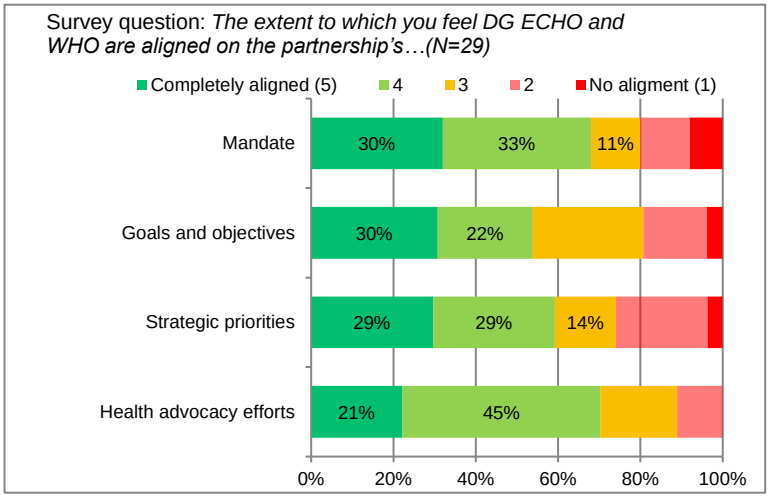
Responses among DG ECHO interviewees were mixed, with one camp, primarily at the operational level, being unaware of a "mutual strategy at any level", and the other harbouring similar views about the partnership's vision. This stretched as high up as the HQ level, with one informant citing DG ECHO's own mission as the vision for the partnership.

The e-survey found that 79% of respondents viewed the DG ECHO-WHO partnership as a strategic one, and 69% felt the partnership extended beyond that of a donor-recipient relationship, citing mutual trust, constructive and open dialogue, and joint initiatives as its primary characteristics. Again, there was divergence in this view between the two partners. While 100% of WHO[144] respondents saw the partnership as

[143] 77% of DG ECHO e-survey respondents were based in HQ, while almost 60% of WHO respondents were based at the country level.
[144] WHO survey respondents were a mix of country, regional and HQ staff.

strategic and extending beyond a donor-recipient relationship, only half of DG ECHO[145] respondents found the partnership strategic and only 27% found it extended beyond a donor-recipient relationship. Some reasons included the lack of a joint vision or strategy, not enough dialogue between the partners, and WHO's lack of understanding and engagement with DG ECHO. The majority of WHO interviewees found the partnership had become more strategic over time. However, there was a stark divide among DG ECHO interviewees, with the field level interviewees generally disregarding the sense of a global strategic partnership, indicating the strategic aspect was highly dependent on personalities at field level. DG ECHO interviewees from HQ were more positive, indicating the partnership had become strategic due to the high-level dialogues and more regular follow-up dialogues among HQ focal points.

Figure 23 Survey results on DG ECHO/WHO partnership - alignment



It is possible WHO's positive responses on understanding the partnership are due to the majority of WHO e-survey respondents being based at field level in countries with strong DG ECHO/WHO relationships (Syria, Sudan, etc.), hence having a strong sense of the partnership. In fact, some WHO interviewees who had worked in different countries with DG ECHO observed the partnership's core priorities were well understood in countries with historically strong relationships between the two partners.

Alignment: The e-survey found that just over 65% of respondents felt that WHO and DG ECHO were aligned with respect to their respective mandates and efforts in health advocacy, with the balance of respondents being roughly equal between the two partners. However, there was divergence between WHO and DG ECHO's views on alignment of strategic priorities (86% versus 33% respectively) and goals and objectives (84% versus 18% respectively).

Challenges to establishing partnership vision and strategic priorities that bridge across levels

Disconnect between the operational and global levels of the partnership affects partnership coherence and synergy

> *"The highest strategic level does not have too much of an impact if we do not work with the soldiers on the ground level"* – [WHO HQ]

There is a gap between the operational and global levels of the partnership, and that what is agreed and understood at the global level does not necessarily trickle down to the operational level and vice versa. The global partnership is driven at the highest level – DG ECHO Deputy Director and WHE Executive Director – who are "really hungry for the partnership to deepen and grow." However, there is no formal mechanism to translate this vision to the operational level. The current forum for the partnership's strategic thinking is the HSD which is limited to HQ level staff with no formal dissemination to operational levels (see findings EQ 11 Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanisms to deliver on its objectives at all levels?).

Further, at the operational level, some countries that have a good partnership relationship, supported by engaging staff and framed by strong Humanitarian Country Teams, will have clear objectives and strategic priorities that do not necessarily trickle up.

[145] For ECHO respondents who provided their details, all were working in operational capacity in countries

Another contributing factor is that DG ECHO and WHO do not seem to be aligned on the engagement of operational and field levels in strategic processes. For WHO, even at the HQ level, the focus and priority of policy decisions are based on what happens at country level and at least on paper, there is a strong culture of strategically engaging the field/operational arms of the organisation.

> *"Our perspective is very much this is country led, if it is not working at country level, then the rest is just, you know, it's just the fine words and coffee and croissants once a year"* – [WHO HQ]

However, for DG ECHO, there seems to be an organisational divide on this approach. The prevalent view at DG ECHO HQ is not to strategically engage the operational and field level in 'high-level' processes. For example, key DG ECHO staff at HQ indicated there was no added value for regional and country level staff to join the HSD, and that the MT does not need to be shared at country level as it "does not concern the Anopheles Group."

DG ECHO lacks an updated, coherent and strategic approach to health

A shared vision and strategic framework require a blending of each partners priorities and interests; hence it is critical that each partner bring to the table a unified thinking on health. WHO has developed, through multi-level and multi-stakeholder processes, relevant frameworks, strategies, and guidance for different areas to health emergencies and health in humanitarian settings (i.e. on the nexus, resilience building and epidemics).[146] At least on paper, WHO brings a unified thinking on health to the partnership.

While DG ECHO has a health policy and general guidance on addressing health in humanitarian emergencies, these are not regularly updated. The primary health policy document[147] , despite much of the guidance remaining valid, is from 2014 and refers to technical guidelines that are outdated, some over two decades old. For example, the reference to WHO's clinical management guidelines for rape is from 2005 and the website link no longer exists.[148] DG ECHO's lack of any documented frameworks/organisational approaches to epidemics, resilience strengthening, nexus, and other critical areas of health and humanitarian work is a marked concern. The ET acknowledges that actual practice at the field level maybe more up-to-date, however, at the global level there is significant non-alignment with WHO's updated policies and frameworks.

DG ECHO does not have an established and clarified process to identify organisational priorities in health. Within DG ECHO, health is fragmented across different units, with most of the health expertise seated at the operational level in the Anopheles Group, which is not involved in policy decisions at HQ. Previously, DG ECHO had thematic policy focal points, including for health, that served as link between technical field staff and Brussels HQ, representing the operational/field realities at high and middle level meetings, but these positions were abolished. DG ECHO interviewees at the field level expressed that since the removal of the health policy post, they have felt more disconnected from HQ. Furthermore, there is no official working group on health that meets regularly to unify strategic thinking on evolving health issues (see further discussion of this in Part A EQ 4 How coherent was DG ECHO's response with that of other EU/EC actions, including those of individual Member States, and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and Global Health Security?).

This results in incoherence on health areas beyond the immediate response to health emergencies, including DG ECHO's role in epidemics, contributing to resilience, and bridging the nexus. In fact, the ET found a disconnect between the verbal and policy commitments at highest level on strengthening resilience and bridging the nexus, and tangible commitments vis-à-vis DG ECHO investments (see findings EQ 12 What is the added value of the DG ECHO-WHO partnership in terms of better health outcomes and health advocacy in humanitarian health emergencies? contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings?). These gaps place DG ECHO on uneven footing with WHO to jointly develop a shared vision and identify strategic priorities for the partnership.

[146] Add references
[147] Thematic Policy Document #7, Health, General Guidelines; DG ECHO, 2014; https://ec.europa.eu/echo/files/policies/sectoral/health2014_annex_b_en.pdf
[148] https://extranet.who.int/iris/restricted/password-login

One reason for this is that DG ECHO has a demand-based approach to programming which reactively responds to health needs as opposed to proactively building a vision and strategy for health. Other interviewees signified that health, while historically a core thematic area, has not typically been a priority area, and was brought to the fore during the COVID-19 epidemic.

Understanding and leveraging the partnership's collaborative advantages

"At the end of the day, WHO is not a humanitarian agency." [DG ECHO HQ]

Within DG ECHO there are varying views on what WHO/WHE brings to the partnership. E-survey respondents highlighted WHO's surveillance of new and ongoing public health events (76%), close relationship with MoHs (69%), functioning effectively as the health cluster coordinator (59%), technical expertise (55%), and their normative role (55%) as key strengths that it brought to the partnership (Table 11). Interviewees cited similar strengths, also highlighting WHO's leadership on global health matters, and their role in the transitioning and hand over to development partners and government.

With respect to health emergencies, across other partners, between 33% and 50% of e-survey respondents felt "field response" was WHO's strength, while only 9% of DG ECHO respondents found it to be a strength that brought value to the partnership. This highlights that WHO's previous standing as not being an operational agency in humanitarian settings, with the exception of protracted crises where WHO has long standing and significant operational roles (i.e. Afghanistan, South Sudan, Syria, Iraq), still very much resonates across DG ECHO - a view consistent among DG ECHO interviewees at both operational and HQ levels.

This is a major point of tension, suggesting a misalignment in expectations. WHO very much sees itself straddling both humanitarian and development arenas and wants to expand its operational capacities and receive increased operational funding from the partnership, yet operations is not what DG ECHO values most in WHO. To add to this complication, DG ECHO interviewees at both HQ and operational levels expressed frustration at WHO getting "stuck" in its normative role, not becoming more operational in other countries (as compared with their work in countries like Afghanistan), and that the partnership would strengthen if WHO had more operational capacity and resources to implement. DG ECHO interviewees highlighted the missed opportunities due to WHO's limited field presence, operational and implementation limitations, as was the case with DG ECHO's € 16M facility for a COVID-19 vaccination campaign in Sub Saharan Africa. This suggests that DG ECHO may value operations above all else and feels WHO should be more operational to bring the most value to the partnership. These conflicting views illustrate a lack of clarity across DG ECHO levels as to what they want and expect from their partnership with WHO, beyond their transactional expectations shared at the first HSD. This uncertainty could be a roadblock and lead to missed opportunities to leverage WHO's strengths.

Table 11 Survey results on WHO's added value in health emergencies

In relation to health emergencies, what WHO strengths bring the most value to the DG ECHO/WHO partnership (up to 5 strengths)	**% Agree N=37**
Surveillance of new and ongoing public health events	76%
Close relationship with Ministry of Health	69%
Functioning effectively as the health cluster coordinator	59%
Technical expertise	55%
Developing norms and guidelines	55%
Work with implementing partners	24%
Providing rapid funds to Ministry of Health during emergencies	21%
Providing logistics support during response	21%
Field response	17%
Coordinating partners across multiple sectors during development of preparedness plans	14%
Developing preparedness plans	10%
Other	3%
Capacity building of the humanitarian system	3%

For WHO, while there may be residual views of DG ECHO as "just the donor", examples where WHO country offices feel entitled to have the lion's share of HIP funding or are frustrated with DG ECHO's "cumbersome" processes, WHO interviewees at all levels consistently expressed strong appreciation for DG ECHO's strengths and comparative advantages, especially at country level. Interviewees highlighted DG ECHO's deep knowledge of the country contexts of where it operates and of what is effective humanitarian intervention: they have their "eyes and ears on the ground". DG ECHO were the first ones in Kiev, and in Yemen DG ECHO came to the middle of a conflict zone to visit a hospital being built.

> *"[The] superpowers of DG ECHO are that they are not going to only have remote conversations, they go to hot zones so [they] can understand situation and priorities"* [WHO Country Office]

At the operational level, WHO interviewees expressed that DG ECHO successfully combines its roles as humanitarian donor, as a technical agency with its Anopheles Group, and as advocates in cases such as Afghanistan and Yemen. DG ECHO is often flexible to changing needs in country - in Iraq they were willing to fund beyond the mainstream and consider, within the overall needs, some more unique but underfunded activities, albeit within the limits of their fairly rigid mandate (see findings EQ 12 What is the added value of the DG ECHO-WHO partnership in terms of better health outcomes and health advocacy in humanitarian health emergencies? contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings?). With respect to epidemics, the majority (81%) of WHO e-survey respondents found DG ECHO's response appropriate, suggesting they value what DG ECHO brings to epidemic response.

Interviewees at WHO HQ felt that DG ECHO Brussels did not have enough health experts to engage in meaningful policy dialogue, especially since Anopheles health experts are not included in the HSDs and other HQ level dialogues. Another common frustration was DG ECHO's rigidity with its mandate, and hesitance to adopt innovative approaches to financing (see EQ 11 Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanisms to deliver on its objectives at all levels? findings).

Leveraging strengths: There are multiple examples at both global and field levels of the partnership leveraging its comparative advantages for value creation. At the global policy level, DG ECHO and WHO, along with other UN agencies engaged in policy and technical exchange to promote mental health services in humanitarian settings (MHPSS). This collaboration is a good example of the partnership leveraging their strengths to operationalise global policy to benefit those in need. The initiative had two arms. The first was the co-development by DG ECHO and WHO of a series of webinars on MHPSS as an advocacy tool targeting donors to fund mental health in humanitarian crisis. The webinar was piloted in WHO's Middle East North Africa region with the goal of expanding to other regions. The second was the development of a new tool by WHO and UNICEF for the provision a minimum service package for MHPSS. Through a grant DG ECHO supported the pilot of this tool in several countries. WHO leveraged DG ECHO's extensive network of partners in the field, by having them adopt the tool into their field projects and provide feedback on its use. The goal is for the minimum service package MHPSS tool to be an integral part of humanitarian health response.

At the country level, in Yemen, DG ECHO leveraged their convener role as well as their ability to conduct bilateral behind-the-scenes advocacy to advocate for health data sharing during COVID-19. The Houthis would not report cases, and with the mounting pressure on WHO to report, DG ECHO rallied partners and approached the Prime Minster and the MoH, not on behalf of WHO, but rather framing the need to share their data as a humanitarian issue. DG ECHO was able to create leverage and convince the Government that the data was not for WHO's sake, but rather so the humanitarian community could help.

Summary

The partnership extends beyond the donor-recipient relationship and has become more strategic due to strengthened dialogue, its exchange of technical knowledge, and its pursuit of joint initiatives with results. Most WHO stakeholders at all levels, and DG ECHO respondents at HQ level, view the partnership as strategic and one which extends beyond that of a donor-recipient relationship. However, this is less the case

for DG ECHO operational staff, who expressed that the partnership lacks both a joint vision and a strategic framework. The partnership lacks an overarching strategy to frame both partner's vision. Instead, at the global level the partnership is marked by annual HSDs and a set of jointly agreed priority actions that are not widely shared or understood across partnership levels. This lack of a shared vision and strategic framework for engaging in humanitarian settings has led to misunderstandings on the partnership's priorities and frustration on both sides. This is especially prevalent at the operational level, where agreements at the global level do not necessarily trickle down to the field level and vice versa.

There is also confusion on alignment on health approaches. WHO has up-to-date and documented frameworks, strategies and guidelines for different areas relevant to health emergencies and health in humanitarian settings (i.e. on the nexus, resilience building and epidemics), Conversely, whilst DG ECHO has a health policy and general guidance on addressing health in humanitarian emergencies, these are out of date and do not include its approaches to important areas of health in humanitarian settings such as epidemics, strengthening resilience and bridging the nexus. DG ECHO does not have an established and clarified process to identify organisational priorities in health. Within DG ECHO, health is fragmented across different units, with most of the health expertise seated at the operational level in the Anopheles Group, which is not involved in policy decisions at HQ level. Furthermore, there is no official working group on health that meets regularly and can represent the organisations position on the highly evolving areas of health and humanitarian emergencies. This results in incoherence on health areas beyond the immediate response to health emergencies, placing DG ECHO on uneven footing with WHO to jointly develop a shared vision and identify strategic priorities for the partnership.

The ET found both partners recognise and appreciate each other's comparative advantages, however there were differing views on both sides about what strengths each institution was bringing to the partnership and how the partnership could best leverage these strengths. There exist strongly-held views within DG ECHO that, barring WHO's work in pandemics and on some protracted crises, WHO is not operational in humanitarian settings. Furthermore, this is not seen by some within DG ECHO to be an area where WHO brings added value, especially when compared to its normative and technical strengths in managing public health events. Paradoxically, DG ECHO staff at both HQ and operational levels expressed that the partnership would strengthen if WHO had more operational capacity and resources for implementation. This suggests a misalignment in expectations between WHO and DG ECHO, as well as within DG ECHO itself. WHO/WHE sees itself as straddling both humanitarian and development arenas, and very much wants to expand its operational capacities and receive increased operational funding from the partnership. For WHO, the partnership would benefit if DG ECHO had more technical health expertise at HQ level.

EQ 11 Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanisms to deliver on its objectives at all levels?	**TRANSACTIONAL**
JC 11.1 Dialogue between DG ECHO and WHO is strategic, effective and leads to concrete actions at HQ, regional and country levels JC 11.2 The DG ECHO-WHO partnership has defined governance, accountability structures and joint processes, and adequate resources to support collaborative, effective, and efficient action.	
Key findings	
• Dialogue between DG ECHO and WHO has improved within levels (global-global, country-country) but not across levels (global-country) leading to disjointed communication that affects partnership decisions and actions • High-level Strategic Dialogues (HSD) have strengthened the engagement of DG ECHO and WHO at the highest level, more firmly establishing them as humanitarian partners. However, DG ECHO's approach to the HSD is exclusive and lacks institutional cohesiveness, which limits its usefulness for the partnership at operational levels • WHO investments in DG ECHO engagement and processes have contributed to an increased number and quality of WHO proposal submissions, DG ECHO-funded actions, and increased DG ECHO funding	

- The partnership has experienced efficiencies in proposal and grant processes, with a decrease in timing from proposal submission to DG ECHO sign-off to release of the first tranche of funds, however, inefficiencies continue with heavy administrative and reporting requirements
- While DG ECHO has made strides in implementing flexible financing, there is still aversion to more innovative financing approaches

Dialogue between DG ECHO and WHO is improving within levels (global-global, country-country), but lack of coherence across levels creates disconnects between operations and HQ

Overall, most key informants felt that dialogue between DG ECHO and WHO has improved in terms of quality and regular frequency, and that it includes more flow and exchange of information. One reason for this improvement is that, unlike before where discussions were ad hoc, regular dialogue is in place at the global level. This includes via the Senior Officials Meetings (SOM) between EU and WHO, more directly through the DG ECHO-WHO High-level Strategic Dialogues (HSD), as well as through regular dialogue between DG ECHO and WHO HQ focal points.

The HSD is the hallmark of the strategic partnership, meeting annually since January 2020. It is co-chaired by the WHE Executive Director and the DG ECHO Director General, with the participation of other DG directorates, and key focal points at DG ECHO and WHE HQ. It is through the HSDs that at the highest level the partnership has been strengthened, more firmly setting DG ECHO and WHO as humanitarian partners. In fact, WHO's high level participation in the European Humanitarian Forum in March 2022, was a priority topic for the HSD. "*A key element to the partnership – regular and frank dialogue, this is clearly number one*." [DG ECHO HQ]

KIIs have characterised HSDs as frank and open discussions between both partners at HQ level. They provide opportunities for setting the global picture of the partnership, and for stock taking at the high level. Furthermore, among survey respondents who had participated in formal dialogues between DG ECHO and WHO, the majority (70%) found them to be structured and two-thirds saw them as a forum to air out challenges or issues. The dialogues were deemed productive – 65% of respondents felt they equally addressed the needs and interests of both partners and that they led to concrete actions.

There are, however, limitations to the HSDs. Only half of survey respondents felt the dialogues were strategic and transparent by sharing outcomes, while less than half felt they identified mutual priorities. These sentiments are corroborated by the following findings:

- ***The HSD does not come from a strategically driven process***: the evaluation found that on the DG ECHO side, the development of the HSD agenda did not involve a collaborative discussion of organisational priorities in health, DG ECHO's position and what it wants to get out of the HSD, but rather was an email exercise whereby different DG ECHO unit focal points provided inputs, which were then sent to WHO for their approval. As a result, there is no 'fil rouge' between the HSDs, and despite the priorities laid out in the Monitoring Table, the actions are often dependent on commitments of smaller technical groups, which may or may not follow-up as expected. *"The HSD is an exercise that is done via email…lacking a bit of strategy, a bit of vision, a bit of mission"* [DG ECHO HQ]
- ***The HSD does not provide the forum to explore the partnership and build on joint strategy***: with the exception of the first HSD, the subsequent meetings are only designated half a day. As a result, there is only enough time to touch the surface of priority topics and does not always cover all the priorities designated in the agenda. As a result, it is a "dialogue to set up more dialogues" in order to cover the strategic discussions.
- ***HSD is highly exclusive, not encouraging inputs from and sharing with the operational levels of the partnership***: the HSD is limited to HQ staff and does not include operational and field staff. As such, the dialogues, which cover highly technical areas, miss out on operational expertise. Further, this approach is favoured by management at DG ECHO HQ, as they do not seem to see how regional and country staff could contribute beyond operational and technical inputs. There are no formal meeting minutes or summary report, only an informal summary of the HSD is shared internally within DG ECHO, but again not

with the field/operational levels. There is no formal mechanism to 'translate" HSD messages to the operational level.

For these reasons the HSD has little impact at the field level, as it does not translate down. KIIs from both DG ECHO and WHO were not aware of what the take-home messages were from the HSD.

"What our directors are talking in Brussels with [WHO], we do not know, sometimes we have no idea, it's probably the same for the WHO colleagues, whatever happens in HQ in Geneva, or what their people discuss in Brussels does not necessarily trickle down..." [DG ECHO Operational Level]

Beyond the HSD, at the global level the partnership has regular dialogue between DG ECHO and WHE partnership focal points, and less frequently among technical and operational focal points. These dialogues are focused on operational and policy aspects, monitoring HSD follow-up actions, identifying and mitigating challenges, and advanced planning. In addition, more technical dialogues take place around EMTs, MHPSS, and other identified priorities.

At the country level, strategic and effective dialogue is varied. Some country settings like Afghanistan, Iraq, and Yemen have a history of good DG ECHO and WHO partnership relations, characteristic of open and horizontal dialogue that extends to other partners and includes strategic planning and collaborative implementation, which culminate in successful funding and impactful actions.

On the other hand, in countries like the heavily politicised Syria, dialogue is an evolving process. Initially, dialogue was turbulent as DG ECHO did not have country presence and was not impartial, leaving WHO to feel on the defensive regarding a whole of Syria approach. However, over time, dialogue improved as ECHO came into the country, and through collaborative approaches such as joint monitoring missions with WHO, were able to increase their awareness of the situation on the ground.

To help even out inconsistencies across countries, WHO has made efforts to strengthen its country offices' capacities to engage with DG ECHO through technical assistance and training (see "How to do DG ECHO" box). This has led to improvements in country dialogue by increasing WHO's capacity to engage DG ECHO and discuss from an operational perspective. These efforts have also changed DG ECHO's approach to WHO.

The evaluation could not identify instances of strengthening partnership dialogue at the regional level taking place during the evaluation period. However, since 2022 WHO's Regional Office for the Eastern Mediterranean (EMRO) initiated regional quarterly briefings that include DG ECHO unit directors, which interviewed stakeholders felt put the partnership on a less transactional trajectory. Interestingly, some DG ECHO KIs at HQ level indicated that they do not believe dialogue is necessary at the regional level, and that dialogue should remain focused on HQ and operational levels. However, most KIs from both partners expressed a strong desire for more formalised and strategic dialogues at both country and regional levels, especially considering the autonomous role of WHO's regional offices and their decision making power for activities in countries.

Transparency and accountability

> *"Whatever is discussed in Brussels, if the results from the field are not in the spirit of what DG ECHO foresees, there's nothing we can do at the strategic level"* [WHO HQ]

There was evidence of improved transparency in funded Actions. For example, in reviewing FicheOps in 2017 there were some Actions where WHO did not follow grant procedures and for example had hired implementers without informing DG ECHO or did not provide adequate financial and results reporting. When reviewing FicheOps for WHO Action in 2021, there were no mentions of such issues, indicating a possible improvement in communications and WHO's grant management.

Even with improved open dialogue between DG ECHO and WHO, communication breakdowns exist within each organisation that can affect the partnership and lead to transparency issues. Both DG ECHO and WHO interviewees gave examples of this. In Iraq and Yemen, mutual understanding between DG ECHO and WHO at country level on what WHO should prioritise in their HIPs proposal were overridden by WHO HQ, without discussion, blindsiding DG ECHO when they received their proposal. Similar examples have come from the

DG ECHO side, including instances where a mutual understanding between both WHO and DG ECHO and operational level being overridden at DG ECHO HQ level as a result of miscommunication.

WHO interviewees pointed to inconsistencies in decision making by both DG ECHO at the field office and desk office at HQ. Despite DG ECHO's clearly delineated decision process, WHO interviewees expressed their frustration at the inconsistencies of decision making across grants. For example, a request for a specific modification may get easily accommodated by one desk person in charge of Country A, but the same modification request would get rejected by another desk person for Country B, while the desk officer for Country C would jump through hoops to make the request happen.

For both partners, these issues are a function of their organisational structure and processes. For DG ECHO, proposal decisions are made at HQ by the geographical units, as they have the responsibility but not necessarily the technical and field knowledge, and they tend to follow the inputs of field staff. Field staff are trusted for their knowledge and experience and make joint decisions with partners in country, like WHO, but they have limited responsibility within DG ECHO. Further, while the geographical units make decisions, they are not influenced much by policy and thematic (health) experts at HQ. These policy and thematic experts have little say on contractual decisions even though they guide DG ECHO's priorities. This disconnect has culminated in issues affecting the partnership. On the WHO side, regional offices are autonomous and often have more say than HQ on how health policy is operationalised at country level. This can create transparency issues for the partnership as regional offices are not systematically engaged in high level dialogues and decisions or partnership processes.

Efficiencies and resourcing

Increased partnership investments

Since the establishment of the WHE, DG ECHO funding to WHO increased substantially, more than doubling from € 30.9M in 2017 to € 67.3M in 2021. Along with increased funding, the number of funded Actions tripled from eight in 2017 to 24 in 2021. This increasing trend was observed for multi-country Actions as well, with none funded in 2017 and three funded in 2020 and another three in 2021. The average amount of funding per action more than doubled during the evaluation period, from just under € 4M per action in 2017 to just over € 10M per action in 2021, suggesting that the rising trend is not only due to more Action proposal approvals, but also more funding per approved Action. The ET acknowledges that the health character of humanitarian programming has probably increased in the era of COVID-19, and this may be contributing to increased funding and approved proposal trends.

Less than a third of e-survey respondents felt the partnership decreased administrative costs and burdens, while only half of respondents felt the partnership provided timely and flexible funding for health emergencies, including for COVID-19. Similarly only 39% found DG ECHO's response flexible and only 38% found their response timely. One area of inefficiency highlighted by interviewees was the delay in grant-signing that often leads to implementation delays, especially if there is no counterpart funding for start-up.

However, an analysis of FicheOp documents for WHO Actions shows that overall, the average duration of DG ECHO proposal and funding processes decreased during the evaluation period (Figure 24). Looking at three different measures of average duration –from WHO proposal submission to DG ECHO sign-off, from WHO proposal submission to DG ECHO first release of funds, and from DG ECHO sign-off to first release of funds – all showed an overall decrease during the evaluation period. While there was annual variation within the former two measures (the drop seen in 2020 is primarily due to the quick turnaround of the 2020 COVID-19 support package), the most notable decrease was in the delay that KII's were most concerned about – the average duration from WHO proposal to DG ECHO sign-off.

The duration from sign-off to receiving the first tranche of funds decreased consistently each year to just over two weeks (going as low as one day for some actions).

The efficiencies gained for these two processes has meant a shorter duration from WHO proposal submission to receiving the first tranche of funds, from just under half a year to a little over four months. While efficiencies were gained in the timing of DG ECHO processes, there are other areas where efficiencies lag. One area that was highlighted is the designated start date. With all other donors, the start date is when the funding agreement is countersigned. However, with DG ECHO, the start date is the date that WHO indicated in the SF when the proposal was written. This can have a major impact on implementation if there is a delay in signing and there is no counterpart funding. For example, if the start date is designated for March 15, but the grant is not signed till June 15, DG ECHO will still consider March 15 as the start date. If WHO could not start implementation on March 15 due to lack of funds, then three months are lost from an already short grant. This leads to the administrative burden of cost extensions, and even if WHO can start implementation, DG ECHO's retroactive payments while flexible, are also administratively heavy.

Figure 24 Average duration of DG ECHO/WHO proposal and funding processes (months)

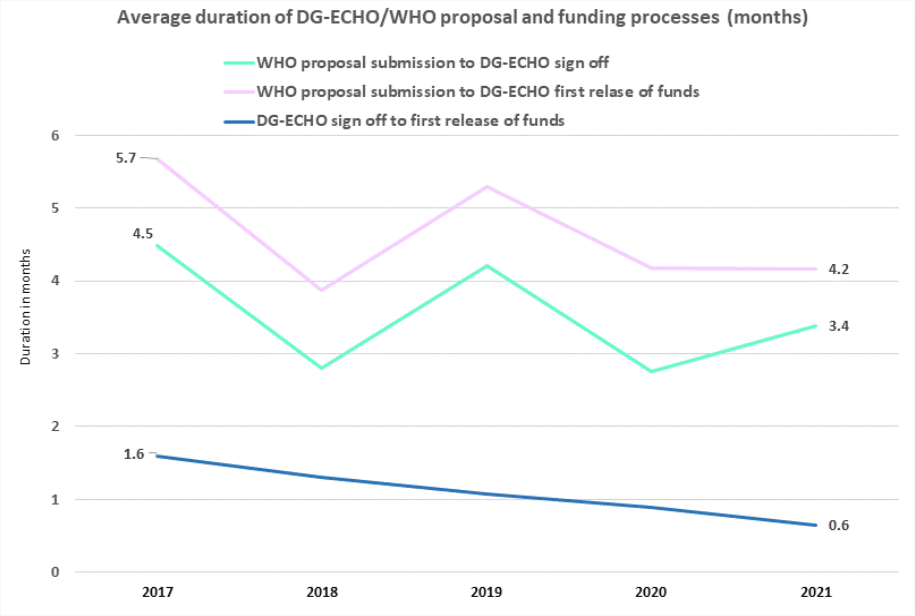


Figure 25 "How to do DG ECHO"

"How to do DG ECHO" - WHO's efforts to strengthen its capacity to engage in DG ECHO processes

"We [WHO] have invested a lot - a lot more than we have done for any other donor - in the relationship with ECHO at country level" [WHO HQ]

WHO even acknowledged the need to strengthen their capacities to submit proposals that are better aligned with HIPs' priorities.[149]The expert conducted over 1100 training episodes with WHO staff on different aspects of the "DG ECHO world" covering proposal writing, understanding the DG ECHO financing decision, DG ECHO procedures and processes, how these apply in the context of WHO, and most importantly how to engage DG ECHO. The training focused on WHO's interactions with DG ECHO, prompting country offices to engage DG ECHO at policy level and early in the HIP process, so that when the call for proposals comes out, WHO is not competing with everyone else's lobbying efforts.

The capacity-strengthening effort has been a success. First, the number of WHO proposals submitted to DG ECHO tripled to 37 in 2020 and 35 in 2021, with the latter all submitted on time. Second, with the increased capacity, proposal quality improved, potentially contributing to their success rate, with 63% approval in 2021, WHO's highest number of approved proposals (22) in the last decade. Third, the majority of KIIs expressed that the DG ECHO-WHO relationship at country level has improved, as WHO is more proactive in engaging with DG ECHO and its processes. One missed opportunity in this regard is that DG ECHO offers multiple trainings for NGO partners but does not include WHO/UN in this capacity strengthening.

Another example highlighted by some WHO interviewees was the tone of DG ECHO proposal refusal letters has changed, and they provide more explanation on reasons for refusal.

[149] Summary Report Strategic Dialogue DG ECHO- WHO (15 January 2020)

Interviewees admitted variable WHO country office capacity in DG ECHO processes, with proposals often prepared a few hours before submission, without any prior engagement with DG ECHO or institutional quality control, and often needing deadline extensions. In many countries there is lost opportunity for engagement, as WHO does not participate when DG ECHO invites partners prior to their call for proposals, often superseded by other UN organisations like OCHA, WFP and UNICEF. While DG ECHO appreciates the complexity of their funding system, the expectation is that WHO will strengthen their capacity to properly engage in these processes. In early 2020, WHO did exactly this, and hired an expert capacity-builder to upskill WHO country offices on "How to do DG ECHO".

DG ECHO reporting is considered burdensome compared to other donors, and as described below in the 2020 COVID-19 support package (see Figure 26), the expectation of such detailed reporting - especially on the financial side – is incompatible with some partners' institutional systems, like those of WHO. In particular, one area of frustration expressed by WHO is the need to report expenditures by results according to the logframe of the eSingleform, a requirement most other donors do not have. DG ECHO expressed frustration with WHO's lack of effort to meet some of the financial reporting requirements, which for DG ECHO are consistent with member states' need for accountability. WHO's financial system is inflexible, and some WHO interviewees admitted this is a frustration for many donors.

WHO interviewees also expressed frustration of trying to play "catch up" with the short HIPs cycles, sometimes only being eight months, where hiring implementing partners for mobile clinics takes at least a month, and project consultants or new staff up to four months. Conversely, DG ECHO interviewees expressed their frustration of WHO's lengthy administrative processes, indicating, for example, that hiring processes could be streamlined, especially for emergency settings.

Resourcing: alternative and innovative approaches to financing

The absence of a DG ECHO designated funding envelope for partnership initiatives at the global level, for example through the D1 unit, is limiting. As illustrated with the 2020 COVID-19 support package, funding for DG ECHO-WHO partnership initiatives are drawn from the HIPs, competing with the geographical units' priorities, and creating the potential for friction.

According to DG ECHO HQ, the D1 Unit was created to explore implementing other models of financing. The first HSD (January 2020) highlighted exploring innovative financing as a priority, and the MT includes follow-up actions to consider different financing approaches and framework agreements.

However, according to the MT's November 2020 and June 2021 updates, there was no progress in this area. Further, in the latest update from February 2022, innovative financing has been dropped altogether. This 'drop' may reflect DG ECHO's general concerns with what sustainable and flexible partnership financing means for UN agencies like WHO.

"UN agencies, all dramatically underfunded, always come with this kind of siren song of partnership, and when you scratch a little bit at the surface, it means basically, give us your money, no questions asked" [DG ECHO HQ]

Most WHO KIs and some DG ECHO KIs expressed the value of alternative funding models for the partnership outside the HIPs and Epidemics Toolbox, as these financing mechanisms are limiting in scope, time frame and funding, especially for progress in protracted crises. While some DG ECHO interviewees expressed the value of unearmarked multiyear funding, most were not supportive of a "blank check" approach, and that more predictable longer-term financing must be context specific, accompanied by a joint strategy and monitoring framework, and with regular reviews to adjust for changing contexts.

WHO has had bilateral meetings with DG ECHO to move towards innovative, flexible and longer-term funding, and in fact, WHO has officially expressed the desire for a programmatic partnership.[150] DG ECHO started piloting these programmatic partnerships (PPP) in 2018, to provide loosely earmarked multiyear funding to programmes at country, regional, global, or thematic levels. The PPPs encompass enhanced dialogue and joint monitoring in the field to reinforce mutual understanding and trust and move away from detailed reporting on outputs to focus on outcome indicators. Initially opened to NGOs (International

[150] Summary Report Strategic Dialogue DG ECHO- WHO (15 January 2020)

Committee of the Red Cross (ICRC) and IFRC have PPPs with DG ECHO) in 2021, the PPPs were opened to UN agencies through a competitive process. WHO applied for a project addressing high-impact epidemics (HIED) recurrent in West and Central Africa, but without success. Some DG ECHO interviews expressed reservation on such an arrangement due to the lack of coherence within DG ECHO geographical and partnership units to ensure alignment of the priorities with the HIPs, potentially falling into a situation where they are "just funding country programs for the organisation." However, DG ECHO initiated PPPs with UNICEF and FAO suggesting their longer-term relationship with DG ECHO may have helped.

Figure 26 COVID-19: a test case for a newly strategic partnership

Only weeks after DG ECHO's and WHO's first high level dialogue (HSD), the world was hit by the COVID-19 pandemic. DG ECHO was the first EC Directorate to fund WHO's Preparedness and Response Plan for COVID-19 with a € 30M grant, an important manifestation for the strategic partnership, given its infancy. The grant, "Support to WHO's COVID-19 Preparedness and Response Plan in high risk and vulnerable countries in Africa and Asia", covered ten countries in fragile states or humanitarian settings - seven in Africa (Burkina Faso, Cameroon, DRC, Ethiopia, Kenya, Nigeria, Somalia,) and three in Asia (Afghanistan, Bangladesh, Philippines). The grant had two objectives: 1. Rapidly establishing international coordination and operations support; and 2. Scaling up country preparedness and response operations for these high risk, vulnerable countries.

Funded from the 2020 HIPs for the Emergency Toolbox, ECHO was able to mobilise resources very quickly, from receipt of request on March 3, signing the agreement 3 days later, and releasing the first tranche of €24M within 2 weeks. This is notable considering the average release time of DG ECHO funds from proposal submission is 4 months, pointing to the potential efficiency and flexibility gains of the HIPs funding tool.

A grant of many firsts

"COVID was the first time ECHO provided a loosely earmarked contribution, which is very different from the very much tightly earmarked project activity approach that we have". [DG ECHO HQ]

For DG ECHO, the grant was ground-breaking as it had many firsts – the first EC to fund WHO's response plan, the first large some of € 30M, the first loosely earmarked grant, the first global multi-country grant, and the first 18-month grant cycle - all of which were out of the norm for DG ECHO. In fact, it was the first time DG ECHO negotiated a partner contract with no predetermined specific geographic coverage beyond being in Africa or Asia. This flexibility allowed WHO to drive the needs and determine where best to use the funds.

"The flexibility of being able to apply that funding to those countries where the most need was, at the time, was hugely useful". [WHO HQ]

DG ECHO had to overcome its general reticence for providing unearmarked funding due to the political challenges of EU member countries' accountability requirements. Another challenge was that the funding was sourced from the HIPs, rather than a separate envelope. This created some friction between the partnerships unit (D1) with the geographic units as they were competing for the same envelope.

The early funding did provide important visibility for DG ECHO. In fact, WHO was required to integrate visibility and communication activities, including an integrated visibility approach with DG ECHO and DG INTPA (letter communications from DG ECHO to WHO). There were also efficiency gains as it was one grant for ten countries, meaning one single form/one FicheOp versus ten, which meant fewer negotiations and less administrative burden.

Resolve through effective dialogue

There were growing pains. DG ECHO originally had ambitious notions of what WHO could feasibly report, expecting a monthly programmatic status report for each of the ten countries. For expenditure data the level of detail wanted means over 10,000 budget lines across the ten countries, and a lot of legwork due to incompatible financial systems. WHO couldn't just click and send the data in a form that DG ECHO wanted.

"It was a bit of a tricky situation as ECHO showed they trusted WHO enough to provide the grant, but they still wanted 'minute by minute reporting'… if people are going to spend all their time writing reports, then they're not going to be spending their time fighting COVID" [WHO HQ]

Through a series of discussions, DG ECHO and WHO found a 'middle ground'. For the programmatic reporting, instead of ten reports per month, every other month virtual meetings were held where three WHO country offices presented their progress on grant activities followed by a structured discussion with attendees which included on DG ECHO's side, field technical advisers, D1 unit partnership staff and relevant technical health staff, and on WHO's side, HQ partnership focal points and relevant regional staff. The discussions were technical with some administrative, with country presentations and meeting minutes documented. While these meetings required a lot of work to organise, both DG ECHO and WHO interviewees felt it was a mechanism that provided a forum to work closely with each other and promoted confidence in the work being done, 'without being too bureaucratic'. The ET reviewed the meeting minutes and country presentations were comparable to the monthly reports in terms of topic areas and depth of information, suggesting the forum as a good alternative to written monthly reports.

Not yet a "game changer"

Some interviewees felt € 30M grant was not a "game changer". The administrative burden was almost the same as country specific grants, especially at the operational level as it was still linked to the e-single form and log frame and still required DG ECHO procedures for any modifications. There were misunderstandings as well, as the grant agreement was early in the pandemic when diagnostic tests were not prevalent, however, at the final report stage DG ECHO asked why a testing indicator wasn't included in the log frame. In some countries, the € 30M grant negatively affected their country specific proposals for COVID-19 support, as the geographical units would ask them to draw from the global grant, highlighting the disconnect within DG ECHO on the purpose of the global grant.

With respect to financial reporting, DG ECHO initially expected WHO to report the same level of detail for the ten countries as it would for one country. When considering the expenditure across ten countries for one year, this meant 10,000 budget lines. For WHO, it wasn't "just click on a button and send this level of detail". While the two organisations managed to agree on a reduced level of detail for financial reporting, DG ECHO interviewees couldn't understand why it was such an issue to report on the financial data they wanted, especially since it meant less verification missions. For WHO, this level of detailed reporting would require WHO to hire new staff to focus on just DG ECHO financial reporting for multi-country grants.

"COVID-19 showed us that it requires a level of operational flexibility that allows partners to intervene where the needs are greatest and where the changing needs are...I hope this is a reflection in house of our overall approach to earmarking". [DG ECHO HQ]

DG ECHO followed the same approach the following year in April 2021 with a € 16M loosely earmarked contribution for the rollout of COVID-19 national vaccination campaigns in 15 African countries. DG ECHO provided at least another € 26M towards the COVID-19 response through WHO country specific Actions. For WHO E-survey respondents, 80% felt DG ECHO provided timely and flexible funding support for COVID-19 and this was pointed out by interviewees as especially true for Afghanistan and Syria. Unfortunately, this was not the case for the € 16M grant, as it was delayed considerably losing five months of implementation.

"COVID-19 enabled us to actually work in practice very closely with ECHO, in a very practical response to COVID". [WHO HQ]

Overall, the two large scale COVID-19 grants showed DG ECHO that allocating unearmarked funds was viable. Several DG ECHO interviewees felt that the COVID-19 grants modality was more efficient and hope DG ECHO will move towards these less earmarked funding modalities. The COVID-19 experience points to a maturing partnership able to resolve hiccups with effective dialogue.

Summary

Most stakeholders thought the partnership supported the resilience of health systems to respond to health emergencies, and good examples of this were provided in Action documents as well as through interviews. A promising trend towards longer Actions was noted, suggesting joint recognition that building resilience requires a slightly slower and more sustained approach in order to have impact. Nonetheless, there may be limits to this trend, as DG ECHO lacks a unifying framework on resilience, especially regarding health emergency preparedness, so efforts to work on these areas through the partnership are governed by the outlook of individual DG ECHO field experts and field offices, rather than stemming from a single point of

reference. In WHO's eyes this has led to lost opportunities, especially when DG ECHO and WHO agree at the policy level on joint initiatives to include preparedness, but such proposals are rejected due to the aversion of some DG ECHO counterparts to interventions which divert scarce resources away from 'pure' humanitarian response. Without a dually agreed strategic approach to strengthening resilience, both organisations run the risk of entrenched complacency, as experienced in South Sudan, where the same preparedness activities have been refunded yearly for over a decade without addressing how to progress towards both DG ECHO and WHO's own policies of sustainable resilience.

The two organisations also approach the nexus differently. WHO has a strong and (especially since 2016) well-institutionalised 'dual mandate' to work across the nexus. In contrast, DG ECHO's stance is less symmetrical: it is an organisation focused primarily on humanitarian action, but with a policy to support work across the nexus. However, in a resource-constrained environment and in the absence of specific guidance on the nexus, DG ECHO staff, especially at field level, have a propensity to steer its support towards traditional response activities.

EQ 12 What is the added value of the DG ECHO-WHO partnership in terms of better health outcomes and health advocacy in humanitarian health emergencies? contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings?	**TRANSFORMATIONAL**
JC 12.2. The DG ECHO-WHO partnership contributed to strengthening health equity and health system resilience. JC 12.1. The DG ECHO-WHO partnership strengthens the humanitarian development nexus in health emergencies	
Key findings	
• The partnership contributed to resilience in the humanitarian health sector, especially in countries where successive grants built on each other and made investments in systems-strengthening for preparedness • DG ECHO has no defined approach to investing in resilience, leading to inconsistencies in funding decisions and missed opportunities • There is a gap between DG ECHO's verbal and policy commitments to the Nexus, and practice, which tends to shy away from investments closer to the development side of the spectrum	

The partnership is contributing to resilience, but it is not yet mainstreamed within DG ECHO

Just over 65% of surveyed respondents felt the DG ECHO-WHO partnership strengthened the resilience of health systems to respond to health emergencies. An analysis of Resilience Markers (RM) in 30 DG ECHO/WHO Actions (SF/FicheOps) found that 75% of Actions received the maximum score of 2. There are concerns of the validity of the RM (see EQ 9 To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?), so a review of these Actions found that certain countries like Afghanistan, Iraq, South Sudan consistently scored high on the RM.

Figure 27 The DG ECHO-WHO partnership in South Sudan

The DG ECHO-WHO partnership in South Sudan: a well-oiled machine?

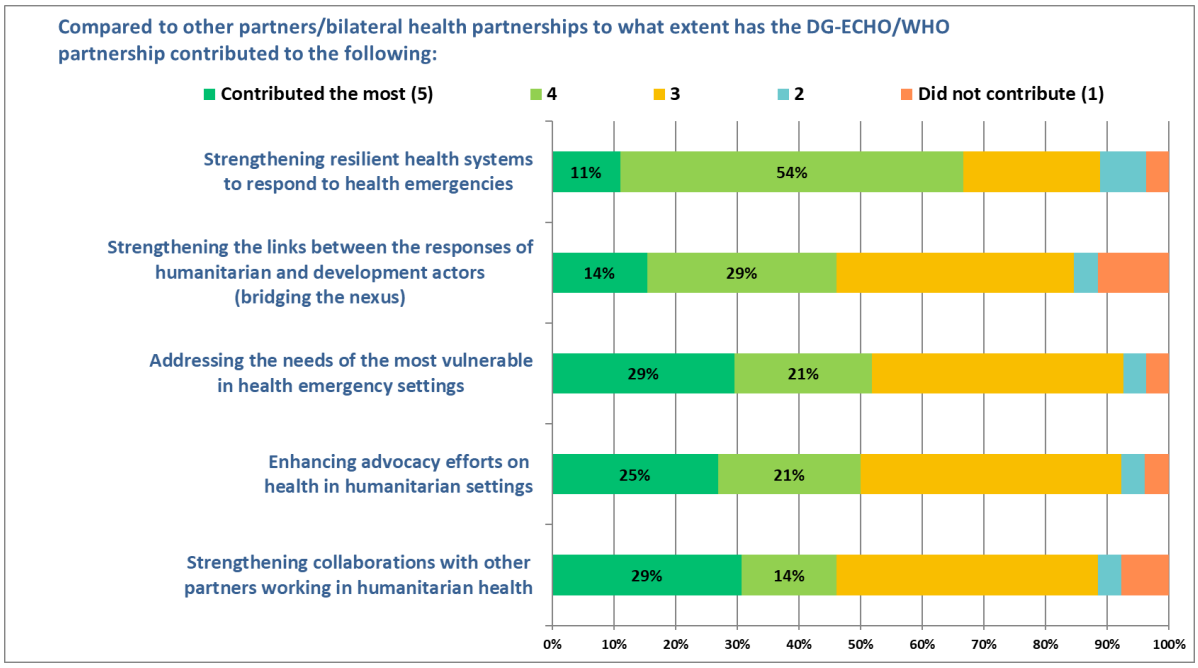
South Sudan has been in protracted armed conflict for almost a decade. With weak health systems, the country is vulnerable to the proliferation of infectious diseases. The DG ECHO – WHO partnership has consistently invested in preparedness, playing a crucial role in supporting and strengthening IDSR and EWARS programs. Since 2011, DG ECHO has contributed € 12.9M from the HIPs for nine activities (see Figure 20 for details). Over the last ten years, the partnership has had time to grow, with regular dialogue and joint monitoring missions, applying lessons learned and optimising what works. As a result, there is a functional supported IDSR and EWARS system with the human resources to maintain it, critical for averting major epidemic crises.

There is no doubt the Actions have been successful in reaching their objectives. However, on closer inspection, what is clear is that DG ECHO has essentially been funding the same activities for the past decade. The partnership has a well-oiled machine, and each new proposal WHO submits to HIPs is a sort of 'cut and paste' from former proposals with some scale up and complimentary activities. DG ECHO approves the funding and its business as usual. While it's understood that the South Sudanese Government has no active plan to absorb the funding of these systems, and not funding would have deleterious effects, there is no indication of longer-term strategy or questioning of sustainability. The investments are towards preparedness, but not resilience, as without the last decades funding, the system would collapse.

This complacency is not aligned with both organisation's own policies of sustainable resilience and bridging the nexus. There is no 'fil rouge' between grants beyond maintaining the system. The question arises as to why these longer-term investments are being funded through the shorter-term HIPs, which focuses on acute response. The partnership could consider alternative modalities to supporting IDSR and EWARS, such as implementing a programmatic partnership with 3-year funding, freeing up the HIPs for more acute needs. A multi-year funding approach provides the security to better plan for resilience, and forces a longer-term vision for sustainability. A trilateral agreement could be explored with a development agency such as INTPA, that could fund the sustainability portion, capacitating the government (perhaps through innovative financing approaches) to incrementally fund EWARS over the funding period.

These are countries with protracted emergencies and a history of WHO operational support. In the case of Afghanistan, the four Actions are essentially successive grants addressing major gaps in trauma care services. Through infrastructure support, capacitating blood banks and staff training, the Actions strengthened the capacity of 131 hospitals to provide trauma services for mass casualties and saving lives, while indirectly contributing to resilience. Other high-scoring Actions stray beyond DG ECHO's normal humanitarian boundary by investing directly into strengthening systems in fragile and humanitarian settings. This was the case for Cox's Bazaar, where DG ECHO funded laboratory infrastructure and training to strengthen surveillance and early warning systems. Similarly, investments in Ethiopia were directed to build a strong frontline surveillance and early warning network to detect disease outbreaks and increases in malnutrition rates.

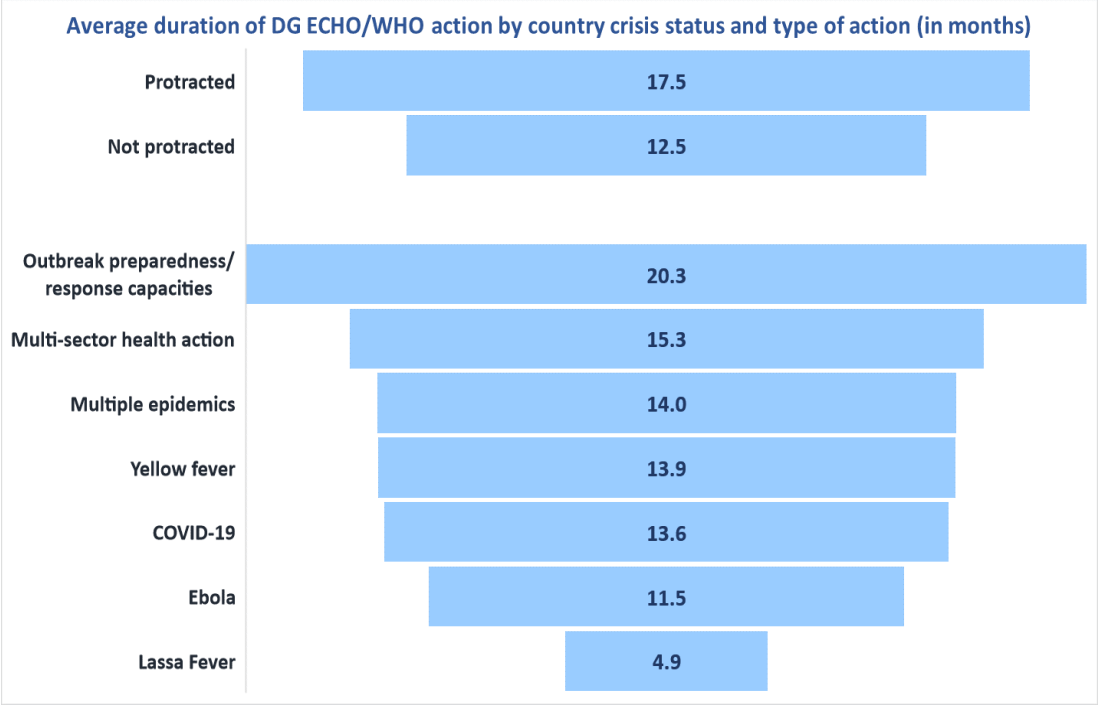
Figure 28 Average duration of DG ECHO/WHO Action by country crisis status and type of Action (in months)



Strengthening resilience requires time, which can be a challenge for DG ECHO's 12-month - and sometimes shorter - project cycles. Over the evaluation period, the average length of DG ECHO/WHO Actions increased from 11 months in 2017 to 15.3 months in 2021, with some extending up to 36 months. This is a promising development as it meets DG ECHO's Grand Bargain commitment for multi-year funding, and moves towards more sustainable impact.

When analysing the length of the grants by type of action, the longer grants are attributed to more resilience-focused activities, like multisector health Actions and strengthening preparedness and response capacities. Even more compelling is that countries in protracted crisis have a much longer project duration: 17.5 months compared to the standard 12.5 months for countries not in protracted crisis. Interestingly, the three countries mentioned above, Afghanistan, Ethiopia and Bangladesh (Cox's Bazaar), also have some of the longest project lengths.

Figure 29 Average duration of DG ECHO/WHO Action by country crisis status and type of Action (in months)



Resilience mainstreaming is highlighted as an expectation of partners in the HIP Thematic Policy Guidance.[151] Yet, DG ECHO has not formally defined a framework for how it will support longer term investments and objectives towards resilience in health. As a result, the partnership does not have a consistent approach to investing in resilience. From certain angles the partnership has led to more resilient and durable approaches, but this has typically been within the confines of DG ECHO's sharply focused mandate that seeks immediate results and counts lives saved, often linked to an ongoing response action, rather than a preventive approach. For some at DG ECHO, this is enough, arguing that lifesaving through emergency response alone contributes to resilience by reducing long term complications stemming from acute health issues.

Examples of where DG ECHO draws the resilience boundary include in Iraq, DG ECHO supported WHO in trauma stabilisation but not for building static field hospitals. When health facilities were bombed in Iraq, DG ECHO would not rebuild, but they supported referrals to the other facilities. In Yemen, DG ECHO would not support refurbishing a hospital, but would support a partner to run the hospital to address excess trauma coming from both sides of the frontline. While this decision might be justified for DG ECHO, these are indirect contributions from investments for life-saving emergency response and do not stem from a global framework that seeks to link short-term humanitarian actions with longer-term sustainable solutions, and highlights the tendency for DG ECHO to tiptoe around capacity and systems strengthening. At least half of DG ECHO interviewees at operational level believe this is good enough and that DG ECHO should steer clear of traditional systems of support.

"The DG ECHO remit of work is attributed to the acute peak mortality that comes out of a shock, as opposed to looking at the systemic issues on what caused the shock, and as an aftermath, how do we prevent tomorrow's shock?" [WHO HQ]

Taking this a step further, key informants highlighted missed opportunities for the partnership due to DG ECHO's "aversion" to investing in the prevention side of health emergencies. For example, the risk predictability of vaccine preventable diseases can allow for pre-emptive strikes against outbreaks, but DG ECHO has rejected WHO proposals geared towards horizon scanning, prevention measures and epidemic preparedness. Of the 67 WHO proposals rejected by DG ECHO during the evaluation period, over two-thirds had a reference to systems strengthening in the action title.

Figure 30 Lost opportunities to strengthen resilience

Lost opportunities to strengthen resilience

Several interviews and desk review highlighted an example of missed opportunities for the partnership to contribute to resilience and bridging the nexus. An agreement was made at the highest level, between DG ECHO Deputy Director and WHE Executive Director, to test the nexus in one region. WHO chose Lake Chad and the Central Sahel to address the imminent "next big explosion" of epidemics by strengthening the Health Resources and Services Availability Monitoring System, which maps capacities of essential health resources and services for both humanitarian and stable areas – considered a useful tool for humanitarian strategic decision making that bridges into resilience.

After two years of discussions between WHO and DG ECHO among operational and technical focal points, there has been no advancement. Several productive and information dialogues have taken place. Despite positive interest at the operational level and support from the highest level, the two submitted proposals were both rejected by DG ECHO geographic units. WHO was not sure why the proposals were rejected, indicating that DG ECHO's feedback were generic rejection emails. This example highlights multiple fault lines in the partnership. First, the disconnect between decision-making at the high level and operational level. Second, the lack of dialogue to address why proposals are rejected and to find a way forward. And third, DG ECHO's aversion to funding anything too much on the development side of the spectrum, posing challenges for the partnership to substantially contribute. In a region that is frequently exposed to epidemic outbreaks (Lake Chad is currently experiencing major yellow fever and cholera outbreaks), reaching a fast resolution on this matter is of vital importance.

[151] Humanitarian Implementation Plans Thematic Policies Annex; 2021.

The partnership is still developing its approach to the nexus

The EU places resilience, through a nexus approach, as a central objective in its development and humanitarian assistance. The 2004 EC/WHO MoU highlights as a policy priority area the promotion of linkages from humanitarian relief to development in health. The 2019 SOM between EC and WHO highlighted the need to focus on strengthening resilience in fragile states with the goal of making the "emergency-development nexus a reality", particularly in protracted crises.

Based on the humanitarian-development-peace nexus or "triple nexus" approach, the 'New Way of Working' involves leveraging the comparative advantage of each actor group and working over multi-year timeframes to achieve collective outcomes. WHO has embraced this, at least at the global policy level, through their recent nexus guide on how to operationalise the New Way of Working within the health sector.[152] However, despite these global-level commitments, only 43% of interviewees felt the partnership strengthened the links between humanitarian and development. *"We as humanitarians need to build development into every action we do. That's the nexus for me."* [WHE Senior Manager]

At the first HSD, WHO expressed that "[the] nexus is part of the DNA of the organisation". WHO feels they have the comparative advantage to bridge the nexus because it is dual-mandated, it has both its health system and emergency response sides. DG ECHO's role is more nuanced. At the highest level, the nexus is always on DG ECHO's global agenda. However, in practice, as described before, there is a disconnect between the verbal commitment, particularly at higher levels, and tangible commitments vis-à-vis DG ECHO funding activities for the nexus.

Part of the problem is that not everyone at DG ECHO is "on board" and as some interviewees expressed - many DG ECHO staff are comfortable with a narrow definition of humanitarian work. In the case of Afghanistan, most interlocutors indicated that the nexus was very much part of the landscape prior to the Taliban takeover, but there were DG ECHO staff who insisted that systems-building should not be the modality for Afghanistan, even though it was already part of the modality.

Moving forward, WHO has expressed interest in expanding the partnership, and to work with DG ECHO to jointly engage DG INTPA to support the transition from humanitarian to development, through more multi-year funding, as short-term project-based funding makes it difficult to bridge the nexus. They have also expressed the same on the implementation side and jointly engaging organisations like UNICEF in joint projects. However, there was not much evidence that the partnership is actively trying to address how it can leverage its comparative advantages to strengthen the nexus.

Summary

Most stakeholders thought the partnership supported the resilience of health systems to respond to health emergencies, and good examples of this were provided in Action documents as well as through interviews. A promising trend towards longer Actions was noted, suggesting joint recognition that building resilience requires a slightly slower and more sustained approach in order to have impact. Nonetheless, there may be limits to this trend, as DG ECHO lacks a unifying framework on resilience, especially regarding health emergency preparedness, so efforts to work on these areas through the partnership are governed by the outlook of individual DG ECHO field experts and field offices, rather than stemming from a single point of reference. In WHO's eyes this has led to lost opportunities, especially when DG ECHO and WHO agree at the policy level on joint initiatives to include preparedness, but such proposals are rejected due to the aversion of some DG ECHO counterparts to interventions which divert scarce resources away from 'pure' humanitarian response. Without a dually agreed strategic approach to strengthening resilience, both organisations run the risk of entrenched complacency, as experienced in South Sudan, where the same preparedness activities have been refunded yearly for over a decade without addressing how to progress towards both DG ECHO and WHO's own policies of sustainable resilience.

[152] Bridging the divide: a guide to implementing the Humanitarian-Development-Peace Nexus for health. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.

The two organisations also approach the nexus differently. WHO has a strong and (especially since 2016) well-institutionalised 'dual mandate' to work across the nexus. In contrast, DG ECHO's stance is less symmetrical: it is an organisation focused primarily on humanitarian action, but with a policy to support work across the nexus. However, in a resource-constrained environment and in the absence of specific guidance on the nexus, DG ECHO staff, especially at field level, have a propensity to steer its support towards traditional response activities.

5. Conclusions and recommendations

5.1. Conclusions and recommendations (Part A)

5.1.1. Overall conclusions and Recommendations – Part A

Epidemics have re-emerged as a serious global health threat. Climate change, environmental degradation, conflict and forced migration are combining in ways that increase the likelihood that epidemics will arise in humanitarian settings or that epidemics will exacerbate humanitarian suffering in those places. DG ECHO has an important role to play in combatting epidemics through prevention, preparedness and response interventions. It has resources and excellent attributes - not least its considerable experience - to bring to bear on epidemics, and it could lead on relevant aspects of the forthcoming EU Global Health Security Strategy. But it needs to address certain weaknesses and adopt a much more purposeful and deliberate approach in order to face the challenge of future epidemics which will surely arise.

DG ECHO already has a good track record in responding effectively to epidemics. Its network of field offices and field experts, supported by the Anopheles network of regional health experts, provide an experienced and knowledgeable platform from which to launch agile and appropriate responses to epidemics. It nurtures effective, value-for-money partnerships with trusted IPs whose sustained presence in humanitarian contexts helps build resilience and whose projects can be adapted quickly to tackle disease outbreaks. DG ECHO supports such adaptation by being a flexible donor, ready to disburse new funds quickly or to allow sensible modifications to existing Actions in line with changing needs. It adds value to overall epidemic response efforts, using its 'feet on the ground' capacity to support humanitarian coordination and to demonstrate leadership where required, including on issues of humanitarian advocacy. Recent initiatives to deploy in-house civil protection capabilities to support humanitarian action have shown some promise.

However, DG ECHO currently has no organising principles that shape its work in relation to epidemics. It has very little policy or thematic guidance relating specifically to epidemics, no 'programme' on this theme, and no single manager or officer who oversees the work in this area. Action on epidemic preparedness and response is one of many types of humanitarian action that DG ECHO engages with, but it does so through a series of ad hoc projects which are only tied together quite loosely through the institutional knowledge of its small cadre of health experts and to a lesser extent through a specific funding tool for epidemics (which only accounts for around 12% of DG ECHO's funding for this type of emergency). Very little work is focused on epidemic preparedness as opposed to response. In sum, DG ECHO has a largely reactive and transactional stance towards epidemics; the ET argues that it now needs a more strategic and proactive approach.

To support this more strategic and proactive approach DG ECHO needs to improve its performance in a number of areas. To maintain integrity of purpose it needs to close certain gaps between institutional policy and its practice in the field, so it puts into action the commitments it has made. It needs to take up its responsibilities within the EU to lead on key aspects of global health security, in accordance with its mandate as the key EU institution focused on countries in humanitarian crisis. And DG ECHO needs to enhance its use of the current tools at its disposal, as well as seek new and flexible ways of adding epidemic response capacity to its current toolkit.

Through the adoption of relatively simple measures, DG ECHO has the opportunity to boost its already strong performance on epidemics in humanitarian contexts. A set of strategic recommendations is set out below, supported by additional rationale, and backed by more detailed 'supporting measures'.

Strategic recommendation 1: *Forge a strategic vision and policy on epidemics*

The importance of epidemics for global health security and for DG ECHO's work require that it sets out a clear direction, backed by a coherent policy framework. DG ECHO's current policy on epidemics is quite thin and is scattered among several reference documents. It also lacks some coherence and fails to provide adequate guidance and direction to its staff and potential implementing partners. This creates 'grey areas' and erodes consistency and quality over time. Based on the findings of this evaluation, key areas demanding better guidance include the balance between epidemic prevention, preparedness and response; using epidemiological data to consider epidemic trajectory; selecting the most appropriate funding tool; prioritising which response pillars to support in different situations; and how to blend humanitarian assistance and civil protection interventions in meaningful ways.

Supporting measures

- The ET suggests that DG ECHO should first address its own lack of clear policy relating to epidemics and define its own specific role and remit within the cadre of EU institutions working on epidemics. Once it has found its place, DG ECHO will be in a position to leverage its technical knowledge and expertise to assume a more leading role on multilateral and global fora to drive policy change and ensure its influence and leadership (in relevant areas) among humanitarian donors.
- Develop a chapter in the forthcoming EU Strategy on Global Health Security which sets out the vision for epidemic prevention and response in humanitarian contexts, including some strategic objectives
- Either write a specific DG ECHO Thematic Policy Document[153] on Epidemics, or revise and update the current DG ECHO Thematic Policy Document: Health General Guidelines (2014) to include a chapter on Epidemics
- Clarify and harmonise the language in all HIP documents relating to epidemics (especially where they are equivocal on the subject of prevention and preparedness)
- Appoint a policy 'champion' for epidemics within the DG ECHO health expert cadre (it should be part of someone's job description to promote and monitor policy coherence on epidemics within DG ECHO and contribute to cross-EU policy discussion and coordination)

Strategic recommendation 2: *Reinforce policy discipline on important cross-cutting issues*

DG ECHO has developed important areas of cross-cutting policy that underpin all its humanitarian work, including its response to epidemics. These policies often embody the leading edge of humanitarian thinking and reflect commitments the EU has made to its own citizens and in international fora. DG ECHO must find ways to ensure practice conforms with policy, preferably through the 'hearts and minds' approach suggested by senior leadership during the evaluation.[154] The ET found several areas where there was significant disparity between published DG ECHO policy and the perspectives and practices of field staff. These divergent and relatively pervasive attitudes ranged from an acknowledgement of 'blind spots' at the mild end of the spectrum, to profound disagreements on policy at the extreme end. They related in particular to AAP, to building resilience, and to working across the humanitarian-development nexus, but practice also deviated from official guidelines on the treatment of vulnerability in project design and the importance of good needs assessments. While there are always differences of opinion about policy in large organisations, the gap between policy and practice in DG ECHO seemed particularly wide in the opinion of the ET, and it clearly spilt over into the quality of Action documents, where sections relevant to policy compliance (such as the Resilience Marker) received weak attention. It is potentially damaging for DG ECHO to espouse bold policy

[153] There already exists a series of these policy documents on various topics

[154] KII with senior leadership, 31 Aug 2022

statements that are not complied with as it has the potential to undermine accountability and sends out confusing messages to IPs.

Supporting measures

- Senior DG ECHO management should start changing aspects of the organisational culture relating to policy discipline. They should use team meetings, field visits, supervision meetings, staff induction sessions etc. to further encourage staff to embrace DG ECHO's policy role (as a path to improve humanitarian aid response and drive the global agenda) and explain why certain policies are in place and the value placed on these by the leadership. Healthy debate should be encouraged, but persistent dissent and exceptionalism should not be tolerated.
- Increased dialogue and training/learning opportunities for HQ and field staff on DG ECHO's policy guidelines should be encouraged to promote a common understanding of the different policies developed and supported by DG ECHO.
- Extended consultation within DG ECHO services, as well as with DG ECHO partners and main stakeholders on the development, evaluation and update of policy guidelines should be further promoted for increased ownership.
- Use the chain of command to encourage policy discipline. Desk Officers and Heads of Unit should ensure minimal levels of compliance are achieved in Action documents and drive accountability downwards, ultimately to IPs filling in the SF.

***Strategic recommendation 3**: Adopt a more proactive role within the EU on Epidemics*

This is a formative time in the EU for its positioning on global health security. DG ECHO needs to help shape the agenda, so the importance of humanitarian needs and the potential of humanitarian action are not overlooked. In the wake of the COVID-19 pandemic the EU is moving quickly to strengthen its own resilience to health shocks, especially epidemics, and to play a fuller part in global health security. The creation of DG HERA, the expansion of ECDC's mandate, and the announcement of a new Global Health Security Strategy are major examples of this agenda. Within DG ECHO, a new response arm - the EHRC - was also announced recently, building on experience gained during the pandemic. These are exciting new initiatives, but will also add some organisational complexity, especially in the short to medium term. This evaluation has several findings relevant to this challenge. There is already a crowded field of agencies, delivery units and initiatives within the EU which all have a bearing on epidemics. EU stakeholders lacked awareness of how they all work together currently and how the absorption of new initiatives might change things. There was also a finding that relevant EU entities had not been well coordinated in responding to epidemics in the recent past. Lastly, although DG ECHO has a key role to play - and ambition to do more in the future – it is seen as reticent among EU stakeholders and as ceding the agenda on global health security to other EC services. This diffidence within the EU at headquarters level is in stark contrast to DG ECHO's leadership and appetite for coordination among external actors in field settings.

Supporting measures

- Increase the number of senior health experts based in Brussels, so DG ECHO is adequately represented within key meetings and initiatives, enabling the implementation of a vision set for DG ECHO's role in epidemics response in humanitarian settings
- Offer to lead on relevant sections of the new Global Health Security Strategy
- Reach out bilaterally to key services and agencies, notably DG INTPA, DG HERA, ECDC and DG SANTE to strengthen collaboration on epidemic prevention, preparedness and response in humanitarian contexts to ensure epidemics response in humanitarian settings are not overlooked.

Strategic recommendation 4: *Enhance the effectiveness of existing tools, instruments and practice*

DG ECHO already makes very effective contributions to addressing epidemics in humanitarian contexts, but it could boost its performance even further by making relatively simple adjustments to its current tools and ways of working.

Firstly, the Epidemics (funding) Tool should be updated and given a more prominent place within DG ECHO's suite of funding instruments. In the absence of strong policies or any specific programme on epidemics, the Epidemics Tool is DG ECHO's only specific instrument dedicated to epidemics. It is highly valued, but not used as often as it could be. The average grant size is probably too small to have sufficient impact, and the release of funds under this instrument slowed significantly in 2020-21. The guidelines governing how it can be used are also rather equivocal in relation to preparedness.

Secondly, more careful attention should be given to how epidemic interventions are selected, and the rationale for the specific approach should be described more fully in the Action documents. The ET found that the majority of epidemic response proposals selected for funding lacked sufficient explanation of context, especially needs and response gaps, and why the proposed intervention was the optimal one, rather than the one most convenient for the IP. Too many such proposals were approved with minimal challenge or commentary by DG ECHO field experts and desk officers. The ET therefore doubted whether the selected interventions were always the most apt and ambitious.

Thirdly, potential civil protection interventions need to be harmonised with humanitarian aid delivery in an objective and holistic way, based on humanitarian principles. DG ECHO incorporates a civil protection wing (that has largely been focused inwardly within the EU) with a humanitarian aid wing (that is focused externally). Recent initiatives to deploy civil protection instruments to support humanitarian assistance – moving 'from donor to doer' - show some promise. However, there was good evidence that some of these initiatives were driven by political needs among EU stakeholders for visible 'action' rather than being prioritised on the basis of need. This widens divisions between the civil protection and humanitarian arms when they still need to be integrated more closely. In addition, rather exaggerated claims are being made about the contribution of civil protection to humanitarian action. Some of these initiatives are still underdeveloped; and some of them will always be of marginal importance.

Fourthly, DG ECHO should explore ways of accessing epidemic response capacities in flexible ways, especially by seeking partnerships with trusted specialist institutions. Epidemics are episodic and unpredictable. It makes sense to be able to draw upon external expertise when needed, but within long-term frameworks. In particular DG ECHO could benefit from epidemiological expertise to understand the trajectory and other trends within disease outbreaks. Other kinds of potential support could include health anthropologists, experts on resilience and epidemic preparedness, and governance advisers.

Supporting measures

- Increase the frequency, average size and scope (to include preparedness) of the Epidemics Tool by adjusting the associated Emergency Toolbox HIP documents and guidance. Monitor the time gap between application and approval to ensure this remains a timely instrument.
- Challenge IPs to explain why their proposed interventions are the most appropriate in each situation, and not just appropriate. Document this analysis in the Action documents. In particular ensure robust explanations of the rationale for the specific proposed action, including considerations of critical response gaps and how epidemic response interventions have been prioritised. Avoid programmatic inertia by encouraging IPs to respond where the greatest needs are - and not just where they happen to be working already.
- Conduct an objective review of the (very welcome) potential of civil protection instruments to support humanitarian action and ensure this capacity operates within the norms of Humanitarian Principles

- Either directly, or indirectly through its IPs, seek appropriate partnerships (under framework agreements) with institutions that can provide expert surge capacity relevant to epidemics. These could include other EU institutions (e.g., ECDC), universities and specialist consultancies.[155]
- Further engage with Directorate-General for Research and Innovation (DG RTD) for operational research (and with partners that have such capacity).

Strategic recommendation 5: *Step up work to bridge the nexus by focusing on preparedness*

DG ECHO should begin programming purposeful and well-structured work on epidemic preparedness in selected humanitarian contexts. The strategic recommendations above are all relevant to working better across the humanitarian-development nexus, but this issue is so important it warrants being brought together through a specific recommendation. Senior DG ECHO leadership has already accepted that a major lesson of recent epidemics is the need to take a longer-term approach and to work alongside others across the nexus. DG ECHO already has some experience of this approach (e.g., in South Sudan), but the examples are relatively few, ad hoc and lack a sense of direction. Field practitioners feel they lack agency without clear guidance and a strong push from senior management. Bridging the nexus can seem daunting when the gulf between humanitarian aid and development is very wide. However, work on epidemic preparedness is a good place to start. It can sit within humanitarian action, but can borrow heavily from development practice, employ operational research, and offers a potential pathway into further health systems' strengthening if the humanitarian situation resolves.

Supporting measures

- Establish a portfolio of epidemic preparedness Actions in selected countries overseen by the epidemics lead health expert in Brussels and respective field expert (see strategic recommendation 2), adequately funded within multi-year timeframes, and in partnership with suitable IPs. Ideally, by way of a pilot project, at least one of these Actions should be funded as a joint venture with DG INTPA and or an EU MS (this "joint venture" would ensure coherence on funding timeframes, implementing partners, complementary activities, within an agreed monitoring and evaluation framework).
- Issue joint DG ECHO-DG INTPA guidelines to field offices on working together across the nexus, building on existent examples of common framework already developed by DG ECHO – EEAS/DG INTPA on an ad hoc basis. This should comprise a framework and a 'menu' of practical ideas and examples of collaboration

5.2. Conclusions and recommendations – part B

5.2.1. Overall conclusions and recommendations – Part B

The DG ECHO-WHO partnership has been slow in the making - as DG ECHO did not see WHO has a major humanitarian implementer and WHO was primarily normative with limited operational capacity. Two milestones changed this. The first was the establishment of WHE in 2016, which provided WHO with the mandate to respond to health emergencies. The second was the prioritisation of health emergencies, preparedness and response as an area of collaboration for the EC – WHO partnership in 2018. Both events corresponded with increases in DG ECHO funding to WHO for implementing health Actions in humanitarian settings. By late 2019, WHO became an official strategic humanitarian partner for DG ECHO, which was formalised in January 2020 with the first annual High-level Strategic Dialogue.

WHO's most significant added value is considered their capacity to work on purely humanitarian interventions. They are an important partner for health activities during pandemics/large scale epidemics or during

[155] The ET learned that such a mechanism was being approved at the time of writing by the EU Parliament and Council under the name of EU Health task Force (and under the coordination of ECDC)

protracted crisis and things can be made more systematic through the partnership. And their normative role should be promoted while working with other partners in areas covering health.

While the partnership extends beyond the donor-recipient relationship at the highest level and in some countries, this is based on good relationships and committed staff, rather than a joint framework that can guide the partnership at all levels. As the partnership is not governed by a specific MoU or agreement, it lacks a shared vision and an overarching framework for engagement, with strategic priorities loosely tethered to an exhaustive list of high-level functions agreed on at the HSD. The HSDs have been essential in solidifying WHO and DG ECHO as humanitarian partners at the global level, but due to their exclusive nature the HSDs have had limited usefulness for the partnership at operational levels. Further, they have failed to provide a strategic framework for the partnership, which is partly due to DG ECHO's lack of unified and cohesive strategy on health.

Despite no framework to guide the partnership, dialogue between DG ECHO and WHO is improving in quantity and quality within levels (global-global, country-country). These productive dialogues have led to actions with added value. DG ECHO-WHO collaborations to develop global policy in providing a minimum package of mental health services in humanitarian settings, has trickled down and rolled out in several countries. Through funding and technical cooperation, the partnership has been essential for developing the classification and minimum standards for EMTs. In countries like Afghanistan with protracted crisis, the partnership has had time to grow, characteristic of open and horizontal dialogue that extend to other partners and include strategic planning and collaborative implementation, which culminate in successful funding and impactful Actions.

However, across levels there is a lack of coherence which creates disconnects between operations and HQ. This has led to a divide between global level decisions and what is understood and implemented at the operational level, sometimes leading to missed opportunities and strained relationships.

The partnership has shown it can improve its functions. WHO's recognition that it needed to invest in strengthening WHO country offices' capacity in DG ECHO engagement and processes paid off with increased number and quality of proposal submissions, DG ECHO funded Actions and overall funding. During the evaluation period the time for proposal approval decreased substantially, and DG ECHO was able to negotiate reduced reporting for € 30M COVID-19 Preparedness and Response Plan. The COVID-19 grant broke new ground with the first loosely earmarked multi-country multiyear grant. Indeed, the length of grants to WHO increased since 2021, especially for countries in protracted crises. These are all promising trends towards efficiency and moving towards investments with longer term impacts towards resilience.

There may be limits to this trend, as DG ECHO lacks a unifying framework on resilience, especially regarding health emergency preparedness, so efforts to work on these areas under the partnership are governed by the outlook of individual DG ECHO field experts and field offices, rather than stemming from a single point of reference. Without a unifying framework, even investments dedicated to preparedness can fall victim to complacency by both organisations, as experienced in South Sudan. Perhaps nowhere is the potential value of the partnership more apparent than in its potential to work across the humanitarian-development nexus, but this requires an alignment of aims, and DG ECHO to establish a more coherent policy on linking humanitarian health response to preparedness, recovery and development.

Strategic recommendation 1: *Co-develop a strategic framework for engaging in humanitarian settings*

Forging a strategic partnership requires shared vision, structure, and mutual understanding of each partners' strengths and gaps. The annual high-level meetings and associated follow-up actions do not provide the momentum to strengthen the partnership across levels to realise its potential added value. The partnership needs a framework to define what it wants to achieve and how it wants to engage in humanitarian settings, as well as the areas of health it wants to invest resources and expertise into, including policy and advocacy.

> *"It is essential that we develop a strong understanding for our commonalities and our common interests"* [KII, DG ECHO HQ]

The first step in this process is for DG ECHO and WHO to come together to map the areas of common interest, each organisation's strengths, areas of complementarity and synergy, and areas of misalignment or tension to achieving a unified approach. Ideally, the partnership should identify strategic priorities that can be mainstreamed into both organisations and across all levels. Example priorities could include ensuring the incorporation mental health services in all responses and integrating standardised resilience strengthening across all Actions.

Developing the framework's development is not just an exercise at HQ level, it requires global ownership, and needs the inputs across all levels, building the strategic priorities from the bottom-up so they reflect the humanitarian health needs on the ground. This requires a collective look at the needs across countries

The framework can serve as a guide across levels and functions, ensuring coherence on policy and strategic priorities across HQ, policy and operational arms of the partnership. For example, operational staff from both organisations can adapt the framework to country contexts when negotiating priorities for the HIPs.

To ensure the framework is mutual, both partners must bring cohesive and strategic thinking on health to the table and find the natural alignment of their respective frameworks that can guide the partnership. This maybe a challenge for DG ECHO without an updated and unified approach to health, something which should be an area to prioritise moving forward.

Supporting measures

- **Utilise multi-level formal dialogues for each step of developing the strategic framework for engagement**: At country and regional levels formal dialogues can be used to do the mapping at operational level and identify mutual strategic priorities that reflect the realities of humanitarian needs on the ground. At the global level, utilise the HSD as the forum to conduct global mapping, develop shared vision and strategic priorities, endorse and update the Strategic Framework.
- **Develop a strategic framework for engagement**, which should include:
  - Inclusive development processes, with inputs spanning from the field level to executive leadership level
  - Shared vision for the partnership
  - Priority areas/workstreams that both organisations hold strategically important, can be mainstreamed into both organisations, translate to the operational level, and can be adapted to country/regional contexts
  - Joint objectives that encompass and expand beyond the HIPs funding objectives
  - Joint approaches to resilience initiatives such as surveillance and early warning systems, strengthening emergency preparedness and response capacity, and ensuring sustainable access to health care. Explore areas of health security to prioritise
  - Joint approaches to bridging the nexus and how the partnership can leverage its collaborative advantages to ensure linkages to resilience and recovery. Consider trilateral cooperation of WHO, DG ECHO and DG INTPA as well as collaborations with other implementers.
  - Joint processes for decision making, defining roles and responsibilities, and that include transparent and inclusive dialogue
  - Provision for multiple funding modalities with a focus on flexibility, efficiency, and reducing administrative burden
  - Monitoring framework for effectiveness rather than just accountability with reviews to adjust for changing context
- **Forge a coherent and unified strategic approach on health** to bring to the partnership
  - Establish a formally endorsed working group on health to provide the forum for technical and policy decisions on health. Membership should include focal points from DG ECHO's relevant units (thematic policy, geographic, civil protection, Anopheles, ECHO Field, etc.) with inputs from other health experts as required
  - Develop DG ECHO's internal position on health and its positioning with respect to the WHO partnership
  - Recruit sufficient health policy expertise at HQ Brussels to better link health policy to operations

- Update the 2014 health policy and related technical guidance by leveraging WHO's and other health partners normative and technical expertise
- Define DG ECHO's position in supporting common areas of health, including epidemics, mental health, health system resilience, bridging the nexus, etc. especially their positioning vis-à-vis other EC directorates.
- Ensure coherence across DG ECHO by engaging relevant staff on evolving health issues and the organization's positioning on these

Strategic recommendation 2: *Engage in more frequent, more inclusive, and more strategically driven dialogue and communication*

The partnership has experienced improved dialogue within levels (global-global, country-country), but the lack of coherence across levels has created a disconnect which impacts the partnerships' efforts. Even though the HSD is the hallmark of the strategic partnership and has solidified DG ECHO and WHO as humanitarian partners, it does not come from a strategically driven process and remains highly exclusive, having little impact at the operational level. Dialogue at the regional level has been limited and at the country level is inconsistent, dependent on country context and wrought with communication breakdowns within each organisation. The overarching strategic framework for engagement can address many of these issues by guiding the dialogue at all levels and establishing the linkages across functional levels. However, the partnership also needs to directly address the quality and frequency of dialogue.

"If you are going to try and build a strategic relationship, one organisation to another, then you have to work at it at all three levels" [KII, WHO HQ]

"It is absolutely imminent, if we want to strengthen our partnership, that we have this annual dialogue for each region and country…discussing strategy so we are all on the same page" [DG ECHO Operational Level]

The partnership needs to expand formal and documented dialogues to all levels, HQ, regional and country. The dialogues should be strategically driven with clear objectives. Cross fertilisation is important, bringing the operational experience closer to HQ by involving more on the ground technical people at the HSD, and including HQ policy people at operational dialogues. To be successful each organisation needs to address their respective internal communication processes.

Supporting measures

- **Strengthen the High-level Strategic Dialogues**
  - ***Approach the HSD through a more strategically driven process****:* develop the HSD agenda through a more inclusive and interactive approach, ensuring all health focal points, including at operational level input into the organisation's position and priorities
  - ***Expand participation*** to relevant DG ECHO and WHO operational and technical staff across levels increase transparency and partnership understanding
  - ***Engage DG ECHO and WHO technical and operational experts*** at different levels in strategic decision making, sharing lessons learned, best practices, and realities from the field
  - ***Invite PAHO*** to participate and share best practices and lessons learned as well as explore collaborative opportunities
  - ***Formalise HSD outcomes*** through jointly validated summary reports or meetings minutes and widely disseminate these to all relevant stakeholders across organisational levels
  - ***Explore alternative meeting formats*** that can better accommodate the agenda and reach decisions such as having breakout rooms or side events to deep dive into priority areas or have more technical discussions
- **Create opportunities for more formalised strategic dialogues at regional and country level**. Annual dialogues that include regional and country staff from both organisations can nurture strategic exchange and ensure that "we are all on the same page". Including HQ technical, policy and operational focal points can further forge coherence and collaboration across levels.

- **Establish a process to formulise DG ECHO-WHO dialogues**, either via minutes, follow-up emails or summary reports etc., and disseminate regularly to the appropriate stakeholders. This will ensure mutual understanding of any issues and decisions, which can help strengthen the cohesiveness of the partnership.
- **Increase transparency of grant decisions** through more detailed feedback in refusal letters to WHO, use these as opportunities to engage in constructive dialogue for lessons learned and to strengthen alignment of priorities and ensuring decision makers are adhering to organisational processes and policies.
- **Support WHO's efforts to strengthen its capacities on "How to do DG ECHO"** by providing constructive feedback on what has improved and what needs strengthening both at HQ and field levels. In addition, help demystify DG ECHO processes by inviting WHO to DG ECHO country-level capacity strengthening efforts offered to NGO partners partnership.

Strategic recommendation 3: *Foster a partnership supported by more flexible, longer-term, and predictable financing that integrates resilience approaches while continuing to save lives*

There are important examples where the partnership has successfully leveraged its comparative advantages to save lives. For example, at the Global level with the Mental Health and Psychosocial Support (MHPSS) and Emergency Medical Teams (EMT) programs, and in Yemen, Syria and Afghanistan through joint health advocacy. Both DG ECHO and WHO agree on the value of more efficient, effective and impactful investments in health in humanitarian settings.

Of the two partners – and especially at the operational level - DG ECHO is less clear about what value it thinks WHO adds to humanitarian settings. However, through structured dialogue at all levels – and mutual recognition and appreciation of comparative strengths - DG ECHO can leverage WHO's normative and technical expertise to help bridge gaps in DG ECHO's health policy (such as a framework for epidemic response). At the highest level, DG ECHO does recognise WHO as a multipurpose development organisation with a humanitarian dimension. DG ECHO can build on this to implement its commitments under the Grand Bargain.

On the WHO side, the perception is that DG ECHO's HIPs and Epidemics Toolbox are valued, but limited in scope, timeframe and funding, leading to missed opportunities, especially for progress in protracted crises and towards bridging the nexus. For WHO, the strategic partnership would preferably establish financing mechanisms outside the HIPs by exploring alternative mechanisms that extend beyond multi-country grants. Alternative and innovative financing approaches can secure impactful work on preparedness, and more timely and appropriate responses to future public health emergencies in humanitarian settings.

Committing to alternative financing modalities such as pilot programmatic partnerships (PPPs) can better integrate resilience approaches into investments, so the partnership can have longer-term impact. Increased investment in innovative financing will require leadership buy-in and an appetite for risk, especially at HQ levels. This is a big stretch without a better understanding of WHO's performance and potential: a first step could be for DG ECHO to commission an independent review of WHO as an implementer, something which was beyond the mandate of this evaluation.

In addition, the two organisations could explore tripartite and multilateral collaborations with other EC services such as DG INTPA to address resilience and nexus-bridging activities; or with other technical/implementing agencies to maximize technical exchange and consider joint initiatives.

Recommendations one and two can both feed into this process of leveraging each other's strengths respective strengths.

Supporting measures

- **Adapt regional funding approach** which can better push globally agreed priorities and increase efficiencies. This will require addressing WHO's and DG ECHO's different regional designations
- Explore funding opportunities for unsolicited proposals

- **Adapt less burdensome grant processes** through more simplified approach to multi-country reporting requiring less detail, especially on the financial side
- **Strengthen coordination and joint planning with DG INTPA** to tackle complementary funding for resilience and nexus activities
- **Explore innovative financing mechanisms** in collaboration with WHO to help overall partnership performance
- **Identify champions for mainstreaming resilience** and ways to operationalise through alternative modes of funding
- **Consider engaging WHO in programmatic partnership** to provide multi-year funding for agreed upon priorities in a defined region or selection of countries

Annexe 1 – Evaluation Matrix

Table 12 Evaluation Matrix

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
1. How appropriate were DG ECHO's plans and interventions in response to epidemics?	1.1. Decisions were based on needs assessments and complementary data	1.1.1. Evidence that funding decisions captured needs assessment findings, drew on external analysis/evidence, and aligned with other national and international actors 1.1.2. Inclusion of analysis of national capacities and estimation of gaps between existing response capacity and needs of the population in assessments	DR • Anopheles Epidemic Assessments • Funding decisions/HIPs • Action documents (FicheOps and eSingleForms) • Funding decisions by other donors KIIs • DG ECHO • IPs • National authorities
	1.2. The magnitude and severity of epidemic crises and their likely trajectory were fully considered when making decisions on how DG ECHO should respond	1.2.1. Evidence of analysis of quantitative metrics relating to morbidity, size of affected population, and geographical extent in funding decisions 1.2.2. Presence of epidemiological analysis to estimate future scale of needs with/without preventative actions in needs assessments 1.2.3. Balance of funding between response and prevention (in % or EUR) and perspectives 1.2.4. Evidence that individual health actions involved response AND containment AND prevention measures	DR • Anopheles Epidemic Assessments • INFORM • Funding decisions/HIPs • Action documents (FicheOps and eSingleForms) • Financial data (HOPE) • Categorisation of actions (HOPE) KIIs • DG ECHO • IPs
2. To what extent did DG ECHO's actions seek the participation of affected populations at all stages of the humanitarian project cycle, and seek to address their needs and priorities?	2.1. Needs assessments made efforts to identify the most vulnerable individuals or households within the wider affected populations	2.1.1. Presence of disaggregated data (e.g., by age and gender) in needs assessments, and analysis/discussion of other factors associated/correlated with increased vulnerability	DR • Anopheles Epidemic Assessments • INFORM • Funding decisions/HIPs • Action documents (FicheOps and eSingleForms) KIIs • DG ECHO • IPs • National authorities
	2.2. Response plans demonstrated a 'do no harm' approach and were sensitive to cultural factors	2.2.1 Evidence in plans that affected populations were consulted regarding their preferences on the location/timing/mode of delivery of relevant health services	DR • DG ECHO thematic policy guidelines (stating Do No Harm standards) • SPHERE/Health Cluster guidance on consultation • Action documents (FicheOps and eSingleForms)

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
			KIIs ● DG ECHO ● IPs ● Local civil society FGDs ● Affected communities
	2.3 Project implementation involved - and demonstrated accountability to - the affected populations	2.3.1. Evidence in implementation that affected populations were asked about the key issues that hinder their access to health services, and the extent to which they can provide support to programme implementation	DR ● DG ECHO thematic policy guidelines (stating Do No Harm standards) ● SPHERE/Health Cluster guidance on consultation ● Action documents (FicheOps and eSingleForms) KIIs ● DG ECHO ● IPs ● Local civil society FGDs ● Affected communities
3. How coherent was DG ECHO's response with that of relevant external actors?	3.1. DG ECHO decisions and actions were aligned with national public health policies, priorities and plans for epidemic response	3.1.1. Evidence of communication/consultation/coordination with national public health bodies	DR ● National public health policies/strategies in selected countries ● Funding decisions/HIPs ● Action documents (FicheOps and eSingleForms) KIIs ● DG ECHO ● National authorities Online survey
	3.2. DG ECHO decisions and actions were coherent with those of other international actors and the WHO	3.2.1. Evidence of coherence with WHO's WHE, and the Global Health Security Agenda 3.2.2. Evidence of coherence with the decisions and programmes of other donors	DR ● IHR/GHSA documents ● WHE documents ● UN HRPs ● Health Cluster documents ● Funding decisions/HIPs ● Action documents (FicheOps and eSingleForms) KIIs ● DG ECHO ● Global Health Cluster ● WHO ● Other donors Online survey

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
	3.3. DG ECHO actively participated in multi-agency coordination mechanisms (including in advocacy), at global and national levels	3.3.1. Evidence of DG ECHO participation and proactivity in global coordination mechanisms before and after COVID-19 (e.g., in relation to the WHO Preparedness and Response Plan to COVID-19, the Task Team on COVID-19 set up by the Global Health Cluster, and COVAX) 3.3.2. Evidence of DG ECHO participation and proactivity in national (sector/cluster) health coordination mechanisms	DR • WHE documents • UN HRPs • Health Cluster documents • Funding decisions/HIPs • Action documents (FicheOps and eSingleForms) • Meeting minutes/communiques KIIs • DG ECHO • Global Health Cluster • WHO • Other donors Online survey
	3.4. DG ECHO's interventions enhanced - and added value to - the overall response	3.4.1. Evidence of DG ECHO decisions/advocacy influencing the behaviour of other donors/agencies and global systems	DR • Health Cluster documents • Meeting minutes/communiques KIIs • DG ECHO • Global Health Cluster • WHO • Other donors • Member States Online survey
4. How coherent was DG ECHO's response with that of other EU/EC actions including those of individual Member States and how can DG ECHO's role evolve given the EC's strategic intent to strengthen European and global health security?	4.1. DG ECHO's coordination with other EU/EC services ensured that its interventions were complementary to – and added value to – epidemic preparedness/response work conducted by the EU/EC as a whole, including that of other member states	4.1.1. Evidence of regular consultation and information-sharing between DG ECHO and other EU/EC services 4.1.2. Evidence of DG ECHO drawing on information/analysis conducted by other services 4.1.3. Evidence that DG ECHO instruments and tools complemented – and added value to - those of other EU/EC services, rather than overlapping (e.g., with joint needs assessments and joint programming)	DR • Joint programming documents • Meeting minutes • Analysis by other EC services • Funding decisions/HIPs KIIs • DG ECHO • Other DGs/agencies • Member state officials Online survey

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
	4.2. DG ECHO's mandate, capacities and potential are being considered strategically in light of ongoing developments in the EC's epidemic response capacity (e.g., EHRC, DG HERA)	4.2.1. Evidence of DG ECHO proactively engaging in the establishment of the new mechanisms to seek clarity on mandates, divisions of labour, communication mechanisms and potential for complementarity/added value	DR ● Meeting minutes ● Analysis by other EC services KIIs ● DG ECHO ● Other DGs/agencies Online survey
5. How effective have DG ECHO's tools and instruments been in addressing epidemics?	5.1. The size of DG ECHO's epidemic/pandemic response architecture was appropriate to the scale of the needs	5.1.1. Evidence that DG ECHO's tools/instruments were of an adequate size to respond to global epidemics e.g., COVID-19	DR ● HOPE/OCHA FTS data ● HIPs/funding decisions ● HRPs ● Global Response Plans KIIs ● DG ECHO ● WHO ● IPs ● Global health actors ● Member States Online survey
	5.2. DG ECHO's tools and instruments were well designed, 'fit for purpose' and do not leave unreasonable gaps in response capacity	5.2.1. Evidence that DG ECHO's different tools and interventions were chosen carefully and appropriate to the situation 5.2.2 Evidence that tools and instruments included appropriate criteria and "triggers" for both response and prevention	DR ● ECHO policy guidelines ● Technical Issue Papers ● HIPs/funding decisions ● Position papers ● Meeting minutes KIIs ● DG ECHO ● WHO ● IPs ● Global health actors ● Member States Online survey
6. What results were achieved by DG ECHO's epidemics response?	6.1. DG ECHO-funded actions and advocacy in response to epidemics mitigated the spread and impact of those epidemics	6.1.1. Infection incidence rates in selected countries/contexts (number of cases per x number of people per day/week/month) 6.1.2. Numbers of beneficiaries reached by funded actions with health services/measures which are scientifically proven or can be reasonably assumed to reduce mortality/morbidity and disease transmission	DR ● Action documents (FicheOps and eSingleForms) ● Mission reports ● Results Frameworks/aggregated monitoring data ● Existing action level evaluations ● National or external incidence data ● National policy changes

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
		6.1.3. Evidence that DG ECHO's advocacy influenced the course and severity of epidemics in select countries 6.1.4 Evidence that DG ECHO supported effective RCCE initiatives leading to positive behaviour change	KIIs • DG ECHO • IPs • WHO • National authorities • Local civil society FGDs Affected communities
	6.2. Unintended negative consequences of DG ECHO-funded actions were minimal and effectively mitigated when identified	6.2.1. Evidence that DG ECHO IP staff were aware of unintended consequences of their programmes and able to react effectively	DR • Action documents (FicheOps and eSingleForms) • Mission reports KIIs • DG ECHO • IPs • WHO • Local civil society FGDs Affected communities
7. Have DG ECHO's actions in response to epidemics been cost-effective?	7.1. DG ECHO-funded actions demonstrated cost-effectiveness	7.1.1. Qualitative evidence that partners and actions supported were cost-effective (ref. *Study on Approaches to Assess Cost-Effectiveness of DG ECHO's Humanitarian Aid Actions*, ADE, August 2016) 7.1.2. Evidence that DG ECHO staff considered both strategic and operational cost-effectiveness when analysing proposals for funding	DR • Action documents (FicheOps and eSingleForms) • Monitoring data • Existing cost effectiveness analysis KIIs • DG ECHO • IPs • WHO Online survey
8. To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?	8.1. EU-funded actions in response to epidemics were timely, demonstrating an appropriate balance between speed and quality of design	8.1.1. Evidence that EU-funding / and other forms of assistance arrived in time to respond to needs 8.1.2. Evidence that EU funding / and other forms of assistance arrived in time to prevent the further multiplication of cases and needs	DR • Epidemiological analysis • Timing data (HOPE) • Action documents (FicheOps and eSingleForms) KIIs • DG ECHO • IPs • WHO • Health cluster FGDs Affected communities Online survey

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
	8.2. EU-funded actions in response to epidemics were flexible enough to enable appropriate adaptation at field level	8.2.1. Partners considered that EU grants provide flexibility to respond to emerging situations and changes in context 8.2.2. Reporting requirements for partners were proportionate	DR • Action documents (FicheOps and eSingleForms) KIIs • DG ECHO • IPs • WHO Online survey
9. To what extent has DG ECHO contributed to the resilience of public health systems for outbreak prevention and response in the countries where it works?	9.1. Humanitarian actions included both immediate relief and recovery/resilience activities	9.1.1. Evidence that interventions included a mixture of measures to cater to a variety of acute and longer-term humanitarian needs 9.1.2 Extent to which investments in national early warning systems, infrastructure, skills were expected to be durable and outlast EU-funding periods 9.1.3. Beneficiaries felt that humanitarian actors have addressed both their "crisis" and longer-term recovery needs 9.1.4. Grant durations were appropriate to the length of emergency situations and enabled transitions to service provision in a more stable environment	DR • HOPE data on contracts • Action documents (FicheOps and eSingleForms) KIIs • DG ECHO • IPs • WHO FGDs Affected communities Online survey • National policies • International indices • National/local authorities • DG ECHO staff at HQ and selected field locations • IPs • Development actors • DG INTPA/NEAR/SANTE staff • Beneficiaries •
	9.2. Coordination with EC services and external actors strengthened linkages between emergency and development programming and transition to nationally owned systems or development programmes where possible	9.2.1. Evidence of linked programming and coordinated efforts between EC services 9.2.2. Evidence that DG ECHO's interventions laid the groundwork for transition/handover to longer-term development support	DR • Programming documents, Team Europe strategies, action plans. • ECHO-INTPA meeting minutes and documents • Joint programming/nexus strategy documents • Action documents (FicheOps and eSingleForms) KIIs • DG ECHO • Other EC services • Development actors • IPs • WHO

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
			FGDs Affected communities Online survey
10. Is the DG ECHO-WHO partnership strategic and synergistic, with a shared vision that leverages collaborative advantages at all levels?	10.1. The DG ECHO-WHO partnership has a shared vision that is understood and valued by both partners at HQ, regional and country levels	10.1.1. Evidence of alignment between DG ECHO and WHO policies, strategies and humanitarian health objectives 10.1.2. Extent to which DG ECHO and WHO staff feel "ownership" of the partnership aims, priorities and actions 10.1.3. Extent to which DG ECHO and WHO staff perceived the partnership as strategic and valuable	DR • DG ECHO and WHO needs assessments/analyses • DG ECHO and WHO policies and strategies • MOUs and similar KIIs • DG ECHO • WHO Online survey
	10.2. Both DG ECHO and WHO understand the collaborative advantages of the partnership and how to leverage these for value creation	10.2.1. Evidence of complementarity between the DG ECHO-WHO partnership and other EC-WHO relations	DR • Wider EU-WHO agreements/MOUs KIIs • DG ECHO • Other EC services • WHO Online survey
11. Is the DG ECHO-WHO partnership supported by effective dialogue and fit for purpose structures and mechanism to deliver on its objectives at all levels?	11.1. Dialogue between DG ECHO and WHO is strategic, effective and leads to concrete actions at HQ, regional and country levels	11.1.1. Evidence that constructive and transparent dialogue took place at the appropriate levels and led to concrete actions 11.1.2. Evidence that DG ECHO-WHO communication and coordination at country-level has increased/improved in recent years and resulted in convergent action	DR • Minutes/communiques • Communications outputs KIIs • DG ECHO • WHO • Global Health Cluster Online survey
	11.2 The DG ECHO-WHO partnership has defined governance and accountability structures and joint processes, and	11.2.1 Evidence that the DG ECHO-WHO partnership maximises efficiencies and decreases management costs and administrative burdens	DR • Minutes/communiques • Communications outputs KIIs • DG ECHO • WHO staff

Evaluation question (EQ)	Judgement criteria	Indicators	Potential data sources and data collection methods
	adequate resources to support collaborative, effective and efficient action	11.2.2 Evidence that DG ECHO-WHO partnership aims for cost effective programming and accountability 11.2.3 Evidence that DG ECHO provided timely and flexible support to WHO's response to COVID-19	• Global Health Cluster Online survey
			DR • HIPs/funding decisions • COVID-19 grant correspondence • Action documents KIIs • DG ECHO • WHO Online survey
12. What is the added value of the DG ECHO-WHO partnership in contributing to sustainable and resilient health systems, and more equitable and improved health outcomes in humanitarian settings?	12.1. The DG ECHO-WHO partnership strengthens the humanitarian-development nexus in health emergencies	12.1.1. Evidence that the DG ECHO-WHO partnership enhanced WHO's efforts in health emergencies, including WHO's response to COVID-19 12.1.2. Evidence of positive outcomes which might be reasonably attributed to the DG ECHO-WHO partnership	DR • Financial data – HOPE and WHO • WHO reports • Monitoring data • National data sets • Advocacy materials • Action documents (FicheOps and eSingleForms) • WHO programming documents KIIs • DG ECHO • WHO • National authorities Online survey
	12.2. DG ECHO's partnership with WHO led to more resilient, equitable and durable approaches in the humanitarian health sector	12.2.1 Evidence that the DG ECHO-WHO partnership that connected short-term humanitarian health actions to longer-term, more resilient systems that benefit the most vulnerable 12.2.2 Evidence that the DG ECHO-WHO partnership enhanced advocacy efforts on health in humanitarian settings.	DR • Financial data – HOPE and WHO • WHO reports • Monitoring data • National data sets • Advocacy materials • Action documents (FicheOps and eSingleForms) • Existing studies and evaluations KIIs • DG ECHO • WHO • National authorities Online survey

Annexe 2 – Key Informant Interviews and Focus Group Discussions conducted

In total, 155 key informant interviews (remote and in-person) were conducted over the full course of the evaluation, with 144 individual interviewees. 26 percent of individuals interviewed were from WHO, while 21 percent were from DG ECHO, 21 percent from other Implementing Partners, 16 percent were other international actors (donors, other UN agencies), and 8 percent were from other EU institutions (e.g. DG INTPA, DG SANTE, HERA)

60 percent of interviewees were male, while 40 percent were female.

In *addition* to individual/ group KIIs detailed below, 10 focus group discussions were conducted with affected populations in the countries of Venezuela and DRC. FGDs included 98 individuals, the majority of whom were females (70 percent).

Table 13: Summary of KIIs conducted by stakeholder category

1.	Stakeholder Category	2.	Number of interviews	3.	Number of interviewees
4.	WHO	5.	43	6.	37
7.	DG ECHO	8.	38	9.	31
10.	Other ECHO IP	11.	31	12.	30
13.	Other international actors (donors/UN etc)	14.	23	15.	23
16.	EU institution (other)	17.	12	18.	12
19.	EU Member State	20.	4	21.	7
22.	Third country govt.	23.	3	24.	3
25.	Local civil society	26.	1	27.	1
28.	**Total**	**29.**	**155**	**30.**	**144**

Figure 31 Interviewees by stakeholder category

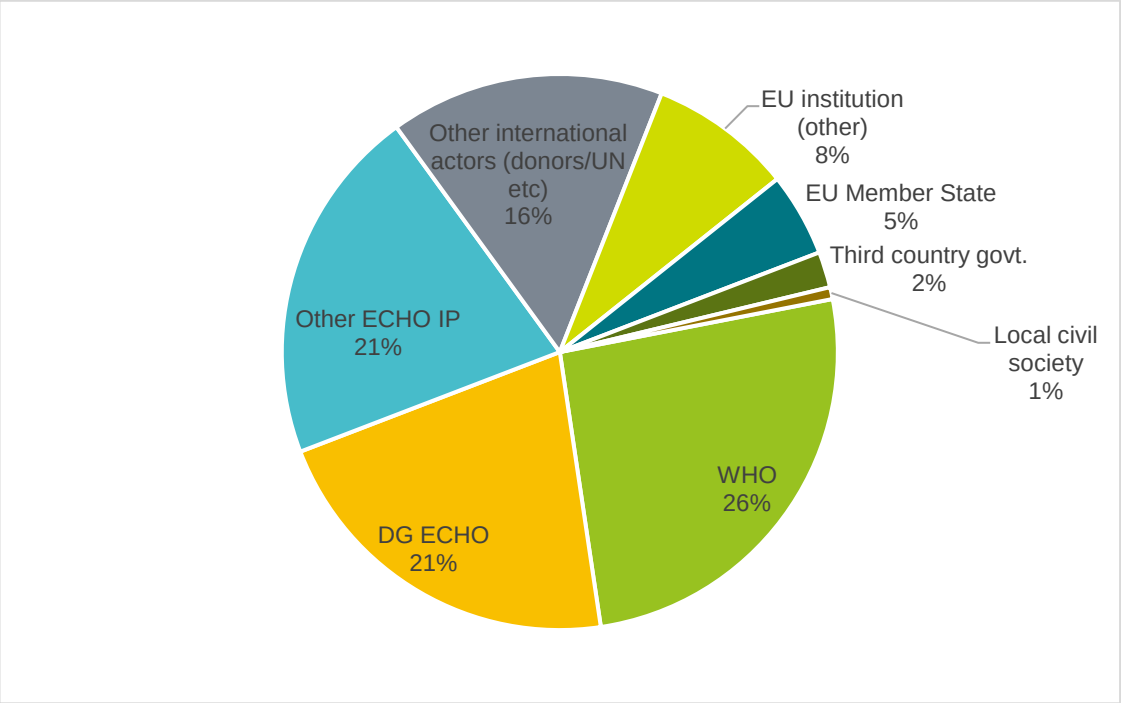


Table 14: Interviewees by sex

31.	Sex	32.	Number of interviewees	33.	% of interviewees
34.	Female	35.	57	36.	40%
37.	Male	38.	87	39.	60%
40.	**Total**	**41.**	**144**	**42.**	

Table 15 KII list by Stakeholder Category and Organisation

Stakeholder Category and Organisation	Number of interviews	Number of interviewees
WHO	**43**	**37**
Health Cluster	1	1
OMS	1	1
PAHO	6	5
WHE	9	9
WHO	25	20
WHO EMRO	1	1
DG ECHO	**38**	**31**
DG ECHO	38	31
Other ECHO IP	**31**	**30**
Acción Solidaria	1	1
ACH	3	3
Action Against Hunger Syria	1	1

ALIMA (Alliance for International Medical Action)	1	1
Caritas	1	1
Caritas LU	3	2
Forum des ONGI	1	1
IFRC	1	1
Intersos	2	2
IRC	4	4
Maltesser	1	1
MDMF	1	1
Medair	2	2
Premiere Urgence	1	1
PU-AMI	1	1
Red cross	1	1
Relief International	1	1
SEMA	2	2
STC	1	1
Syrian American Medical Society	2	2
Other international actors (donors/UN etc)	**23**	**23**
ACBAR	1	1
British Embassy	1	1
FCDO	1	1
IFRC	1	1
ITM	1	1
Médecins Sans Frontières (MSF)	1	1
OCHA	4	4
PNUD	1	1
Swiss Cooperation	1	1
UNICEF	6	6
US CDC	1	1
USAID	1	1
WFP	2	2
World Bank	1	1
EU institution (other)	**12**	**12**
DG DEVCO	1	1
DG INTPA	2	2
DG RTD	1	1
DG SANTE	2	2
ECDC	1	1
European Union Delegation (EUD)	2	2
EUD/INTPA	1	1
HERA	2	2
EU Member State	**4**	**7**
Belgium	1	1
French Embassy	2	2
SIDA	1	4
Third country govt.	**3**	**3**
INRB	1	1

MoH	2	2
Local civil society	**1**	**1**
Forum des ONGI	1	1
Grand Total	**155**	**144**

Annexe 3 – List of KIIs

Table 16 List of KIIs

Tab	Stakeholder category	Organisation
Syria	Other ECHO IP	Syrian American Medical Society
Part B	WHO	WHE
DRC	Other international actors (donors/UN etc)	OCHA
South Sudan	Other ECHO IP	ALIMA
Afghanistan	Other ECHO IP	IFRC
Syria	Other ECHO IP	Relief International
Afghanistan	DG ECHO	DG ECHO
South Sudan	EU institution (other)	DG INTPA
Part B	WHO	WHE
HQ A	EU institution (other)	HERA
South Sudan	WHO	WHO
Afghanistan	Other ECHO IP	Intersos
Part B	WHO	WHO
South Sudan	Other international actors (donors/UN etc)	USAID
Venezuela	WHO	PAHO
Part B	WHO	WHE
DRC	DG ECHO	DG ECHO
HQ A	DG ECHO	DG ECHO
Syria	Other ECHO IP	ACH
Part B	WHO	WHO

Syria	WHO	Health Cluster
Syria	Other international actors (donors/UN etc)	WFP
Part B	WHO	WHE
Venezuela	WHO	PAHO
DRC	Local civil society	Forum des ONGI
Venezuela	WHO	WHO
Venezuela	Other international actors (donors/UN etc)	OCHA
Syria	Other ECHO IP	ACH
Afghanistan	WHO	WHO
Venezuela	Other ECHO IP	Caritas LU
Syria	WHO	WHO
South Sudan	Other ECHO IP	Medair
Part B	WHO	WHO
Venezuela	Other ECHO IP	Acción Solidaria
Afghanistan	DG ECHO	DG ECHO
Region A	DG ECHO	DG ECHO
Part B	WHO	WHO
Venezuela	Other ECHO IP	Caritas LU
Venezuela	WHO	PAHO
DRC	Other international actors (donors/UN etc)	UNICEF
DRC	WHO	WHO
Part B	WHO	WHO
Syria	Other ECHO IP	Syrian American Medical Society
Venezuela	DG ECHO	DG ECHO
Part B	WHO	WHO

Venezuela	Other international actors (donors/UN etc)	WFP
Afghanistan	Other international actors (donors/UN etc)	OCHA
HQ A	EU institution (other)	DEVCO
Venezuela	Other ECHO IP	Caritas
Venezuela	Other international actors (donors/UN etc)	UNICEF
Region A	DG ECHO	DG ECHO
DRC	EU Member State	French Embassy
DRC	EU institution (other)	EUD
Venezuela	DG ECHO	DG ECHO
DRC	DG ECHO	DG ECHO
DRC	Other ECHO IP	Maltesser
South Sudan	Third country govt.	MoH
Part B	WHO	WHE
South Sudan	WHO	WHO
Venezuela	WHO	PAHO
Afghanistan	Other ECHO IP	PU-AMI
Venezuela	Other ECHO IP	Red cross
South Sudan	Other international actors (donors/UN etc)	OCHA
South Sudan	DG ECHO	DG ECHO
Part B	WHO	WHO
Part B	WHO	WHE
DRC	Other international actors (donors/UN etc)	World Bank
Afghanistan	Other international actors (donors/UN etc)	ACBAR
DRC	EU institution (other)	HERA

Syria	DG ECHO	DG ECHO
Venezuela	DG ECHO	DG ECHO
Venezuela	Other ECHO IP	ACH
Part B	WHO	WHO
Part B	WHO	WHO
DRC	Other international actors (donors/UN etc)	PNUD
Venezuela	WHO	PAHO
Syria	DG ECHO	DG ECHO
Venezuela	Other international actors (donors/UN etc)	IFRC
Afghanistan	WHO	WHO
Afghanistan	Other ECHO IP	Intersos
Venezuela	Other ECHO IP	IRC
Venezuela	Other international actors (donors/UN etc)	UNICEF
DRC	EU institution (other)	EUD/INTPA
Part B	WHO	WHE
Part B	WHO	WHO EMRO
Syria	Other ECHO IP	SEMA
Syria	Other ECHO IP	SEMA
Syria	WHO	WHO
South Sudan	WHO	WHO
Venezuela	Other ECHO IP	Forum des ONGI
DRC	Other ECHO IP	MEDAIR
Venezuela / Region A	DG ECHO	DG ECHO
Part B	WHO	WHE
Syria	DG ECHO	DG ECHO
DRC	EU Member State	French Embassy

DRC	Other ECHO IP	STC
DRC	WHO	OMS
Venezuela	Other international actors (donors/UN etc)	Swiss Cooperation
Afghanistan / Part B	WHO	WHO
DRC	Other international actors (donors/UN etc)	British Embassy
DRC	Other international actors (donors/UN etc)	UNICEF
South Sudan	Other international actors (donors/UN etc)	FCDO
Part B	WHO	WHE
Syria	Other ECHO IP	IRC
DRC	Other international actors (donors/UN etc)	UNICEF
South Sudan	EU institution (other)	EU
DRC	EU Member State	Belgium
DRC	Other international actors (donors/UN etc)	MSF
DRC	Third country govt.	INRB
South Sudan	Other international actors (donors/UN etc)	US CDC
Part B	DG ECHO	DG ECHO
DRC	Third country govt.	MOH
Syria	Other ECHO IP	Action Against Hunger Syria
Part B	WHO	WHO
Venezuela	Other ECHO IP	Premiere Urgence
Venezuela	Other international actors (donors/UN etc)	UNICEF
Afghanistan	Other ECHO IP	IRC

Venezuela	Other ECHO IP	IRC
DRC	Other international actors (donors/UN etc)	ITM
Venezuela	Other ECHO IP	MDMF
South Sudan	EU Member State	SIDA (4x interviewees in one interview)
HQ Part A/B	DG ECHO	DG ECHO
HQ Part A/B	DG ECHO	DG ECHO
HQ Part A/B	DG ECHO	DG ECHO
HQ Part A/B	DG ECHO	DG ECHO
HQ A	EU institution (other)	DG SANTE
HQ A	DG ECHO	DG ECHO
HQ A	DG ECHO	DG ECHO
HQ A	EU institution (other)	ECDC
HQ A	EU institution (other)	DG RTD
HQ A	DG ECHO	DG ECHO
HQ A	DG ECHO	DG ECHO
HQ A	EU institution (other)	DG INTPA
Region A	DG ECHO	DG ECHO
Region A	DG ECHO	DG ECHO
Region A	DG ECHO	DG ECHO
Region A	DG ECHO	DG ECHO
Region A	DG ECHO	DG ECHO
Region A	DG ECHO	DG ECHO
Part B	DG ECHO	DG ECHO
Part B	EU institution (other)	DG SANTE

Annexe 4 – Sampling Frameworks of DG ECHO Actions

Overall portfolio of actions: All actions within the scope of the evaluation. Includes all actions tagged to subsector 'Epidemics' in HOPE database, submitted between 2017 and 2021. Plus, additional relevant actions brought to our attention by DG ECHO. Included 201 actions. See Table 17 for details. This is the sample used for quantitative portfolio analysis undertaken and presented in the synthesis report.

Sampling frame 1 (Selected countries): As above but including only the relevant Part A actions within 5 selected countries of Syria, DRC, Venezuela, Afghanistan and South Sudan between 2017 and 2021. Included 39 actions. See Table 18 for details.

Sampling frame 2 (Actions selected for detailed review within selected countries) : Within sampling frame 1, a smaller number of actions were selected for a detailed review during the evaluation – including document review of the Action documents (FichOps and single forms) during the desk phase. These included 23 actions, as listed in Table 19**.**

Table 17 Actions within scope of evaluation (n=201)

Agreement No.	Partner	Reference number	Country	Action title	Amount	EC Amount	Status
ECHO/SYR/BUD/2022/91011	WHO	2021/01243	SYRIAN ARAB REPUBLIC	Sustaining provision of life saving health services within humanitarian response in Syria through the provision of integrated primary and specialized secondary health services to the most vulnerable groups	€ 7,553,520.16	€ 6,000,000.00	ONGOING
ECHO/-HF/BUD/2021/91055	FEDERATION HANDICAP-FR	2021/01196	ETHIOPIA	Integrated emergency life-saving response for conflict affected IDPs and host communities	€ 3,150,000.00	€ 3,000,000.00	ONGOING
ECHO/-XA/BUD/2021/91044	WHO	2021/01134	Nepal	Health Emergency Preparedness of Prehospital, Hospital and Post-hospital	€ 1,251,963.60	€ 1,000,000.00	ONGOING

				in response to COVID-19 Pandemic in Nepal.			
ECHO/DRF/BUD/2021/91039	MDM-BE	2021/01124	Tunisia	Appui à la réponse de la Tunisie face à la crise sanitaire (SEHAT ETTWENSA, santé des Tunisiens)	€ 700,000.00	€ 700,000.00	ONGOING
ECHO/-XA/BUD/2021/91043	WHO	2021/01123	Sri Lanka	Emergency response to COVID-19 pandemic in Sri Lanka	€ 1,588,972.71	€ 1,400,000.00	ONGOING
ECHO/-XA/BUD/2021/91045	IOM-CH	2021/01121	Nepal	Effective case management by strengthening Isolation centers and Ground Crossing Points (GCPs) management for Rapid Response and Preparedness against COVID-19	€ 1,500,000.00	€ 1,500,000.00	ONGOING
ECHO/-XA/BUD/2021/91042	WV-DE	2021/01120	Sri Lanka	COVID-19 prevention, case management and vaccination Response for Communities in Central, North Eastern, North Western and Western provinces in Sri Lanka	€ 642,000.00	€ 600,000.00	ONGOING
ECHO/DRF/BUD/2021/91035	FICR-CH	2021/01118	Indonesia	COVID-19 Response in Indonesia	€ 605,012.44	€ 500,000.00	ONGOING
ECHO/-AM/BUD/2021/91073	PAHO	2021/01113	BOLIVIA	Strengthening COVID-19 response capacities in health facilities and vulnerable indigenous communities in Santa Cruz Department, Bolivia	€ 786,991.42	€ 700,000.00	ONGOING
ECHO/DRF/BUD/2021/91034	IRC-DE	2021/01090	MYANMAR	COVID-19 Clinical Care through Home-Based Interventions and Community Care Corner	€ 750,000.00	€ 750,000.00	ONGOING
ECHO/DRF/BUD/2021/91033	UNICEF-US	2021/01089	Myanmar	Improved access to COVID-19 care and response	€ 1,418,867.85	€ 500,000.00	ONGOING

ECHO/DRF/BUD/2021/91031	CROIX-ROUGE-DK	2021/01088	Myanmar	Emergency response to COVID-19 outbreak and conflict affected communities in Myanmar	€ 1,210,438.00	€ 1,150,438.00	ONGOING
ECHO/-AS/BUD/2021/91025	FICR-CH	2021/01056	AFGHANISTAN	Access to essential health care and WASH in hard-to-reach areas of Afghanistan	€ 2,383,290.00	€ 1,500,000.00	ONGOING
ECHO/-AS/BUD/2021/91023	WHO	2021/01053	AFGHANISTAN	Providing trauma care, emergency primary healthcare and emergency nutrition services for populations in underserved and conflict affected areas of Afghanistan	€ 16,810,726.00	€ 14,000,000.00	ONGOING
ECHO/DRF/BUD/2021/91020	WHO	2021/01047	Nepal	Emergency COVID-19 case management and containment support in Nepal	€ 753,445.09	€ 500,000.00	ONGOING
ECHO/DRF/BUD/2021/91013	UNICEF-US	2021/01041	Nepal	UNICEF Nepal Health Response to the current COVID-19 crisis	€ 2,820,787.50	€ 1,500,000.00	ONGOING
ECHO/DRF/BUD/2021/91010	WHO	2021/01035	India	Emergency response to COVID-19 pandemic in India	€ 2,496,080.00	€ 2,200,000.00	ONGOING
ECHO/DRF/BUD/2021/91040	WHO	2021/01003	BURUNDI, CAMEROON, CENTRAL AFRICAN REPUBLIC, CHAD, CONGO DEMOCRATIC REPUBLIC OF, GUINEA, LIBERIA, MADAGASCAR,	Support to the rollout of COVID-19 national vaccination campaigns in Africa and reinforcement of national health systems? resilience to epidemics	€ 17,539,902.41	€ 16,000,000.00	ONGOING

			MALI, MOZAMBIQUE, NIGER, NIGERIA, SOMALIA, SOUTH SUDAN REPUBLIC, SUDAN				
ECHO/DRF/BUD/2021/91027	IOM-CH	2021/00998	NIGER	Supporting Niger National Vaccination Campaign through capacity-building, logistical and sensitization support in the Agadez region	€ 1,053,883.66	€ 1,000,000.00	ONGOING
ECHO/DRF/BUD/2021/91026	PUI-FR	2021/00995	Libya	Improving safe access to an effective and efficient COVID-19 vaccination campaign for vulnerable people living in Al Kufra, Libya.	€ 1,100,000.00	€ 1,000,000.00	ONGOING
ECHO/DRF/BUD/2021/91008	CICR-CH	2021/00988	Papua New Guinea	ICRC activities geared towards helping prevent the spread of the COVID-19 virus in Papua New Guinea (PNG), notably: health in detention; primary-health-care (PHC); and protection of detainees.	€ 1,436,558.26	€ 1,000,000.00	ONGOING
ECHO/DRF/BUD/2021/91003	ALIMA-FR	2021/00903	GUINEA	Réponse à l?épidémie de Maladie à Virus Ebola en Guinée	€ 1,000,000.00	€ 1,000,000.00	ONGOING
ECHO/-AF/BUD/2021/91038	UNHCR-CH	2021/00893	UGANDA	Comprehensive Response: Providing Protection and Assistance to Refugees and Asylum-Seekers in Uganda	€ 28,950,872.67	€ 7,800,000.00	ONGOING
ECHO/-AF/BUD/2021/91018	IRC-DE	2021/00886	UGANDA	Epidemic preparedness and response and life-saving health services to newly	€ 3,300,000.00	€ 3,000,000.00	ONGOING

				arrived refugees and vulnerable host community members in Uganda			
ECHO/IRQ/BUD/2021/91010	WHO	2021/00870	IRAQ	Strengthen essential primary, referral, and preventive health care services in conflict-affected governorates of Iraq as well as support the emergency health interventions to respond to COVID-19 epidemic in Iraq	€ 14,552,480.00	€ 2,500,000.00	ONGOING
ECHO/DRF/BUD/2020/91032	PAHO	2021/00848	BRAZIL, COLOMBIA, PERU	Response to COVID-19 outbreaks in the North Amazon Basin	€ 941,600.00	€ 900,000.00	ONGOING
ECHO/-AS/BUD/2021/91004	CICR-CH	2021/00840	AFGHANISTAN	ICRC health activities for detainees, hospital services/secondary care, physical rehabilitation services, and prevention (IHL dissemination and implementation) and protection activities in Afghanistan.	€ 10,955,779.60	€ 8,000,000.00	ONGOING
ECHO/-NF/BUD/2021/91017	UNICEF	2021/00787	Egypt	Supporting access to COVID vaccination, basic education and child protection services for refugee and migrant children, their families, and other vulnerable populations in Egypt.	€ 2,532,157.15	€ 2,200,000.00	ONGOING
ECHO/-AF/BUD/2021/91019	NRC-NO	2021/00771	SOUTH SUDAN REPUBLIC	Integrated Emergency Preparedness and Response to address critical humanitarian needs in South Sudan	€ 5,555,555.56	€ 5,000,000.00	ONGOING
ECHO/COD/BUD/2021/91020	MEDAIR-DE	2021/00706	CONGO DEMOCRATIC REPUBLIC OF	Emergency multi-sectoral response in favour of vulnerable populations affected by conflict and outbreaks in Eastern Democratic Republic of the Congo	€ 6,591,666.67	€ 5,700,000.00	ONGOING

ECHO/COD/BUD/2021/91008	MDM-FR	2021/00705	CONGO DEMOCRATIC REPUBLIC OF	Réponse d'urgence aux besoins de santé des populations affectées par les conflits dans la zone de santé (ZS) de Nyemba, province du Tanganyika	€ 2,893,000.00	€ 2,593,000.00	ONGOING
ECHO/COD/BUD/2021/91011	UNICEF-US	2021/00695	CONGO DEMOCRATIC REPUBLIC OF	Reduce the incidence and transmission of cholera through an integrated and evidence-based community approach in North Kivu, South Kivu and Tanganyika in the DRC	€ 8,222,998.31	€ 3,500,000.00	ONGOING
ECHO/COD/BUD/2021/91025	WHO	2021/00683	CONGO DEMOCRATIC REPUBLIC OF	Amelioration de l? offre des services et soins de santé de base aux populations affectées par la crise humanitaire et les épidémies dans les 4 provinces du Nord Kivu, Sud Kivu, Ituri et Tanganyika.	€ 1,948,507.90	€ 1,550,000.00	ONGOING
ECHO/-XA/BUD/2021/91008	WHO	2021/00682	Bangladesh	Ensuring a coordinated delivery of essential health services amidst disease outbreaks and in emergency and response preparedness in low resource settings in Cox?s Bazar, Bangladesh	€ 2,470,449.60	€ 2,100,000.00	ONGOING
ECHO/-AM/BUD/2021/91068	PAHO	2021/00670	VENEZUELA	Improving access to safe and quality essential health services to Venezuelans in situation of vulnerability	€ 2,740,000.00	€ 2,500,000.00	ONGOING
ECHO/-AM/BUD/2021/91067	MDM-ES	2021/00616	VENEZUELA	Contribute to the provision of integrated health, MHPSS and WASH services of the most vulnerable populations, including prevention of the spread of COVID-19, in Sucre State of Venezuela.	€ 2,200,000.00	€ 2,200,000.00	ONGOING
ECHO/-XA/BUD/2021/91001	ACF-ES	2021/00563	PHILIPPINES	REACH: Response to the Unmet Humanitarian Needs of the Most Vulnerable Populations In Mindanao	€ 4,550,000.00	€ 4,400,000.00	ONGOING

				and the Visayas Affected by Conflict, Disasters and the COVID-19 pandemic			
ECHO/-AM/BUD/2021/91012	PUI-FR	2021/00512	VENEZUELA, COLOMBIA	Addressing the most urgent needs of populations affected by the Venezuelan crisis through a multi-sectoral integrated assistance, including COVID-19 programming	€ 2,800,000.00	€ 2,700,000.00	ONGOING
ECHO/-HF/BUD/2021/91011	IRC-DE	2021/00480	ETHIOPIA	Multi-Sectoral Humanitarian Response for Conflict Affected and Internally Displaced People in SNNPR	€ 2,310,000.00	€ 2,200,000.00	ONGOING
ECHO/-HF/BUD/2021/91040	IRC-DE	2021/00432	KENYA	Improved health and nutritional status for refugees and surrounding host communities in Kenya	€ 3,495,994.96	€ 3,131,200.00	ONGOING
ECHO/-HF/BUD/2021/91041	WHO	2021/00428	ETHIOPIA	Strengthening humanitarian support to crisis-affected populations in Ethiopia	€ 9,398,133.01	€ 6,445,000.00	ONGOING
ECHO/SYR/BUD/2021/91062	WHO	2021/00403	SYRIAN ARAB REPUBLIC	Continuing the health humanitarian response in Syria through the provision of comprehensive package of health care services to the most vulnerable groups	€ 2,883,940.37	€ 2,500,000.00	ONGOING
ECHO/-AF/BUD/2021/92071	ALIMA-FR	2021/00399	CAMEROON	Assistance médico-nutritionnelle aux populations vulnérables affectées par les crises dans les régions anglophones, DS de Batibo, Bali et de Santa et dans les DS de Makary, Mada et Kousseri, impactés par la crise du bassin du Lac Tchad	€ 2,300,000.00	€ 1,950,000.00	ONGOING
ECHO/-AM/BUD/2021/91047	UNICEF-US	2021/00394	BRAZIL, COLOMBIA, ECUADOR,	Comprehensive humanitarian response for the Protection, Education and Health of Venezuelan refugee and migrant	€ 4,408,654.86	€ 3,700,000.00	ONGOING

			PERU, TRINIDAD AND TOBAGO, DOMINICAN REPUBLIC	children in Brazil, Colombia, Dominican Republic, Ecuador, Peru and Trinidad & Tobago			
ECHO/-AF/BUD/2021/92085	ALIMA-FR	2021/00358	MAURITANIA	Améliorer l?accès des populations vulnérables dans la Wilaya du Brakna, en Mauritanie à des soins médico-nutritionnels de qualité.	€ 1,684,211.00	€ 1,600,000.00	ONGOING
ECHO/YEM/BUD/2021/91011	SI-FR	2021/00357	YEMEN	Integrated Emergency Multisector Assistance to Populations Affected by Conflict or Sudden Shock in RoYG Controlled Territories	€ 3,500,000.00	€ 3,350,000.00	ONGOING
ECHO/-AF/BUD/2021/92030	IRC-DE	2021/00243	NIGERIA	Improving access to lifesaving integrated services for vulnerable host communities, IDPs and returnees in Borno State	€ 1,391,000.00	€ 1,300,000.00	ONGOING
ECHO/-AF/BUD/2021/91002	WHO	2021/00214	SOUTH SUDAN REPUBLIC	Strengthening Public Health Surveillance and Response systems in South Sudan	€ 1,263,648.00	€ 1,000,000.00	ONGOING
ECHO/-AF/BUD/2021/92122	STC-DK	2021/00174	MALI	Appui au renforcement de l?accès aux soins médico-nutritionnels de qualité pour les populations vulnérables des districts sanitaires de Mopti et Niafunké	€ 1,777,777.78	€ 1,600,000.00	ONGOING
ECHO/YEM/BUD/2021/91006	MDM-FR	2021/00149	YEMEN	Emergency Medical Assistance for host and displaced population affected by current crisis in Yemen	€ 1,315,789.48	€ 1,250,000.00	ONGOING
ECHO/SYR/BUD/2021/91040	ACF-ES	2021/00139	SYRIAN ARAB REPUBLIC	Life-saving support and increased COVID emergency response for the most vulnerable people in northern Syria	€ 1,980,000.00	€ 1,800,000.00	ONGOING

ECHO/-NF/BUD/2021/91007	UNICEF	2021/00104	Algeria	Improving safe and inclusive access to quality learning and healthcare through COVID-19 vaccination related activities in the five Sahrawi refugee camps	€ 2,408,146.55	€ 1,677,000.00	ONGOING
ECHO/-AF/BUD/2021/92028	ALIMA-FR	2021/00066	CENTRAL AFRICAN REPUBLIC	Projet d?assistance médicale et nutritionnelle d?urgence des populations hôtes et déplacées affectées par la crise dans la Nana-Gribizi et la pandémie Covid-19 à Bimbo en RCA	€ 1,930,000.00	€ 1,930,000.00	ONGOING
ECHO/-AF/BUD/2021/92017	ALIMA-FR	2021/00055	MALI	Assistance médico-nutritionnelle aux populations affectées par la crise dans la région de Tombouctou, Nord Mali	€ 1,745,000.00	€ 1,600,000.00	ONGOING
ECHO/-AM/BUD/2020/91049	CROIX-ROUGE-ES	2021/00003	GUATEMALA	Mitigating the Impact of Hurricanes Eta and Iota on the Health of the Most Vulnerable Families in Alta Verapaz and Izabal, Guatemala	€ 700,000.00	€ 700,000.00	ONGOING
ECHO/-AF/BUD/2020/91027	GOAL-IR	2020/00993	SUDAN	Multi-sector lifesaving response for the conflict-affected population of Kutum and Al Waha localities in North Darfur, and Talodi and Habila localities in South Kordofan	€ 4,757,514.00	€ 4,000,000.00	ONGOING
ECHO/HTI/EDF/2020/01002	PAHO	2020/00970	HAITI	Response to the COVID-19 Pandemic in Haiti	€ 4,469,080.00	€ 4,000,000.00	ONGOING
ECHO/MWI/EDF/2020/01001	STC-IT	2020/00968	MALAWI	Support to 7 high risk districts and communities in Malawi to prevent, rapidly detect and effectively respond to COVID-19	€ 1,792,456.00	€ 1,700,000.00	ONGOING

ECHO/MWI/EDF/2020/01003	UNHCR-CH	2020/00967	MALAWI	Timely, consistent and coordinated preparedness and response in the event of COVID-19 outbreak in refugee population and their hosts, Malawi	€ 642,274.00	€ 300,000.00	CLOSED
ECHO/MWI/EDF/2020/01002	COOPI-IT	2020/00966	MALAWI	Support to at risk districts and communities in Malawi to prevent, rapidly detect and effectively respond to COVID-19	€ 1,793,356.00	€ 1,700,000.00	ONGOING
ECHO/HTI/EDF/2020/01004	MDM-ES	2020/00965	HAITI	Appui au système de santé haïtien dans sa réponse à la pandémie de COVID-19	€ 905,726.00	€ 800,000.00	ONGOING
ECHO/HTI/EDF/2020/01005	IOM-CH	2020/00963	HAITI	Supporting the most vulnerable people affected by Covid-19 in Haiti through immediate, integrated humanitarian assistance	€ 3,793,523.00	€ 3,000,000.00	ONGOING
ECHO/SYR/BUD/2020/91034	WHO	2020/00956	SYRIAN ARAB REPUBLIC	Strengthening COVID-19 preparedness and response in northwest Syria	€ 1,251,963.00	€ 1,000,000.00	ONGOING
ECHO/-AM/BUD/2020/91043	CARITAS-LU	2020/00947	COLOMBIA, VENEZUELA, BRAZIL	PCPR: Promoting COVID-19 Prevention and Resilience among vulnerable refugees and migrants, indigenous people and host communities in Brazil, Colombia and Venezuela lacking effective public health policies and responses.	€ 1,050,000.00	€ 850,000.00	ONGOING
ECHO/SYR/BUD/2020/91033	STC-DK	2020/00930	Lebanon	Community Led Household-level Shielding Approach – Protecting the Most Vulnerable from COVID-19 Infection	€ 300,000.00	€ 250,000.00	CLOSED

ECHO/PSE/BUD/2020/91007	CROIX-ROUGE-DK	2020/00926	Palestinian Territory, Occupied	Response and Preparedness to the COVID-19 Crisis and Escalations of Violence in Palestine	€ 1,875,000.00	€ 1,700,000.00	ONGOING
ECHO/COD/BUD/2020/91020	STC-NO	2020/00921	CONGO DEMOCRATIC REPUBLIC OF	Contain and Control the Spread of Covid-19 in the Tshangu District of Kinshasa Province, DRC	€ 1,370,108.00	€ 1,300,000.00	ONGOING
ECHO/-SF/EDF/2020/01015	CROIX-ROUGE-FR	2020/00905	COMOROS	Réponse sanitaire d'urgence, surveillance épidémiologique et consolidation des acquis en contexte de crise Covid-19, suivant une approche « LRRD ».	€ 526,315.00	€ 500,000.00	ONGOING
ECHO/COD/BUD/2020/91021	FICR-CH	2020/00903	CONGO DEMOCRATIC REPUBLIC OF	Réponse à la pandémie de la COVID-19 en RDC, province de Kinshasa	€ 1,571,393.00	€ 1,200,000.00	ONGOING
ECHO/-SF/EDF/2020/01011	CROIX-ROUGE-DK	2020/00902	MALAWI	Prevent, control and contain the COVID-19 epidemic in Malawi	€ 1,333,333.00	€ 1,200,000.00	ONGOING
ECHO/-SF/EDF/2020/01010	WHO	2020/00888	MAURITIUS, SEYCHELLES	Strengthening the National Action Preparedness and Response plan, related to access to testing services , infection prevention control measures in public health facilities serving underserved populations; and reinforcing risk communication and community engagement among hard to reach populations	€ 338,798.87	€ 250,000.00	ONGOING
ECHO/-SF/EDF/2020/01009	WHO	2020/00887	BOTSWANA	Strengthening epidemic preparedness and response to Covid-19 to reduce excess morbidity and mortality due to Covid-19 and other epidemic prone	€ 1,255,236.73	€ 1,000,000.00	ONGOING

				disease in the high-risk population in Botswana.			
ECHO/-WF/BUD/2020/91043	GOAL-IR	2020/00844	NIGER	Reducing the Spread of COVID-19 in Niger through Community Led Action and Strengthening Health System Response Capacity	€ 493,033.00	€ 400,000.00	CLOSED
ECHO/-AF/BUD/2020/91009	IRC-DE	2020/00759	UGANDA	Epidemic preparedness and response and life-saving health services to newly arrived refugees and vulnerable host community members in Uganda	€ 4,516,125.00	€ 4,150,000.00	CLOSED
ECHO/-AS/BUD/2020/91009	IRC-DE	2020/00739	Pakistan	Containing the spread of COVID-19 and strengthening existing capacities of health system in Pakistan.	€ 8,135,227.00	€ 8,000,000.00	ONGOING
ECHO/-AS/BUD/2020/91017	CONCERN WORLDWIDE-IR	2020/00738	Pakistan	Health Systems Strengthening and Response to COVID-19 in Vulnerable Districts of Sindh	€ 1,650,000.00	€ 1,650,000.00	ONGOING
ECHO/DRF/BUD/2020/91003	WHO	2020/00727	CAMEROON, CONGO DEMOCRATIC REPUBLIC OF, ETHIOPIA, BURKINA FASO, SOMALIA, KENYA, PHILIPPINES, AFGHANISTAN, NIGERIA, BANGLADESH	Support to WHO?s COVID-19 Preparedness and Response Plan in high risk and vulnerable countries in Africa and Asia	€ 37,500,000.00	€ 30,000,000.00	ONGOING

ECHO/DRF/BUD/2019/91034	PAHO	2020/00653	VENEZUELA	Response to the Yellow Fever Outbreak in Venezuela	€ 670,890.00	€ 600,000.00	ONGOING
ECHO/-AM/BUD/2020/91029	AYUDA EN ACCION-ES	2020/00597	VENEZUELA, COLOMBIA, ECUADOR, PERU	Addressing relief and protection needs of vulnerable populations affected by the Venezuelan crisis and impacted/at risk of COVID-19 pandemic in a gender-responsive and disability inclusive way in urban and peri-urban areas in VENEZUELA and in transit and border areas of COLOMBIA, ECUADOR and PERU	€ 2,842,373.89	€ 2,500,000.00	ONGOING
ECHO/-AF/BUD/2020/91011	UNHCR-CH	2020/00584	UGANDA	Protection and Humanitarian Assistance to Refugees and Host Communities in Support of the Comprehensive Refugee Response in Uganda.	€ 43,453,333.00	€ 10,500,000.00	CLOSED
ECHO/-AM/BUD/2020/91035	MDM-ES	2020/00570	VENEZUELA	Contribute to improve health and protection of the most vulnerable populations, including prevention of the spread of COVID-19, in various States of Venezuela.	€ 2,300,000.00	€ 2,300,000.00	ONGOING
ECHO/-AS/BUD/2020/91007	RI-FR	2020/00549	IRAN	Enhancing Access to Education and Health Care Services for Vulnerable Afghans in Iran - and Responding to the COVID-19 outbreak	€ 7,500,000.00	€ 7,500,000.00	ONGOING
ECHO/-AF/BUD/2020/91003	MEDAIR-DE	2020/00524	SOUTH SUDAN REPUBLIC	Emergency Response in South Sudan	€ 4,322,885.00	€ 1,500,000.00	CLOSED
ECHO/-AS/BUD/2020/91003	INTERSOS-IT	2020/00481	AFGHANISTAN	Provision of essential and quality services through an integrated protection, health and nutrition response	€ 1,242,380.86	€ 1,200,000.00	ONGOING

				for vulnerable conflict-affected population in Southern Afghanistan.			
ECHO/-AS/BUD/2020/91005	IRC-DE	2020/00466	AFGHANISTAN	Integrated Emergency Protection and Health response in Kabul, Helmand, Badghis, Herat, Laghman, Khost, Nangarhar and Paktya provinces of Afghanistan	€ 2,578,127.00	€ 2,400,000.00	CLOSED
ECHO/COD/BUD/2020/91001	UNICEF-US	2020/00394	CONGO DEMOCRATIC REPUBLIC OF	Targeted rapid interventions to cholera cases through community outbreak response teams	€ 3,487,808.63	€ 500,000.00	CLOSED
ECHO/-XA/BUD/2020/91019	WHO	2020/00393	Bangladesh	Reduce the avoidable morbidity and mortality through public health action in the world's largest refugee camps	€ 600,000.00	€ 500,000.00	CLOSED
ECHO/-HF/BUD/2020/91011	UNICEF-US	2020/00375	ETHIOPIA	Emergency Health and Nutrition Response to Crisis Affected Areas of Ethiopia	€ 16,294,720.24	€ 6,327,096.69	CLOSED
ECHO/-AF/BUD/2020/91017	ALIMA-FR	2020/00309	SOUTH SUDAN REPUBLIC	Integrated multi-sectoral (Nutrition, Health and Protection) intervention for the most vulnerable population of Raja County, Western Bahr el Ghazal State, South Sudan	€ 1,465,000.00	€ 1,250,000.00	CLOSED
ECHO/-WF/BUD/2020/91032	STC-ES	2020/00201	NIGER	Programme multisectoriel visant la réduction de la mortalité et de la morbidité des populations vulnérables liées à l?insécurité nutritionnelle dans les régions de Maradi et Zinder au Niger	€ 821,667.00	€ 755,000.00	CLOSED
ECHO/-WF/BUD/2020/91009	ALIMA-FR	2020/00173	BURKINA FASO	Réponse d?urgence pour l?accès à des services de santé de qualité des personnes affectées par la crise	€ 1,867,000.00	€ 1,250,000.00	CLOSED

				sécuritaire et humanitaire dans la région du Centre-Nord, au Burkina Faso			
ECHO/-WF/BUD/2020/91030	MDM-BE	2020/00078	MALI	Assistance médico-nutritionnelle pour les populations affectées par les crises dans le District Sanitaire (DS) de Gao, Nord Mali	€ 1,181,370.00	€ 970,000.00	CLOSED
ECHO/-WF/BUD/2020/91010	WHO	2020/00002	BURKINA FASO	Maintien et renforcement des services de santé essentiels pour les populations touchées par la crise humanitaire et réaction rapide aux urgences sanitaires aiguës en appui aux capacités nationales.	€ 502,010.83	€ 300,000.00	CLOSED
ECHO/YEM/BUD/2020/91005	INTERSOS-IT	2019/00985	YEMEN	Provision of emergency health & nutrition services, with integration of protection services, for conflict and displacement affected people in Aden, Hajja and Lahj governorates	€ 2,606,670.66	€ 2,500,000.00	CLOSED
ECHO/-WF/BUD/2019/91066	ALIMA-FR	2019/00911	NIGER	Assistance aux populations affectées par les conflits par un RRM et une préparation aux urgences dans les DS de Abala Ayerou Banibangou Guidam Roumdji Tahoua et Tassara, PEC médico-nutritionnelle dans les DS de Mirriah et Dakoro et appui à la PEC du COVID19 à l?HGR de Niamey et DS de Dakoro	€ 3,213,243.00	€ 2,650,000.00	CLOSED
ECHO/DRF/BUD/2019/91021	WHO	2019/00867	BURUNDI	Renforcement de la coordination et surveillance épidémiologique d'alerte précoce et augmentation des capacités du pays à répondre aux situations d?urgence de santé publique dont la maladie à virus Ebola dans 4 districts	€ 465,000.00	€ 465,000.00	CLOSED

				sanitaires à haut risque en frontière terrestre avec la RDC			
ECHO/COD/BUD/2019/91032	MALTESER HILFSDIENST-DE	2019/00843	CONGO DEMOCRATIC REPUBLIC OF	Contribuer à réduire la mortalité et la morbidité liées à la flambée épidémique de MVE, de COVID-19 et de la peste dans la région du Nord-Est de l'?Ituri et du Haut Uélé.	€ 850,000.00	€ 800,000.00	CLOSED
ECHO/COD/BUD/2019/91030	FICR-CH	2019/00837	CONGO DEMOCRATIC REPUBLIC OF	Integrated Community-Based Interventions in the Ebola Virus Disease Response 2019	€ 1,744,998.00	€ 1,500,000.00	ONGOING
ECHO/COD/BUD/2019/91025	WHO	2019/00801	CONGO DEMOCRATIC REPUBLIC OF	MR 2020 Update:. Rapid Response to the Ebola Virus Disease (EVD) and Measles Epidemics in Nord Kivu, Sud Kivu, Ituri, Bas-Uele, Equateur, Haut Uele, Kasai, Kinshasa, Kongo Central, Kwilu, Mai-Ndombe, Mongala, Sud-Ubangi and Tshuapa in the DRC.	€ 12,178,703.60	€ 9,670,000.00	CLOSED
ECHO/COD/BUD/2019/91021	ZOA-NL	2019/00723	CONGO DEMOCRATIC REPUBLIC OF	Emergency Response to the Ebola Outbreak in Eastern DRC	€ 785,000.00	€ 785,000.00	CLOSED
ECHO/COD/BUD/2019/91020	STC-NO	2019/00718	CONGO DEMOCRATIC REPUBLIC OF	Ebola Emergency Response	€ 1,072,234.00	€ 800,000.00	CLOSED
ECHO/COD/BUD/2019/91022	MCE-UK	2019/00716	CONGO DEMOCRATIC REPUBLIC OF	Pamoya tujikengele ku Ebola - Ensemble contre Ebola	€ 807,271.00	€ 715,000.00	CLOSED
ECHO/-AF/BUD/2019/91020	ALIMA-FR	2019/00711	SOUTH SUDAN REPUBLIC	Capacity Strengthening for Rapid Response and Early Action for Viral Haemorrhagic Diseases in South Sudan	€ 1,529,678.00	€ 1,500,000.00	CLOSED

ECHO/DRF/BUD/2019/91010	ALIMA-FR	2019/00680	CONGO DEMOCRATIC REPUBLIC OF	Réponse à la flambée de rougeole dans la Zone de Santé (ZS) de Kalonda Ouest, Province du Kasaï	€ 395,000.00	€ 395,000.00	CLOSED
ECHO/-AF/BUD/2019/91008	ZOA-NL	2019/00660	SOUTH SUDAN REPUBLIC	Emergency Response in South Sudan	€ 3,750,000.00	€ 1,500,000.00	CLOSED
ECHO/-AM/BUD/2019/91033	PAHO	2019/00575	ARUBA, COLOMBIA, ECUADOR, BRAZIL, GUYANA, PERU, SURINAME, TRINIDAD AND TOBAGO, VENEZUELA	Improve indiscriminatory access to and delivery of essential healthcare services in Venezuela and countries recipient of Venezuelan migrants	€ 8,339,750.00	€ 8,000,000.00	ONGOING
ECHO/-AM/BUD/2019/91029	MDM-ES	2019/00495	VENEZUELA	Contribute to reduce the impact of the crisis of Venezuela health system, through the capacity building of the local health organizations serving the most vulnerable populations, plus the strengthening of the response capacity to health emergencies	€ 1,048,000.00	€ 1,048,000.00	CLOSED
ECHO/-AS/BUD/2019/91008	PUI-FR	2019/00446	AFGHANISTAN	Multi-sector lifesaving assistance to conflict and COVID-19 affected populations in Eastern Afghanistan	€ 4,200,000.00	€ 4,200,000.00	CLOSED
ECHO/-AS/BUD/2019/91011	WHO	2019/00422	AFGHANISTAN	Provision of emergency trauma care and primary healthcare services for the internally displaced population, host communities, and those affected by conflicts	€ 25,794,006.23	€ 16,299,999.89	ONGOING

ECHO/COD/BUD/2019/91013	MDM-FR	2019/00397	CONGO DEMOCRATIC REPUBLIC OF	Réponse d'urgence aux besoins de santé des populations affectées par le conflit dans la zone de santé (ZS) de Nyemba, province du Tanganyika.	€ 4,045,000.00	€ 3,500,000.00	CLOSED
ECHO/-AF/BUD/2019/92029	PUI-FR	2019/00369	CHAD, CHAD	Renforcement de l'accès à des soins de santé primaire et secondaire intégrés de qualité pour les enfants de moins de 5 ans et les FEFA et la réponse aux urgences dans les provinces du Lac et du Ouaddai	€ 1,220,854.00	€ 1,200,000.00	CLOSED
ECHO/-AF/BUD/2019/92038	IMC-UK	2019/00360	CENTRAL AFRICAN REPUBLIC	Emergency Assistance for Conflict-Affected Communities in the Ouaka Prefecture, Central African Republic	€ 1,042,097.00	€ 1,000,000.00	CLOSED
ECHO/IRQ/BUD/2019/91011	WHO	2019/00202	IRAQ	Ensuring lifesaving and preventive, primary and secondary health care services for IDPs and hosting communities in conflict-affected governorates of Iraq.	€ 12,118,438.35	€ 3,000,000.00	CLOSED
ECHO/IRQ/BUD/2019/91008	UNICEF-US	2019/00198	IRAQ	Multi-sector WASH, Education, Child Protection, Health and Nutrition including COVID-19 Response response to displaced populations affected by conflict and displacement in Iraq	€ 5,670,364.90	€ 5,500,000.00	CLOSED
ECHO/SYR/BUD/2019/91052	WHO	2019/00169	Syrian Arab Republic	Strengthening essential health services in Syria, including for Covid-19 preparedness and response	€ 11,615,897.85	€ 9,000,000.00	ONGOING
ECHO/-WF/BUD/2019/91048	STC-DK	2019/00141	MALI	Réponse intégrée Santé/Nutrition et Education en situations d'urgence dans les regions de Mopti et de Tombouctou	€ 3,477,777.77	€ 3,130,000.00	CLOSED

ECHO/-WF/BUD/2019/91028	ALIMA-FR	2019/00124	MALI	Assistance médico-nutritionnelle aux populations vulnérabilisées par la crise au nord du Mali, dans la région de Tombouctou	€ 3,375,949.00	€ 3,270,000.00	CLOSED
ECHO/-WF/BUD/2019/91050	MDM-FR	2019/00099	NIGERIA	Emergency Medical Assistance for Host and Displaced Populations in Northeast Nigeria	€ 4,500,000.00	€ 2,500,000.00	CLOSED
ECHO/-WF/BUD/2019/91051	ALIMA-FR	2019/00086	NIGER	Prise en charge médico-nutritionnelle curative et préventive pour les enfants de moins de cinq ans et amélioration de la santé maternelle au Niger	€ 2,500,000.00	€ 2,000,000.00	CLOSED
ECHO/-AS/BUD/2019/91004	CICR-CH	2018/01209	Pakistan	ICRC Health activities in Pakistan	€ 3,918,899.00	€ 1,600,000.00	CLOSED
ECHO/-AF/BUD/2019/91015	STC-FI	2018/01179	SUDAN	Improving access and utilization of life-saving Health, Nutrition and Food Security services for the most vulnerable IDPs, refugees and host communities in West Darfur, North Darfur and South Kordofan, respond to COVID-19 outbreak in Khartoum and support the flood-affected population in Sudan	€ 4,800,000.00	€ 4,800,000.00	CLOSED
ECHO/-AF/BUD/2019/91006	IMC-UK	2018/01174	SUDAN	Integrated Humanitarian Health, Nutrition & WASH Assistance to Conflict Affected and Vulnerable Populations of Central and South Darfur and South Kordofan states	€ 2,200,000.00	€ 2,200,000.00	CLOSED
ECHO/YEM/BUD/2019/91004	INTERSOS-IT	2018/01134	YEMEN	Provision of emergency primary and secondary health & nutrition services, with integration of protection services,	€ 2,114,532.15	€ 2,000,000.00	CLOSED

				for conflict and displacement affected people, in Aden and Hajjah governorates			
ECHO/YEM/BUD/2018/91024	IRC-DE	2018/01132	YEMEN	Integrated Health and Nutrition Support for Conflict-Affected Populations in Al Dhale?e Governorate of Yemen	€ 3,764,612.00	€ 3,500,000.00	CLOSED
ECHO/YEM/BUD/2019/91012	IMC-UK	2018/01127	YEMEN	Integrated Life-Saving Assistance for Conflict-Affected People in Yemen	€ 1,092,011.00	€ 1,000,000.00	CLOSED
ECHO/-HF/BUD/2019/91007	IRC-DE	2018/01104	UGANDA	Epidemic disease surveillance and response and improvements of life-saving health services to newly arrived refugees and vulnerable host community members in Uganda	€ 4,400,000.00	€ 4,000,000.00	CLOSED
ECHO/-HF/BUD/2019/91003	IRC-DE	2018/01053	KENYA	Improved health, nutritional status and protection for refugees and surrounding host communities in Kenya	€ 3,889,579.00	€ 3,313,000.00	CLOSED
ECHO/-HF/BUD/2019/91005	IMC-UK	2018/01046	SOMALIA	Improving access to life-saving health and nutrition services for vulnerable populations in Galkacyo/Mudug and Jowhar /Middle Shabelle regions of Somalia	€ 1,010,897.00	€ 1,000,000.00	CLOSED
ECHO/COD/BUD/2018/91035	FICR-CH	2018/01007	CONGO DEMOCRATIC REPUBLIC OF	Ebola 2018	€ 2,454,670.00	€ 2,000,000.00	CLOSED
ECHO/DRF/BUD/2018/91019	ALIMA-FR	2018/01003	NIGER	Riposte à l'épidémie de choléra dans le District de Maradi commune (Région de Maradi)	€ 275,000.00	€ 275,000.00	CLOSED
ECHO/DRF/BUD/2018/91012	CISP-IT	2018/00943	VENEZUELA	Emergency Humanitarian Aid for those families affected by Heavy Rains Floods	€ 300,000.00	€ 300,000.00	CLOSED

				in Apure, Táchira and Amazonas states.			
ECHO/-AF/BUD/2018/91044	WHO	2018/00914	SOUTH SUDAN REPUBLIC	Strengthening early detection, verification, investigation, identification and response to outbreaks to reduce excess morbidity and mortality due to infectious hazard events.	€ 2,624,778.20	€ 2,250,000.00	CLOSED
ECHO/-AM/BUD/2018/91045	UNHCR-CH	2018/00880	PERU, ARUBA, BRAZIL, COLOMBIA, ECUADOR, TRINIDAD AND TOBAGO, VENEZUELA, NETHERLANDS ANTILLES, PANAMA	Emergency interventions to ensure provision of protection and life-saving humanitarian assistance to vulnerable populations affected by the crisis in Venezuela.	€ 21,625,101.00	€ 14,095,000.00	CLOSED
ECHO/-AM/BUD/2018/91043	PAHO	2018/00879	VENEZUELA, COLOMBIA, ECUADOR, PERU	Strengthening the health sector's capacities to deal with active outbreaks and increased health needs in Venezuela and neighboring countries recipient of Venezuelan migrants	€ 5,424,550.00	€ 5,000,000.00	CLOSED
ECHO/COD/BUD/2018/91026	IOM-CH	2018/00856	CONGO DEMOCRATIC REPUBLIC OF	EBOLA OUTBREAK RESPONSE IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)	€ 500,000.00	€ 500,000.00	CLOSED
ECHO/DRF/BUD/2018/91008	CROIX-ROUGE-ES	2018/00855	GUATEMALA	Humanitarian aid for the most vulnerable people affected by the eruption of the Volcán de Fuego in Guatemala.	€ 300,000.00	€ 300,000.00	CLOSED

ECHO/DRF/BUD/2018/91006	WHO	2018/00846	CONGO DEMOCRATIC REPUBLIC OF	Rapid Response to the Ebola Virus Disease (EVD) Epidemic in the Democratic Republic of the Congo	€ 6,921,262.00	€ 5,500,000.00	CLOSED
ECHO/-XA/BUD/2018/91026	RI-UK	2018/00796	BANGLADESH	Integrated Health, Protection, and Food Security Support for Vulnerable Rohingya Refugee Households Living in Cox's Bazar	€ 1,510,000.00	€ 1,500,000.00	CLOSED
ECHO/DRF/BUD/2018/91002	WHO	2018/00733	NIGERIA	Addressing Lassa Fever in Nigeria through a strategic response plan	€ 639,528.00	€ 500,000.00	CLOSED
ECHO/COD/BUD/2018/91007	GVC-IT	2018/00678	BURUNDI	Assistance médico/nutritionnel aux demandeurs d'asile en provenance de RDC dans la zone du Sud de BURUNDI	€ 100,000.00	€ 100,000.00	CLOSED
ECHO/SYR/BUD/2018/91009	SI-FR	2018/00601	SYRIAN ARAB REPUBLIC	Provision of integrated, principled and flexible life-saving and sustaining humanitarian assistance for vulnerable populations in Syria.	€ 2,170,000.00	€ 2,000,000.00	CLOSED
ECHO/SYR/BUD/2017/91049	WHO	2018/00436	SYRIAN ARAB REPUBLIC	Strengthening Emergency and Essential Health Assistance Delivery in Syria	€ 12,651,484.00	€ 3,000,000.00	CLOSED
ECHO/IRQ/BUD/2018/91007	RI-UK	2018/00429	IRAQ	Emergency Health Response II: Anbar (EHR II)	€ 1,800,000.00	€ 1,800,000.00	CLOSED
ECHO/YEM/BUD/2018/91009	INTERSOS-IT	2018/00421	YEMEN	Provision of emergency primary health services through support of 8 existing health facilities and integrated nutrition and protection services supported by a network of community volunteers in 4 districts Ibb Governorate	€ 1,413,800.00	€ 1,400,000.00	CLOSED

ECHO/-HF/BUD/2018/91056	UNHCR-CH	2018/00395	UGANDA	Protection and Humanitarian Assistance to Refugees and Host Communities in Support of the Comprehensive Refugee Response in Uganda.	€ 20,751,061.00	€ 6,800,000.00	CLOSED
ECHO/-HF/BUD/2018/91046	RI-UK	2018/00384	UGANDA	Integrated Emergency Health and Surveillance for Resilience and Recovery - Uganda	€ 2,158,509.71	€ 2,000,000.00	CLOSED
ECHO/-HF/BUD/2018/91047	MDM-FR	2018/00351	UGANDA	Sustaining access to primary healthcare, mental health and psychosocial support, sexual and reproductive health, including treatment and care for victims of gender-based violence in Northern Uganda - Health response to the impact of the protracted South Sudanese crisis in Uganda	€ 4,563,042.00	€ 2,400,000.00	CLOSED
ECHO/IRQ/BUD/2018/91001	WHO	2018/00346	IRAQ	Increasing health security and resilience for IDPs, returnees and host communities in the most conflict-affected governorates of Iraq	€ 10,585,534.00	€ 4,500,000.00	CLOSED
ECHO/COD/BUD/2018/91021	MEDAIR-CH	2018/00301	CONGO DEMOCRATIC REPUBLIC OF	Emergency Health response in favour of vulnerable populations affected by conflict and outbreaks in Nord Kivu province and neighbouring areas in Eastern Democratic Republic of the Congo.	€ 4,819,889.00	€ 4,088,052.00	CLOSED
ECHO/-AS/BUD/2018/91014	PUI-FR	2018/00273	AFGHANISTAN	Lifesaving integrated emergency health response and Emergency Response Mechanism (ERM) in the conflict and disaster affected areas of Afghanistan.	€ 800,000.00	€ 800,000.00	CLOSED

ECHO/-AS/BUD/2018/91019	WHO	2018/00266	AFGHANISTAN	Provision of emergency primary healthcare services and trauma care for the populations affected by conflicts, natural catastrophes and limited accessibility to healthcare services	€ 2,095,956.73	€ 800,000.00	CLOSED
ECHO/-AF/BUD/2017/92053	IMC-UK	2018/00214	CENTRAL AFRICAN REPUBLIC	Emergency Assistance for Conflict-Affected Communities in the Ouaka Prefecture, Central African Republic	€ 1,389,619.75	€ 1,309,751.00	CLOSED
ECHO/-AF/BUD/2017/92051	ALIMA-FR	2018/00211	CENTRAL AFRICAN REPUBLIC	Assistance médicale d'urgence auprès des populations vulnérables affectées par le conflit en RCA	€ 1,300,000.00	€ 950,000.00	CLOSED
ECHO/-AF/BUD/2018/92022	IMC-UK	2018/00208	CHAD	Reinforcement of the response to the humanitarian crisis through integrated, health and nutrition intervention in the Lake Chad Region	€ 2,000,000.00	€ 2,000,000.00	CLOSED
ECHO/-AF/BUD/2018/92025	WHO	2018/00169	CAMEROON	Strengthen emergency preparedness for epidemic-prone diseases in the Far North region.	€ 635,168.00	€ 500,000.00	CLOSED
ECHO/-WF/BUD/2018/91037	ALIMA-FR	2018/00142	BURKINA FASO, NIGER, MALI	Réponses aux urgences médico-nutritionnelles à travers la Plateforme des ONG du Sahel dans la zone des trois frontièreset la région de Maradi, Afrique de l'Ouest	€ 600,000.00	€ 500,000.00	CLOSED
ECHO/-WF/BUD/2018/91049	TDH-CH	2018/00123	MALI	Renforcement de l'intégration des activités de prévention et de prise en charge de la malnutrition aigüe sévère dans le système de santé et réponse aux urgences médico-nutritionnelles dans les districts sanitaires de Ségou, Markala, Macina et Niono (Région de Ségou, Mali)	€ 850,000.00	€ 850,000.00	CLOSED

ECHO/-WF/BUD/2018/91038	ALIMA-FR	2018/00114	MALI	Prévention et prise en charge et la MAS dans la région de Koulikoro, et assistance médico-nutritionnelle aux populations vulnérabilisées par la crise au Nord du Mali dans la Région de Tombouctou	€ 2,886,122.00	€ 2,650,000.00	CLOSED
ECHO/-WF/BUD/2018/91031	SI-FR	2018/00091	NIGERIA	IMPROVEMENT OF ACCESS TO BASIC NUTRITION, HEALTH AND WASH SERVICES FOR IDPS AND HOST COMMUNITIES IN BORNO STATE	€ 7,750,000.00	€ 7,200,000.00	CLOSED
ECHO/-WF/BUD/2018/91069	MDM-BE	2018/00078	MALI, MALI	Assistance médico-nutritionnelle pour les populations affectées par les crises dans le District Sanitaire (DS) de Gao et les Districts Sanitaires de la Région de Ménaka, Nord Mali	€ 3,509,803.00	€ 2,600,000.00	CLOSED
ECHO/-XA/BUD/2018/91002	CROIX-ROUGE-DE	2018/00055	BANGLADESH	Provision of emergency assistance to displaced Undocumented Myanmar Nationals and host communities in Cox's Bazar	€ 4,000,000.00	€ 4,000,000.00	CLOSED
ECHO/-XA/BUD/2018/91021	WHO	2018/00043	BANGLADESH	Reducing avoidable morbidity and mortality among Rohingya refugees in Cox's Bazar	€ 3,790,410.20	€ 1,000,000.00	CLOSED
ECHO/-XA/BUD/2018/91006	CICR-CH	2017/01195	Myanmar	ICRC health and protection activities in Myanmar	€ 7,700,809.00	€ 1,650,000.00	CLOSED
ECHO/-AF/BUD/2018/91035	CONCERN WORLDWIDE-IR	2017/01189	SUDAN	"Life-saving Services for All" (LSA) through provision of integrated health, nutrition, WASH and NFI/shelter services in West Kordofan, Sudan	€ 1,442,000.00	€ 1,352,000.00	CLOSED

ECHO/-AF/BUD/2018/91029	WV-UK	2017/01179	SUDAN	Enhancing life-saving support through continuation of Health, Nutrition and WASH in Nutrition services among vulnerable conflict affected populations in South Darfur	€ 1,143,188.03	€ 1,093,188.00	CLOSED
ECHO/-AF/BUD/2018/91030	GOAL-IR	2017/01178	SUDAN	Provision of multi-sector lifesaving response for the conflict-affected population of Kutum and Al Waha localities, North Darfur, and Habila and Talodi localities, South Kordofan	€ 2,461,827.00	€ 2,300,000.00	CLOSED
ECHO/-HF/BUD/2018/91008	IMC-UK	2017/01093	SOMALIA	Provision of life-saving health and nutrition services to vulnerable populations in Galkacyo/Mudug, Jowhar /Middle Shabelle and Abudwak/Galgaduud regions of Somalia regions of Somalia	€ 2,201,385.00	€ 2,000,000.00	CLOSED
ECHO/-HF/BUD/2018/91017	IRC-UK	2017/01037	KENYA	Improved health, nutritional status and protection for refugees and surrounding host communities in Kenya	€ 1,315,407.00	€ 981,000.00	CLOSED
ECHO/-HF/BUD/2018/91021	SOS KINDERDORF INT-AT	2017/01015	SOMALIA	SOS Children's Villages International Mother and Child Health Care Programme	€ 5,105,157.00	€ 1,750,000.00	CLOSED
ECHO/-CR/EDF/2017/02003	PAHO	2017/00999	DOMINICA	Health emergency response to Dominica following Hurricane Maria	€ 829,250.00	€ 500,000.00	CLOSED
ECHO/DRF/BUD/2017/91018	FICR-CH	2017/00984	MADAGASCAR	Accelerated Action against Plague in Madagascar	€ 286,231.00	€ 192,021.00	ONGOING

ECHO/DRF/BUD/2017/91017	UNICEF-US	2017/00983	MADAGASCAR	Emergency response to plague outbreak in Madagascar	€ 189,711.00	€ 150,000.00	CLOSED
ECHO/DRF/BUD/2017/91015	ALIMA-FR	2017/00976	CONGO DEMOCRATIC REPUBLIC OF	Riposte à l'épidémie de choléra dans les provinces du Kasaï et du Haut-Lomami	€ 300,000.00	€ 300,000.00	CLOSED
ECHO/-AM/BUD/2017/91021	PAHO	2017/00958	ANTIGUA AND BARBUDA, CUBA, TURKS AND CAICOS ISLANDS, NETHERLANDS ANTILLES	Health emergency response to Caribbean disaster-affected areas following Hurricane Irma	€ 749,000.00	€ 500,000.00	CLOSED
ECHO/-AF/BUD/2017/91039	STC-FI	2017/00924	SUDAN, SUDAN	Integrated life-saving response to humanitarian needs of South Sudanese refugees in South Kordofan and North Darfur	€ 1,700,000.00	€ 1,700,000.00	CLOSED
ECHO/IRQ/BUD/2017/91028	WHO	2017/00920	IRAQ	Provision of emergency trauma care and essential life-saving primary and secondary health care services to vulnerable populations in Iraq	€ 22,620,662.50	€ 7,000,000.00	CLOSED
ECHO/-HF/BUD/2017/91057	CROIX-ROUGE-DE	2017/00909	SOMALIA	Integrated emergency response for 2017 drought affected population in Togdheer region - Somaliland.	€ 907,899.06	€ 800,000.00	CLOSED
ECHO/SYR/BUD/2017/91034	IRC-UK	2017/00876	SYRIAN ARAB REPUBLIC	Multi-sectoral humanitarian response for conflict-affected populations in Syria	€ 7,814,417.00	€ 7,445,974.00	ONGOING
ECHO/SYR/BUD/2017/91047	WHO	2017/00867	SYRIAN ARAB REPUBLIC	Strengthening Emergency and Essential Health Assistance Delivery in Syria	€ 12,651,484.00	€ 3,000,000.00	CLOSED

ECHO/-WF/BUD/2017/91089	MDM-BE	2017/00831	MALI	Assistance Médicale aux populations affectées par les crises dans le Nord du Mali.	€ 800,000.00	€ 800,000.00	CLOSED
ECHO/-AF/EDF/2017/01020	UNICEF-US	2017/00828	SOUTH SUDAN REPUBLIC	UNICEF response to key emergency issues related to health and child protection in south Sudan	€ 9,747,067.78	€ 5,100,000.00	CLOSED
ECHO/-HF/BUD/2017/91053	UNICEF-US	2017/00800	SOMALIA,	Multi-sectoral drought response, including emergency response to the cholera outbreak in Somalia.	€ 10,445,099.30	€ 7,500,000.00	CLOSED
ECHO/DRF/BUD/2017/91004	ACF-FR	2017/00733	SOMALIA	Integrated emergency WASH and Health response to the cholera outbreak in Bakool region of Somalia	€ 550,000.00	€ 500,000.00	CLOSED
ECHO/IRQ/BUD/2017/91020	IMC-UK	2017/00689	IRAQ	Improving Access to integrated Primary Health and MPHSS services for Conflict-Affected Populations in Mosul and the South Central Region of Iraq	€ 4,349,157.00	€ 4,000,000.00	CLOSED
ECHO/IRQ/BUD/2017/91005	RI-UK	2017/00678	IRAQ, IRAQ, IRAQ	Emergency Health Response (EHR): Anbar, Salahaldin and Recently Retaken Areas	€ 1,400,000.00	€ 1,400,000.00	CLOSED
ECHO/-AF/EDF/2017/01026	WHO	2017/00624	SOUTH SUDAN REPUBLIC	Strengthening epidemic preparedness and response to reduce excess morbidity and mortality among the emergency affected populations of South Sudan	€ 1,397,145.00	€ 1,000,000.00	CLOSED
ECHO/-AS/BUD/2016/91049	WHO	2017/00606	AFGHANISTAN	Providing emergency primary health services and trauma care for people affected by conflicts, natural calamities and limited accessibility to health services	€ 5,893,088.00	€ 2,440,000.00	CLOSED

ECHO/-AS/BUD/2017/91016	ICMC-CH	2017/00587	PAKISTAN	Provision of Integrated Protection and Health Assistance to Afghan Refugees	€ 2,930,640.00	€ 2,800,000.00	CLOSED
ECHO/UKR/BUD/2017/91007	STC-SE	2017/00483	UKRAINE	Building a safer environment for conflict-affected children and their families in Eastern Ukraine by improving access to integrated health and protection services	€ 1,057,847.00	€ 965,920.00	CLOSED
ECHO/-AS/BUD/2016/91047	PUI-FR	2017/00355	AFGHANISTAN	Preparedness and response to conflict-induced and natural disaster related medical emergencies in Afghanistan	€ 980,000.00	€ 980,000.00	CLOSED
ECHO/-HF/BUD/2017/91034	IMC-UK	2017/00302	SOMALIA,	Provision of life-saving health and nutrition services to vulnerable populations in Galkacyo/Mudug and Jowhar /Middle Shabelle regions of Somalia.	€ 1,286,717.00	€ 1,000,000.00	CLOSED
ECHO/-HF/BUD/2017/91013	OXFAM-UK	2017/00270	ETHIOPIA,	Lifesaving EFSL, WASH, Nutrition and Emergency Health Drought Response in Somali Region, Ethiopia	€ 5,547,930.90	€ 5,270,000.00	CLOSED
ECHO/-HF/BUD/2017/91025	SOS KINDERDORF INT-AT	2017/00222	SOMALIA,	SOS Children's Villages International Mother and Child Health Care Programme	€ 2,782,000.00	€ 1,000,000.00	CLOSED
ECHO/COD/BUD/2017/91008	COOPI-IT	2017/00202	CONGO DEMOCRATIC REPUBLIC OF	Assistance Sanitaire et de Protection aux populations vulnérables affectées par les conflits dans les Provinces du Nord Kivu et du Kasai Central.	€ 1,688,000.00	€ 1,650,000.00	CLOSED
ECHO/COD/BUD/2017/91024	MEDAIR-CH	2017/00172	CONGO DEMOCRATIC REPUBLIC OF	Emergency Health Response to Vulnerable Populations in Lubero, Walikale and Masisi Territories, Nord Kivu Province	€ 2,216,256.72	€ 1,500,000.00	CLOSED

ECHO/-HF/BUD/2017/91031	IRC-UK	2017/00153	SOMALIA	Multi-Sector Emergency Assistance to Vulnerable Populations in Somalia	€ 2,361,958.42	€ 2,000,000.00	CLOSED
ECHO/COD/BUD/2017/91016	UNICEF-US	2017/00149	CONGO DEMOCRATIC REPUBLIC OF	Réponse Rapide aux Mouvements de Population (RRMP)	€ 38,540,615.51	€ 4,000,000.00	CLOSED
ECHO/YEM/BUD/2017/91017	WHO	2017/00116	YEMEN	Saving lives by improving access to primary health care, strengthening outbreak surveillance, control and response to vulnerable populations in conflict affected areas of Yemen	€ 22,766,226.50	€ 5,000,000.00	CLOSED
ECHO/-AF/BUD/2017/92013	ALIMA-FR	2017/00105	CENTRAL AFRICAN REPUBLIC	Projet d'assistance médico-nutritionnelle d'urgence pour les populations vulnérables du District Sanitaire de Boda - Préfecture de la Lobaye	€ 1,070,000.00	€ 1,000,000.00	CLOSED
ECHO/-AF/BUD/2017/92027	IMC-UK	2017/00094	CHAD	Reinforcement of the humanitarian response to emergency nutrition needs in Chad through integrated, multi-sectorial interventions in Abdi District	€ 2,050,000.00	€ 2,050,000.00	CLOSED
ECHO/-SF/BUD/2017/91007	UNICEF-US	2017/00008	MADAGASCAR	Improving the survival of children affected by severe acute malnutrition in the El Nino drought affected regions of southern Madagascar MR01-01 See Annex	€ 1,562,943.00	€ 1,200,000.00	CLOSED

Table 18 Sampling frame 1 (Selected countries) (n=39)

Agreement No.	Partner short name	Reference number	Country	Action title	Total Amount	EC Amount	Status
ECHO/-AS/BUD/2021/91025	FICR-CH	2021/01056	AFGHANISTAN	Access to essential health care and WASH in hard-to-reach areas of Afghanistan	€ 2,383,290.00	€ 1,500,000.00	ONGOING
ECHO/-AS/BUD/2021/91023	WHO	2021/01053	AFGHANISTAN	Providing trauma care, emergency primary healthcare and emergency nutrition services for populations in underserved and conflict affected areas of Afghanistan	€ 16,810,726.00	€ 14,000,000.00	ONGOING
ECHO/-AS/BUD/2021/91004	CICR-CH	2021/00840	AFGHANISTAN	ICRC health activities for detainees, hospital services/secondary care, physical rehabilitation services, and prevention (IHL dissemination and implementation) and protection activities in Afghanistan.	€ 10,955,779.60	€ 8,000,000.00	ONGOING
ECHO/-AS/BUD/2020/91003	INTERSOS-IT	2020/00481	AFGHANISTAN	Provision of essential and quality services through an integrated protection, health and nutrition response for vulnerable conflict-affected population in Southern Afghanistan.	€ 1,242,380.86	€ 1,200,000.00	ONGOING
ECHO/-AS/BUD/2020/91005	IRC-DE	2020/00466	AFGHANISTAN	Integrated Emergency Protection and Health response in Kabul, Helmand, Badghis, Herat, Laghman, Khost,	€ 2,578,127.00	€ 2,400,000.00	CLOSED

				Nangarhar and Paktya provinces of Afghanistan			
ECHO/-AS/BUD/2019/91008	PUI-FR	2019/00446	AFGHANISTAN	Multi-sector lifesaving assistance to conflict and COVID-19 affected populations in Eastern Afghanistan	€ 4,200,000.00	€ 4,200,000.00	CLOSED
ECHO/-AS/BUD/2019/91011	WHO	2019/00422	AFGHANISTAN	Provision of emergency trauma care and primary healthcare services for the internally displaced population, host communities, and those affected by conflicts	€ 25,794,006.23	€ 16,299,999.89	ONGOING
ECHO/-AS/BUD/2018/91014	PUI-FR	2018/00273	AFGHANISTAN	Lifesaving integrated emergency health response and Emergency Response Mechanism (ERM) in the conflict and disaster affected areas of Afghanistan.	€ 800,000.00	€ 800,000.00	CLOSED
ECHO/-AS/BUD/2018/91019	WHO	2018/00266	AFGHANISTAN	Provision of emergency primary healthcare services and trauma care for the populations affected by conflicts, natural catastrophes and limited accessibility to healthcare services	€ 2,095,956.73	€ 800,000.00	CLOSED
ECHO/-AS/BUD/2016/91049	WHO	2017/00606	AFGHANISTAN	Providing emergency primary health services and trauma care for people affected by conflicts, natural calamities and limited accessibility to health services	€ 5,893,088.00	€ 2,440,000.00	CLOSED
ECHO/-AS/BUD/2016/91047	PUI-FR	2017/00355	AFGHANISTAN	Preparedness and response to conflict-induced and natural disaster	€ 980,000.00	€ 980,000.00	CLOSED

				related medical emergencies in Afghanistan			
ECHO/-AM/BUD/2019/91033	PAHO	2019/00575	ARUBA, COLOMBIA, ECUADOR, BRAZIL, GUYANA, PERU, SURINAME, TRINIDAD AND TOBAGO, VENEZUELA	Improve indiscriminatory access to and delivery of essential healthcare services in Venezuela and countries recipient of Venezuelan migrants	€ 8,339,750.00	€ 8,000,000.00	ONGOING
ECHO/DRF/BUD/2021/91040	WHO	2021/01003	BURUNDI, CAMEROON, CENTRAL AFRICAN REPUBLIC, CHAD, CONGO DEMOCRATIC REPUBLIC OF, GUINEA, LIBERIA, MADAGASCAR, MALI, MOZAMBIQUE, NIGER, NIGERIA, SOMALIA, SOUTH SUDAN REPUBLIC, SUDAN	Support to the rollout of COVID-19 national vaccination campaigns in Africa and reinforcement of national health systems? resilience to epidemics	€ 17,539,902.41	€ 16,000,000.00	ONGOING

ECHO/DRF/BUD/2020/91003	WHO	2020/00727	CAMEROON, CONGO DEMOCRATIC REPUBLIC OF, ETHIOPIA, BURKINA FASO, SOMALIA, KENYA, PHILIPPINES, AFGHANISTAN, NIGERIA, BANGLADESH	Support to WHO?s COVID-19 Preparedness and Response Plan in high risk and vulnerable countries in Africa and Asia	€ 37,500,000.00	€ 30,000,000.00	ONGOING
ECHO/-AM/BUD/2020/91043	CARITAS-LU	2020/00947	COLOMBIA, VENEZUELA, BRAZIL	PCPR: Promoting COVID-19 Prevention and Resilience among vulnerable refugees and migrants, indigenous people and host communities in Brazil, Colombia and Venezuela lacking effective public health policies and responses.	€ 1,050,000.00	€ 850,000.00	ONGOING
ECHO/COD/BUD/2021/91020	MEDAIR-DE	2021/00706	CONGO DEMOCRATIC REPUBLIC OF	Emergency multi-sectoral response in favour of vulnerable populations affected by conflict and outbreaks in Eastern Democratic Republic of the Congo	€ 6,591,666.67	€ 5,700,000.00	ONGOING
ECHO/COD/BUD/2021/91008	MDM-FR	2021/00705	CONGO DEMOCRATIC REPUBLIC OF	Réponse d'urgence aux besoins de santé des populations affectées par les conflits dans la zone de santé (ZS) de Nyemba, province du Tanganyika	€ 2,893,000.00	€ 2,593,000.00	ONGOING
ECHO/COD/BUD/2021/91011	UNICEF-US	2021/00695	CONGO DEMOCRATIC REPUBLIC OF	Reduce the incidence and transmission of cholera through an integrated and evidence-based	€ 8,222,998.31	€ 3,500,000.00	ONGOING

				community approach in North Kivu, South Kivu and Tanganyika in the DRC			
ECHO/COD/BUD/2021/91025	WHO	2021/00683	CONGO DEMOCRATIC REPUBLIC OF	Amelioration de l? offre des services et soins de santé de base aux populations affectées par la crise humanitaire et les épidémies dans les 4 provinces du Nord Kivu, Sud Kivu, Ituri et Tanganyika.	€ 1,948,507.90	€ 1,550,000.00	ONGOING
ECHO/COD/BUD/2020/91020	STC-NO	2020/00921	CONGO DEMOCRATIC REPUBLIC OF	Contain and Control the Spread of Covid-19 in the Tshangu District of Kinshasa Province, DRC	€ 1,370,108.00	€ 1,300,000.00	ONGOING
ECHO/COD/BUD/2020/91021	FICR-CH	2020/00903	CONGO DEMOCRATIC REPUBLIC OF	Réponse à la pandémie de la COVID-19 en RDC, province de Kinshasa	€ 1,571,393.00	€ 1,200,000.00	ONGOING
ECHO/COD/BUD/2020/91001	UNICEF-US	2020/00394	CONGO DEMOCRATIC REPUBLIC OF	Targeted rapid interventions to cholera cases through community outbreak response teams	€ 3,487,808.63	€ 500,000.00	CLOSED
ECHO/COD/BUD/2019/91032	MALTESER HILFSDIENST-DE	2019/00843	CONGO DEMOCRATIC REPUBLIC OF	Contribuer à réduire la mortalité et la morbidité liées à la flambée épidémique de MVE, de COVID-19 et de la peste dans la région du Nord-Est de l'?Ituri et du Haut Uélé.	€ 850,000.00	€ 800,000.00	CLOSED
ECHO/COD/BUD/2019/91030	FICR-CH	2019/00837	CONGO DEMOCRATIC REPUBLIC OF	Integrated Community-Based Interventions in the Ebola Virus Disease Response 2019	€ 1,744,998.00	€ 1,500,000.00	ONGOING

ECHO/COD/BUD/2019/91025	WHO	2019/00801	CONGO DEMOCRATIC REPUBLIC OF	MR 2020 Update:. Rapid Response to the Ebola Virus Disease (EVD) and Measles Epidemics in Nord Kivu, Sud Kivu, Ituri, Bas-Uele, Equateur, Haut Uele, Kasai, Kinshasa, Kongo Central, Kwilu, Mai-Ndombe, Mongala, Sud-Ubangi and Tshuapa in the DRC.	€ 12,178,703.60	€ 9,670,000.00	CLOSED
ECHO/COD/BUD/2019/91021	ZOA-NL	2019/00723	CONGO DEMOCRATIC REPUBLIC OF	Emergency Response to the Ebola Outbreak in Eastern DRC	€ 785,000.00	€ 785,000.00	CLOSED
ECHO/COD/BUD/2019/91020	STC-NO	2019/00718	CONGO DEMOCRATIC REPUBLIC OF	Ebola Emergency Response	€ 1,072,234.00	€ 800,000.00	CLOSED
ECHO/COD/BUD/2019/91022	MCE-UK	2019/00716	CONGO DEMOCRATIC REPUBLIC OF	Pamoya tujikengele ku Ebola - Ensemble contre Ebola	€ 807,271.00	€ 715,000.00	CLOSED
ECHO/DRF/BUD/2019/91010	ALIMA-FR	2019/00680	CONGO DEMOCRATIC REPUBLIC OF	Réponse à la flambée de rougeole dans la Zone de Santé (ZS) de Kalonda Ouest, Province du Kasaï	€ 395,000.00	€ 395,000.00	CLOSED
ECHO/COD/BUD/2019/91013	MDM-FR	2019/00397	CONGO DEMOCRATIC REPUBLIC OF	Réponse d'urgence aux besoins de santé des populations affectées par le conflit dans la zone de santé (ZS) de Nyemba, province du Tanganyika.	€ 4,045,000.00	€ 3,500,000.00	CLOSED
ECHO/COD/BUD/2018/91035	FICR-CH	2018/01007	CONGO DEMOCRATIC REPUBLIC OF	Ebola 2018	€ 2,454,670.00	€ 2,000,000.00	CLOSED

ECHO/DRF/BUD/2017/91015	ALIMA-FR	2017/00976	CONGO DEMOCRATIC REPUBLIC OF	Riposte à l'épidémie de choléra dans les provinces du Kasaï et du Haut-Lomami	€ 300,000.00	€ 300,000.00	CLOSED
ECHO/COD/BUD/2018/91026	IOM-CH	2018/00856	CONGO DEMOCRATIC REPUBLIC OF	EBOLA OUTBREAK RESPONSE IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)	€ 500,000.00	€ 500,000.00	CLOSED
ECHO/COD/BUD/2017/91008	COOPI-IT	2017/00202	CONGO DEMOCRATIC REPUBLIC OF	Assistance Sanitaire et de Protection aux populations vulnérables affectées par les conflits dans les Provinces du Nord Kivu et du Kasai Central.	€ 1,688,000.00	€ 1,650,000.00	CLOSED
ECHO/DRF/BUD/2018/91006	WHO	2018/00846	CONGO DEMOCRATIC REPUBLIC OF	Rapid Response to the Ebola Virus Disease (EVD) Epidemic in the Democratic Republic of the Congo	€ 6,921,262.00	€ 5,500,000.00	CLOSED
ECHO/COD/BUD/2017/91024	MEDAIR-CH	2017/00172	CONGO DEMOCRATIC REPUBLIC OF	Emergency Health Response to Vulnerable Populations in Lubero, Walikale and Masisi Territories, Nord Kivu Province	€ 2,216,256.72	€ 1,500,000.00	CLOSED
ECHO/COD/BUD/2018/91021	MEDAIR-CH	2018/00301	CONGO DEMOCRATIC REPUBLIC OF	Emergency Health response in favour of vulnerable populations affected by conflict and outbreaks in Nord Kivu province and neighbouring areas in Eastern Democratic Republic of the Congo.	€ 4,819,889.00	€ 4,088,052.00	CLOSED
ECHO/COD/BUD/2017/91016	UNICEF-US	2017/00149	CONGO DEMOCRATIC REPUBLIC OF	Réponse Rapide aux Mouvements de Population (RRMP)	€ 38,540,615.51	€ 4,000,000.00	CLOSED

ECHO/-AM/BUD/2018/91045	UNHCR-CH	2018/00880	PERU, ARUBA, BRAZIL, COLOMBIA, ECUADOR, TRINIDAD AND TOBAGO, VENEZUELA, NETHERLANDS ANTILLES, PANAMA	Emergency interventions to ensure provision of protection and life-saving humanitarian assistance to vulnerable populations affected by the crisis in Venezuela.	€ 21,625,101.00	€ 14,095,000.00	CLOSED
ECHO/-AF/BUD/2021/91019	NRC-NO	2021/00771	SOUTH SUDAN REPUBLIC	Integrated Emergency Preparedness and Response to address critical humanitarian needs in South Sudan	€ 5,555,555.56	€ 5,000,000.00	ONGOING
ECHO/-AF/BUD/2021/91002	WHO	2021/00214	SOUTH SUDAN REPUBLIC	Strengthening Public Health Surveillance and Response systems in South Sudan	€ 1,263,648.00	€ 1,000,000.00	ONGOING
ECHO/-AF/BUD/2020/91003	MEDAIR-DE	2020/00524	SOUTH SUDAN REPUBLIC	Emergency Response in South Sudan	€ 4,322,885.00	€ 1,500,000.00	CLOSED
ECHO/-AF/BUD/2020/91017	ALIMA-FR	2020/00309	SOUTH SUDAN REPUBLIC	Integrated multi-sectoral (Nutrition, Health and Protection) intervention for the most vulnerable population of Raja County, Western Bahr el Ghazal State, South Sudan	€ 1,465,000.00	€ 1,250,000.00	CLOSED
ECHO/-AF/BUD/2019/91020	ALIMA-FR	2019/00711	SOUTH SUDAN REPUBLIC	Capacity Strengthening for Rapid Response and Early Action for Viral Haemorrhagic Diseases in South Sudan	€ 1,529,678.00	€ 1,500,000.00	CLOSED

ECHO/-AF/BUD/2019/91008	ZOA-NL	2019/00660	SOUTH SUDAN REPUBLIC	Emergency Response in South Sudan	€ 3,750,000.00	€ 1,500,000.00	CLOSED
ECHO/-AF/BUD/2018/91044	WHO	2018/00914	SOUTH SUDAN REPUBLIC	Strengthening early detection, verification, investigation, identification and response to outbreaks to reduce excess morbidity and mortality due to infectious hazard events.	€ 2,624,778.20	€ 2,250,000.00	CLOSED
ECHO/-AF/EDF/2017/01020	UNICEF-US	2017/00828	SOUTH SUDAN REPUBLIC	UNICEF response to key emergency issues related to health and child protection in south Sudan	€ 9,747,067.78	€ 5,100,000.00	CLOSED
ECHO/-AF/EDF/2017/01026	WHO	2017/00624	SOUTH SUDAN REPUBLIC	Strengthening epidemic preparedness and response to reduce excess morbidity and mortality among the emergency affected populations of South Sudan	€ 1,397,145.00	€ 1,000,000.00	CLOSED
ECHO/SYR/BUD/2021/91062	WHO	2021/00403	SYRIAN ARAB REPUBLIC	Continuing the health humanitarian response in Syria through the provision of comprehensive package of health care services to the most vulnerable groups	€ 2,883,940.37	€ 2,500,000.00	ONGOING
ECHO/SYR/BUD/2021/91040	ACF-ES	2021/00139	SYRIAN ARAB REPUBLIC	Life-saving support and increased COVID emergency response for the most vulnerable people in northern Syria	€ 1,980,000.00	€ 1,800,000.00	ONGOING
ECHO/SYR/BUD/2020/91034	WHO	2020/00956	SYRIAN ARAB REPUBLIC	Strengthening COVID-19 preparedness and response in northwest Syria	€ 1,251,963.00	€ 1,000,000.00	ONGOING

ECHO/SYR/BUD/2019/91052	WHO	2019/00169	SYRIAN ARAB REPUBLIC	Strengthening essential health services in Syria, including for Covid-19 preparedness and response	€ 11,615,897.85	€ 9,000,000.00	ONGOING
ECHO/SYR/BUD/2017/91049	WHO	2018/00436	SYRIAN ARAB REPUBLIC	Strengthening Emergency and Essential Health Assistance Delivery in Syria	€ 12,651,484.00	€ 3,000,000.00	CLOSED
ECHO/SYR/BUD/2017/91034	IRC-UK	2017/00876	SYRIAN ARAB REPUBLIC	Multi-sectoral humanitarian response for conflict-affected populations in Syria	€ 7,814,417.00	€ 7,445,974.00	ONGOING
ECHO/SYR/BUD/2017/91047	WHO	2017/00867	SYRIAN ARAB REPUBLIC	Strengthening Emergency and Essential Health Assistance Delivery in Syria	€ 12,651,484.00	€ 3,000,000.00	CLOSED
ECHO/SYR/BUD/2018/91009	SI-FR	2018/00601	SYRIAN ARAB REPUBLIC	Provision of integrated, principled and flexible life-saving and sustaining humanitarian assistance for vulnerable populations in Syria.	€ 2,170,000.00	€ 2,000,000.00	CLOSED
ECHO/-AM/BUD/2021/91068	PAHO	2021/00670	VENEZUELA	Improving access to safe and quality essential health services to Venezuelans in situation of vulnerability	€ 2,740,000.00	€ 2,500,000.00	ONGOING
ECHO/-AM/BUD/2021/91067	MDM-ES	2021/00616	VENEZUELA	Contribute to the provision of integrated health, MHPSS and WASH services of the most vulnerable populations, including prevention of the spread of COVID-19, in Sucre State of Venezuela.	€ 2,200,000.00	€ 2,200,000.00	ONGOING

ECHO/DRF/BUD/2019/91034	PAHO	2020/00653	VENEZUELA	Response to the Yellow Fever Outbreak in Venezuela	€ 670,890.00	€ 600,000.00	ONGOING
ECHO/-AM/BUD/2020/91035	MDM-ES	2020/00570	VENEZUELA	Contribute to improve health and protection of the most vulnerable populations, including prevention of the spread of COVID-19, in various States of Venezuela.	€ 2,300,000.00	€ 2,300,000.00	ONGOING
ECHO/-AM/BUD/2019/91029	MDM-ES	2019/00495	VENEZUELA	Contribute to reduce the impact of the crisis of Venezuela health system, through the capacity building of the local health organizations serving the most vulnerable populations, plus the strengthening of the response capacity to health emergencies	€ 1,048,000.00	€ 1,048,000.00	CLOSED
ECHO/-AM/BUD/2021/91012	PUI-FR	2021/00512	VENEZUELA, COLOMBIA	Addressing the most urgent needs of populations affected by the Venezuelan crisis through a multi-sectoral integrated assistance, including COVID-19 programming	€ 2,800,000.00	€ 2,700,000.00	ONGOING
ECHO/-AM/BUD/2020/91029	AYUDA EN ACCION-ES	2020/00597	VENEZUELA, COLOMBIA, ECUADOR, PERU	Addressing relief and protection needs of vulnerable populations affected by the Venezuelan crisis and impacted/at risk of COVID-19 pandemic in a gender-responsive and disability inclusive way in urban and peri-urban areas in VENEZUELA and in transit and border areas of COLOMBIA, ECUADOR and PERU	€ 2,842,373.89	€ 2,500,000.00	ONGOING

ECHO/-AM/BUD/2018/91043	PAHO	2018/00879	VENEZUELA, COLOMBIA, ECUADOR, PERU	Strengthening the health sector's capacities to deal with active outbreaks and increased health needs in Venezuela and neighboring countries recipient of Venezuelan migrants	€ 5,424,550.00	€ 5,000,000.00	CLOSED
ECHO/DRF/BUD/2018/91012	CISP-IT	2018/00943	VENEZUELA, VENEZUELA, VENEZUELA	Emergency Humanitarian Aid for those families affected by Heavy Rains Floods in Apure, Táchira and Amazonas states.	€ 300,000.00	€ 300,000.00	CLOSED

Table 19: Sampling frame 2 (Actions selected for detailed review within selected countries) (n=23)

Agreement No.	Partner short name	Reference number	Country	Action title	Total Amount	EC Amount	Status
ECHO/-AS/BUD/2021/91025	FICR-CH	2021/01056	Access to essential health care and WASH in hard-to-reach areas of Afghanistan	AFGHANISTAN	€ 2,383,290	€ 1,500,000	ONGOING
ECHO/-AS/BUD/2021/91023	WHO	2021/01053	Providing trauma care, emergency primary healthcare and emergency nutrition services for populations in underserved and conflict affected areas of Afghanistan	AFGHANISTAN	€ 16,810,726	€ 14,000,000	ONGOING
ECHO/COD/BUD/2021/91011	UNICEF-US	2021/00695	Reduce the incidence and transmission of cholera through an integrated and evidence-based community approach in North Kivu, South Kivu and Tanganyika in the DRC	CONGO DEMOCRATIC REPUBLIC OF	€ 8,222,998	€ 3,500,000	ONGOING
ECHO/COD/BUD/2021/91025	WHO	2021/00683	Amelioration de l? offre des services et soins de santé de base aux populations affectées par la crise humanitaire et les épidémies dans les 4 provinces du Nord Kivu, Sud Kivu, Ituri et Tanganyika.	CONGO DEMOCRATIC REPUBLIC OF	€ 1,948,508	€ 1,550,000	ONGOING
ECHO/-AM/BUD/2021/91067	MDM-ES	2021/00616	Contribute to the provision of integrated health, MHPSS and WASH services of the most vulnerable populations, including prevention of the spread of COVID-19, in Sucre State of Venezuela.	VENEZUELA	€ 2,200,000	€ 2,200,000	ONGOING
ECHO/-AF/BUD/2021/91002	WHO	2021/00214	Strengthening Public Health Surveillance and Response systems in South Sudan	SOUTH SUDAN REPUBLIC	€ 1,263,648	€ 1,000,000	ONGOING
ECHO/SYR/BUD/2021/91040	ACF-ES	2021/00139	Life-saving support and increased COVID emergency response for the most vulnerable people in northern Syria	SYRIAN ARAB REPUBLIC	€ 1,980,000	€ 1,800,000	ONGOING

ECHO/SYR/BUD/2020/91034	WHO	2020/00956	Strengthening COVID-19 preparedness and response in northwest Syria	SYRIAN ARAB REPUBLIC	€ 1,251,963	€ 1,000,000	ONGOING
ECHO/COD/BUD/2020/91021	FICR-CH	2020/00903	Réponse à la pandémie de la COVID-19 en RDC, province de Kinshasa	CONGO DEMOCRATIC REPUBLIC OF	€ 1,571,393	€ 1,200,000	ONGOING
ECHO/DRF/BUD/2019/91034	PAHO	2020/00653	Response to the Yellow Fever Outbreak in Venezuela	VENEZUELA	€ 670,890	€ 600,000	ONGOING
ECHO/-AM/BUD/2020/91035	MDM-ES	2020/00570	Contribute to improve health and protection of the most vulnerable populations, including prevention of the spread of COVID-19, in various States of Venezuela.	VENEZUELA	€ 2,300,000	€ 2,300,000	ONGOING
ECHO/-AS/BUD/2020/91003	INTERSOS-IT	2020/00481	Provision of essential and quality services through an integrated protection, health and nutrition response for vulnerable conflict-affected population in Southern Afghanistan.	AFGHANISTAN	€ 1,242,381	€ 1,200,000	ONGOING
ECHO/-AS/BUD/2020/91005	IRC-DE	2020/00466	Integrated Emergency Protection and Health response in Kabul, Helmand, Badghis, Herat, Laghman, Khost, Nangarhar and Paktya provinces of Afghanistan	AFGHANISTAN	€ 2,578,127	€ 2,400,000	CLOSED
ECHO/COD/BUD/2019/91021	ZOA-NL	2019/00723	Emergency Response to the Ebola Outbreak in Eastern DRC	CONGO DEMOCRATIC REPUBLIC OF	€ 785,000	€ 785,000	CLOSED
ECHO/-AF/BUD/2019/91020	ALIMA-FR	2019/00711	Capacity Strengthening for Rapid Response and Early Action for Viral Haemorrhagic Diseases in South Sudan	SOUTH SUDAN REPUBLIC	€ 1,529,678	€ 1,500,000	CLOSED
ECHO/DRF/BUD/2019/91010	ALIMA-FR	2019/00680	Réponse à la flambée de rougeole dans la Zone de Santé (ZS) de Kalonda Ouest, Province du Kasaï	CONGO DEMOCRATIC REPUBLIC OF	€ 395,000	€ 395,000	CLOSED

ECHO/-AM/BUD/2019/91029	MDM-ES	2019/00495	Contribute to reduce the impact of the crisis of Venezuela health system, through the capacity building of the local health organizations serving the most vulnerable populations, plus the strengthening of the response capacity to health emergencies	VENEZUELA	€ 1,048,000	€ 1,048,000	CLOSED
ECHO/-AS/BUD/2019/91008	PUI-FR	2019/00446	Multi-sector lifesaving assistance to conflict and COVID-19 affected populations in Eastern Afghanistan	AFGHANISTAN	€ 4,200,000	€ 4,200,000	CLOSED
ECHO/SYR/BUD/2019/91052	WHO	2019/00169	Strengthening essential health services in Syria, including for Covid-19 preparedness and response	SYRIAN ARAB REPUBLIC	€ 11,615,898	€ 9,000,000	ONGOING
ECHO/-AM/BUD/2018/91043	PAHO	2018/00879	Strengthening the health sector's capacities to deal with active outbreaks and increased health needs in Venezuela and neighboring countries recipient of Venezuelan migrants	VENEZUELA, COLOMBIA, ECUADOR, PERU	€ 5,424,550	€ 5,000,000	CLOSED
ECHO/DRF/BUD/2018/91006	WHO	2018/00846	Rapid Response to the Ebola Virus Disease (EVD) Epidemic in the Democratic Republic of the Congo	CONGO DEMOCRATIC REPUBLIC OF, CONGO DEMOCRATIC REPUBLIC OF, CONGO DEMOCRATIC REPUBLIC OF	€ 6,921,262	€ 5,500,000	CLOSED
ECHO/-AS/BUD/2016/91049	WHO	2017/00606	Providing emergency primary health services and trauma care for people affected by conflicts, natural calamities and limited accessibility to health services	AFGHANISTAN	€ 5,893,088	€ 2,440,000	CLOSED

ECHO/-AS/BUD/2016/91047	PUI-FR	2017/00355	Preparedness and response to conflict-induced and natural disaster related medical emergencies in Afghanistan	AFGHANISTAN	€ 980,000	€ 980,000	CLOSED

Annexe 5 – WHE Work Area Aims and Activities

Table 20 WHE Work area aims and activities

Work Area	Aims	Example activities
Surveillance	• Disease surveillance data to: • serve as an early warning system for impending outbreaks that could become public health emergencies; • enable monitoring and evaluation of the impact of an intervention, helps track progress towards specified goals; and • monitor and clarify the epidemiology of health problems, guiding priority-setting and planning and evaluation of public health policy and strategies.	- Surveillance System of Attacks on Healthcare - Surveillance for specific diseases such as malaria and influenza - Monitoring & Evaluation (M&E) of IHR implementation - Global surveillance and monitoring of substandard and falsified medical products - EWARS box provision
Operations	• Promote best practice and standards for emergency operation centres and build Member States' capacity to rapidly respond and detect public health emergencies as mandated by the IHR • Monitors global public health events around the clock and facilitates international collaboration during public health emergencies	- Public Health Emergency Operations Centre Network and Strategic Health Operations Centre - Grading of public health events and emergencies - Supporting IHR implementation - National Action Plans for Health Security -WHO Humanitarian Response Plans - Simulation exercises - Emergency Response Reviews - Provision of disease commodity packages - Risk assessments

		- Risk communication - Provision of emergency health kits
Research	Quickly gather and share the best available knowledge and evidence on diseases, and on potential available countermeasures, in order to prevent and respond to catastrophic events like pandemics, natural disasters and the emergence, or re-emergence, of highly pathogenic diseases	- The Research & Development Blueprint - COVID-19 research database - International Clinical Trials Registry Platform - Health emergencies and disaster risk management (Health EDRM) Research
Training	Create a coherent, coordinated and high-quality approach and standards for learning to build WHO's health emergency workforce and surge capacity supported by partners.	- the OpenWHO online learning platform - the Health Security Learning Platform
Partnerships	Support countries to prepare for, detect and respond to health emergencies of all kinds, ranging from disease outbreaks to conflicts to natural disasters, through partnerships and networks	- Cluster coordination (see above) - Global Health Cluster - GOARN (see below) - Standby partnerships - Emergency Medical Teams and Mobile Clinics - Standby Partners Programme - Emerging Diseases Clinical Assessment and Response Network
Funding	WHO's emergency work is funded through a variety of streams including: the WHO Programme Budget, Humanitarian Response Plans, the United Nations Central Emergency Response Fund and a specific COVID-19 appeal. WHO has also established a "Contingency Fund for Emergencies" to enable a non-earmarked initial rapid response to an outbreak/emergency (ahead of mobilisation by donors)	

Annexe 5 – Focus Group Discussion (minutes)

Venezuela

FGD details

Table 21 FGD tables

Date	June 1st			
IP = Caritas	Country	Province/ state	District/ county	Town/suburb/village
Location	Venezuela	Sucre	Carupano	Caritas Headquarters
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women			
Approximate age range (e.g., 16-19; 55-75 etc)	25-34 years old			
# of participants	5 participants			
# of females	5 females			
# of males	0 males			

# with a disability	
Additional comments	1 pregnant woman

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Which is the donor of the project?	Knowledge of donor	They do not know who the donor is.
What do you know about infections?	Knowledge of infections	Infections are virus that grow in the human body, and there can be many different types.
Which diseases are most talked about in the community?	Knowledge of infections	COVID-19, HIV, Yellow Fever, Hepatitis.

How do you feel the involvement of other organisations in passing on information about diseases has been?	Knowledge of infections and organisation participation	There have been few healthdays performed by the MoH in the community.
What action should be taken if someone is affected by an infectious disease?	Knowledge of infections and case management	Discuss with your doctor to see what to do next. The most common action to do at home is administrate acetaminophen. You can take the person for blood tests, and not leave them sick for a long time.
What kind of new behaviours have they learned through staff from other organisations?	Behavior change and RCCE	Washing hands, use of facemasks, social distancing. They mention that there hasn't been any vaccine hesitancy. Caritas has resolved any doubts that they might have had.
How do you feel the involvement of people in communities to pass on	RCCE	They would like to know the donor, since the work that Caritas has performed is big and has impacted their lives.

disease knowledge could be improved?		
What is the level of trust that exists with external actors who come to the communities to give them new information about infections?	Impact of organisation	There is a high level of trust in the organisation. "I have a baby that was born with cleft palate. The doctors at the hospital did not notice this situation. But thanks to the help from Caritas, they have changed my baby's life. They were able to provide support to perform surgery on the baby, since he was already having malnutrition issues. Without their help, I wouldn't be able to tell this story".
Does this project go hand in hand with the realities in the country in terms of challenges?	Evaluation of vulnerabilities	The project has integrated and formed part of the community. They go to the schools and consider the problems at hand.
What has been the impact of the project?	Impact of Project	All the donations have been able to help prevent further cases.

What has been the perception of the communities since the arrival of the project?	Impact of the project	Thanks to Caritas, the community has been the change in children that were previously with malnutrition indexes and now can be found with a healthy weight.

Date	June 2nd			
IP =	Country	Province/ state	District/ county	Town/suburb/village
Location	Venezuela	Sucre	Carupano	San Martin
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women with children			
Approximate age range (e.g., 16-19; 55-75 etc)	7-39 years old			
# of participants	11 participants			
# of females	10 females			
# of males	1 male			

# with a disability	Three participants with arterial hypertension and diabetes mellitus.
Additional comments	one 7-year-old boy

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Which is the donor of the project?	Knowledge of donor	They do not know the donor.
What do you know about infections?	Knowledge of infections	They know about urine infections, respiratory infections, diarrhoea, strep throat, and skin infections.
Which diseases are most talked about in the community?	Knowledge of infections	COVID, throat infections, flu.

How do you feel the involvement of other organisations in passing on information about diseases has been?	Knowledge of infections and organisation participation	They have not had any informational talks. Some mention, that occasionally there might be a talk about COVID, but not about other infections. They often visit the different houses in the communities but have not gone to the schools.
What action should be taken if someone is affected by an infectious disease?	Knowledge of infections and case management	The use of face mask, isolation, social distancing, handwashing, and go to the doctor.
What kind of new behaviours have they learned through staff from other organisations?	Behavior change and RCCE	They do not feel there has been any change in behavior, just an increase in handwashing.
How do you feel the involvement of people in communities to pass on	RCCE	There are doctors in the community that they did not have access to before.

disease knowledge could be improved?		
What is the level of trust that exists with external actors who come to the communities to give them new information about infections?	Impact of organisation	There are good doctors, good service, and they care about the community.
Does this project go hand in hand with the realities in the country in terms of challenges?	Evaluation of vulnerabilities	
What has been the impact of the project?	Impact of Project	The community sees a positive change from the doctors, as well as the nutrition. Caritas has been helping everyone as much as they can, even providing help to attend a private doctor appointment.

What has been the perception of the communities since the arrival of the project?	Impact of the project	Pleasant, very greatful

Date	June 3rd			
IP =	Country	Province/ state	District/ county	Town/suburb/village
Location	Venezuela	Sucre	Carupano	Guarimar
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women and men			
Approximate age range (e.g., 16-19; 55-75 etc)	19-49 years old			
# of participants	13 participants			
# of females	10 females			
# of males	3 males			

# with a disability	
Additional comments	One pregnant woman

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Which is the donor of the project?	Knowledge of donor	They do not know the donor.
What do you know about infections?	Knowledge of infections	They are diseases that children often get, but adults can also get infected; like COVID-19, STDs.
Which diseases are most talked about in the community?	Knowledge of infections	Flu, UTI, diarrhoea, vomit, fever.

How do you feel the involvement of other organisations in passing on information about diseases has been?	Knowledge of infections and organisation participation	No involment
What action should be taken if someone is affected by an infectious disease?	Knowledge of infections and case management	They need to protect the community. However they do not know much of any measures necessary other than the need of going to the doctor.
What kind of new behaviours have they learned through staff from other organisations?	Behavior change and RCCE	With COVID-19 they learned about the need of isolation, the use of antibacterial, social distancing, handwashing, and the use of face masks.
How do you feel the involvement of people in communities to pass on	RCCE	The organisation has been able to include more members of the community, however they do not count with the enough human resources to cover all the needs of the community.

disease knowledge could be improved?		
What is the level of trust that exists with external actors who come to the communities to give them new information about infections?	Impact of organisation	People trust completely in the organisation since it is the only one that has reached this community.
Does this project go hand in hand with the realities in the country in terms of challenges?	Evaluation of vulnerabilities	They have evaluated the priorities and vulnerabilities of the community and addressed them accordingly.
What has been the impact of the project?	Impact of Project	There has been a change in the community, with all the treatment that the organisation has been able to provide, the members have improved.

What has been the perception of the communities since the arrival of the project?	Impact of the project	The members of the community are very receptive and happy with the collaboration from Caritas.

Date	June 3rd			
IP =	Country	Province/ state	District/ county	Town/suburb/village
Location	Venezuela	Sucre	Carupano	OIM Headquarters
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women			
Approximate age range (e.g., 16-19; 55-75 etc)	31-65 years old			
# of participants	13 participants			
# of females	11 females			
# of males	2 males			

# with a disability	2 participants with arterial hypertension, 1 with thyroid problems, 1 with a previous stroke.
Additional comments	1 pregnant woman

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Which is the donor of the project?	Knowledge of donor	They do not know the name of the donor; two participants recall that it was mentioned during the distribution of kits at the school.
What do you know about infections?	Knowledge of infections	The specifically know about COVID, which was discussed on that talk. Which is a disease that is transmitted from one person to another. It is a virus. It has spread globally, without any discrimination, causing many deaths. There is a need to be well protected, therefore the school principal asked for the distribution of kits at school for the children.
Which diseases are most talked about in the community?	Knowledge of infections	AHT, DM, Stroke, flu, diarrhoea, malnutrition.

How do you feel the involvement of other organisations in passing on information about diseases has been?	Knowledge of infections and organisation participation	They feel it was satisfactory.
What action should be taken if someone is affected by an infectious disease?	Knowledge of infections and case management	Isolation, staying at home, go to the doctor, and take the assigned treatment.
What kind of new behaviours have they learned through staff from other organisations?	Behavior change and RCCE	Use of antibacterial, other families have been applying different measures, the use of face masks.
How do you feel the involvement of people in communities to pass on	RCCE	Conduct more talks and workshops at a community level and schools. They believe that the distribution of aid in school is appropriate, and that the previous talks have been didactic.

disease knowledge could be improved?		
What is the level of trust that exists with external actors who come to the communities to give them new information about infections?	Impact of organisation	There has been a high level of trust in IOM in the past.
Does this project go hand in hand with the realities in the country in terms of challenges?	Evaluation of vulnerabilities	At that moment, it was what the community needed to be able to start school safely.
What has been the impact of the project?	Impact of Project	It was positive for all the children to receive the help at school.

What has been the perception of the communities since the arrival of the project?	Impact of the project	The community was excited to be considered.

Date	June 8th			
IP =	Country	Province/ state	District/ county	Town/suburb/village
Location	Venezuela	Distrito Capital	Caracas	Simon Rodriguez
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women and men			
Approximate age range (e.g., 16-19; 55-75 etc)	20-40 years old			
# of participants	8 participants			
# of females	7 females			
# of males	1 male			

# with a disability	
Additional comments	

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Which is the donor of the project?	Knowledge of donor	They do not know the name of the donor.
What do you know about infections?	Knowledge of infections	They are caused by virus, bacteria, and can be transmitted by water and different types of contamination.
Which diseases are most talked about in the community?	Knowledge of infections	COVID-19
How do you feel the involvement	Knowledge of infections and	It has been really good, they have performed many workshops, even one on First Aid.

of other organisations in passing on information about diseases has been?	organisation participation	
What action should be taken if someone is affected by an infectious disease?	Knowledge of infections and case management	When discussing Dengue and diarrhoea they isolate the patients and call the doctor. However, they remember the recipe for homemade oral rehydration solution in case of diarrhoea.
What kind of new behaviours have they learned through staff from other organisations?	Behavior change and RCCE	Disinfection of items when entering the house, correct use of face masks, correct handwashing technique, use of antibacterial, social distancing.
How do you feel the involvement of people in communities to pass on disease knowledge	RCCE	They would like more workshops, since they are very interested in learning.

could be improved?		
What is the level of trust that exists with external actors who come to the communities to give them new information about infections?	Impact of organisation	100%
Does this project go hand in hand with the realities in the country in terms of challenges?	Evaluation of vulnerabilities	They do align with the communities' priorities.
What has been the impact of the project?	Impact of Project	The community has changed, and now people support each other more.
What has been the perception of the communities	Impact of the project	People are ready to collaborate more.

since the arrival of the project?		

Date	June 8th			
IP =	Country	Province/ state	District/ county	Town/suburb/village
Location	Venezuela	Distrito Capital	Caracas	Simon Rodriguez
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women and men			
Approximate age range (e.g., 16-19; 55-75 etc)	60-98 years old			
# of participants	10 participants			
# of females	9 females			
# of males	1 male			
# with a disability	7 participants with arterial hypertension			
Additional comments				

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Which is the donor of the project?	Knowledge of donor	They do not know the name of the donor.
What do you know about infections?	Knowledge of infections	Infections can be acquired through any system, any type of contamination, for example, through water, open wounds, etc.
Which diseases are most talked about in the community?	Knowledge of infections	COVID-19, TB.
How do you feel the involvement of other organisations in passing on information	Knowledge of infections and organisation participation	They feel that they are the spoiled community by the RC. The organsation has trained members of the community to form a Health Brigade.

about diseases has been?		
What action should be taken if someone is affected by an infectious disease?	Knowledge of infections and case management	They do not know the measures for case managements, only traditional medicines passed by generations. They remember the recipe for homemade Oral Rehydration Solution explained by the RC in case of diarrhoea.
What kind of new behaviours have they learned through staff from other organisations?	Behavior change and RCCE	The correct handwashing technique, correct use of face masks, antibacterial, social distancing.
How do you feel the involvement of people in communities to pass on disease knowledge could be improved?	RCCE	They would like to have more workshops and informative talks.

What is the level of trust that exists with external actors who come to the communities to give them new information about infections?	Impact of organisation	They trust the RC more than any other organisation.
Does this project go hand in hand with the realities in the country in terms of challenges?	Evaluation of vulnerabilities	They feel that they go along with the priorities of the community, however, they must be more constant with their visits.
What has been the impact of the project?	Impact of Project	They have helped a lot, there is an increase of solidarity in the community.
What has been the perception of the communities since the	Impact of the project	They are very grateful with the work of the RC.

arrival of the project?		

Democratic Republic of Congo

Masina

FGD details

Date	Saturday , June 4th 2022			
	Country	Province/ state	District/ county	Town/suburb/village
Location	RDC	KINSHASA	MASINA 1/RDC	
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women and men			
Approximate age range (e.g., 16-19; 55-75 etc)	30-60 years old			
# of participants	8 Participants			
# of females	4 females			
# of males	4 males			

# with a disability	1 people with comorbilities
Additional comments	Les participants tirés parmi les membres de communauté engagés dans les activités de lutte contre la covid-19 avec l'appui de DG ECHO à travers Save the children.

Findings of FGD

Evaluation Question (e.g., Q2)	Judgement Criteria	Findings
Questions introductives	**1. Quelles sont les maladies dont on parle le plus dans la communauté ?**	- Choléra - Rougeole - Poliomyélite - Paludisme - Covid 19 - Fièvre typhoïde - Gastro entérite - Malnutrition - Varicelle - Toux - Engine - Diabète
	2. Quel a été l'impact de ces maladies dans communauté ?	- Souvent avec le paludisme, quand la prise ne charge n'est pas correcte, il y a l'anémie qui peut être fatale - La pauvreté qui cause l'automédication - Stress, dépassement - La tension - Divorce - Instabilité - Prostitution des jeunes filles - Délinquance juvénile - Manque de scolarisation -
	3. Quelle était la principale méthode de communication ?	- Dans la plupart de temps, nous faisons les visites à domicile - Les causeries éducatives - La sensibilisation de masse - Avec les canaux émetteurs dans les carrefours -
EQ2a. Dans quelle mesure les actions de la riposte au Covid-19 ont assuré la participation des bénéficiaires du début jusqu'à la fin des projets ?	4**. Comment est-ce que l'organisation, à travers son projet de réponse au Covid-19 a-t-il impliqué la communauté dans la planification des actions ?**	- Le partenaire était venu dans la ZS, avait demandé d'échanger avec le Médecin Chef de Zone de Santé, l'infirmier superviseur, l'animat€communautaire et le technicien d'assainissement, il a demandé les problèmes prioritaires que nous avions par rapport à la pandémie de la covid 19 et après ils ont dit qu'ils avaient besoin de rencontrer les communautaires, c'est là qu'on nous avait appelé ; raison pour laquelle nous sommes appelés « recos Save » Ils nous avaient demandé « vous les recos, comme vous êtes le pont entre la communauté et le CS, parlez-nous d'abord des rumeurs en rapport avec la covid 19 ?

		- Ils nous ont posé les questions sur les rumeurs qui couraient dans la communauté sur la pandémie de la covid 19 - Ils nous avaient demandé d'associer les chefs des rues, chefs de quartiers, les leaders communautaires - Ils nous avaient demandé « pour nous la communauté, une pandémie qui existe, que faudra-t-il faire pour protéger la communauté ? C'était une causerie éducative que Save avait faite qui avait réunis les chefs de rues, les chefs de quartiers, les leaders communautaires et les infirmiers de toutes les structures sanitaires qui sont dans les Aires de Santé - Et aussi, ils avaient dit que nous avions besoin de la formation
	5. Comment pensez-vous que cette participation/implication devrait être améliorée ?	- Dans les formations, Il faudra qu'il y ait de bons supports de formation - Les boites à images, les dépliants - Que Save appuis surtout les centres mères des aires de santé pour que la vaccination soit proche de la population afin qu'elle en bénéfice facilement - Que les sites de vaccinations soient dans tous les Centres de Santé et en permanence
	6. Dans quelle mesure la communauté a-t-elle participé à la mise en œuvre du projet ?	- Il y a les lave-mains dans chaque ménage, la communauté a su que c'est important de laver les mains à chaque moment, porter obligatoirement le cash nez, se promener avec son gel désinfectant - La communauté a commencé à réclamer d'elle-même la vaccination - Les personnes avec comorbidités se sont fait vacciner en masse vu que nous

		l€avions sensibilisé comment se protéger vu que l€immunité est devenue faible - La communauté a compris que le port de masque était important pour l€santé
	7. Comment pensez-vous que cette participation a contribué à l'atteinte des résultats du projet ?	- Diminution des cas de covid 19 dans la communauté ainsi que la diminution de la plupart des maladies des mais sales
	8**. Quel est le niveau de confiance des communautés bénéficiaires envers l'organisation qui a mis en œuvre les actions de la réponse au COVID ?**	- Save The Children a utilisé l'approche communautaire, il est venu dans les 12 aires de santé de Masina et a installé dans tous les Centres de Santé les sites de comorbidités pour que chaque cas suspect puisse être testé et avoir le traitement gratuitement, cela a beaucoup attiré la confiance de la communauté qui a compris que les Centres de Santé de Masina sont les centres de l'ONG et ils ont commencé à les fréquenter. - Save a aussi mis ses panneaux publicitaires, des laves- mains/citernes dans chaque carrefour ; la motivation des recos qui étaient aux points de lavage de mains. Save a aussi impliqué les APA (autorités politico administratives) - Avec l'approche communautaire que Save a utilisée, nous avons brisé les rumeurs car avant on disait si l'on reçoit le vaccin on deviendra le cochon, chien, le coq, on vend les cadavres de Covid - Par la sensibilisation que nous faisions, car nous avons approché la communauté par les visites à domicile, notre permanence et sensibilisation aux points de lavages des mains - Le fait que nous-mêmes, nous nous sommes fait vaccinés a augmenté le niveau de confiance de la communauté car nous avons prêché par l'exemple

EQ2b. Dans quelle mesure les actions de la riposte au cholera ont tenu compte des besoin et priorités des bénéficiaires ?	**9. Quelles ont été les priorités des communautés en période de Covid-19 ?**	- L'épargne était devenue une priorité pour beaucoup de foyers, les familles qui ne faisaient pas des provisions avaient commencé à le faire car elles ne savaient pas ce qui pouvait arriver lors du confinement - Les gens ne participaient plus dans les manifestations publiques - Les corps/ Cadavres n'arrivaient plus à domicile - La plupart d'hommes mariés ne sortaient plus pour aller dans les terrasses, la priorité était la vie de famille que d'aller dehors parc qu'ils ne connaissaient pas le lendemain - Le sexe était devenu une priorité car il y n'avait plus d'autres distractions et il y avait eu beaucoup des naissances après.
	10**. Ce projet cadrait-il avec les réalités des communautés en termes de besoins et priorités ?**	- Oui parce que le projet avait d'abord contacté la communauté avant - Pas tellement parce que la communauté s'attendait aussi qu'on l€donne l'argent pour les soutenir comme dans les autres pays étrangers
	11. Comment le projet a-t-il été adapté aux besoins prioritaires des communautés pendant sa mise en œuvre afin de continuer à bénéficier aux groupes bénéficiaires ?	- Au début le projet mettait les citernes d'eau sans savon mais après avoir remarqué la pauvreté de la communauté, ils ont mis les savons et les gels désinfectants partout où il y avait des lave-mains
	12. Quelle a été la perception des communautés tout au long du projet ?	- Au début du projet, lors que nous sensibilisions, les membres de la communauté hésitaient, ils acceptaient le message mais n'arrivaient pas à le manifester. Peu à peu ils ont commencé à changer d'attitude parce que les acteurs de mis en œuvre du projet ont prêché eux-mêmes par l'exemple
QE6 : Quels résultats ont été obtenus par la réponse aux	13. Depuis la mise en œuvre des activités de réponses au Covid-19 par SCI, qu'est-ce qui a changé dans votre communauté ?	- L'assainissement du milieu s'est amélioré - La pratique de lavage des mains est devenue obligatoire sans que personne ne fasse le rappel même pour les petits enfants

épidémies de la DG ECHO ?		- Le fait que le projet avait disponibilisé les laves plus savons, une fois qu'une personne se lavait les mains, les autres se voyaient être attiraient et se lavaient à l€tour même s'ils n'avaient pas envie de se laver les mains
	14. Qui sont les personnes qui ont le plus bénéficié dans la communauté ?	- Les personnes avec comorbidités, les PVVIH, les tuberculeux - En général les personnes âgées - Les leaders d'opinions qui étaient formés par exemples les *kuluna* (bandits urbains)
	15. Quel a été le niveau de transmission et de compréhension des connaissances transmises par le personnel du projet ?	- Très bien, ils avaient la compétence, l€niveau était supéri€car ils nous ont transmis la matière pour laquelle nous étions des ignorants - Comme l'autre Dr là que nous avions envié, il a dispensé la matière sans support du début à la fin et l'auditoire était très active
	16. Quel genre de nouveaux comportements avez-vous appris grâce au personnel de l'organisation ?	- La distanciation sociale - La gestion des déchets - L'hygiène de lavage des mains, hygiène corporelle - Avant, je buvais dans le même verre avec mes camarades mais depuis que le projet est arrivé, je bois seul dans mon verre - Le port obligatoire des masques - Avant, on faisait les accolades, on se saluait en se serrant la main, mais depuis que le projet est venu, ce comportement n'existe plus - Depuis que nous avons été formés par Save, même si je dois prendre le déjeuner à la maison ou boire de l'eau, j'ai un gobelet à moi seul, mon mari a le sien - Avant, je ne savais qu'à la maison, je pouvais avoir le lave-mains et que les gens l'utilisaient pour laver les mains mais pour le moment s'il n'y a pas le lave mains donc, il n'y a pas moyen
	17. Comment est-ce que ce changement a impacté votre communauté ?	- A partit de ce changement, la communauté a compris que si une personne est malade, elle doit aller à l'hôpital, la fréquentation et le taux d'utilisation de service ont augmenté

		- Avant les gens craignaient d'aller à l'hôpital s'ils ont la toux par crainte d'être dépisté comme ayant la covid alors qu'ils étouffaient la toux de la tuberculose
	18. A part save the Children, qu'elle est l'implication des autres organisations dans la transmission d'informations et connaissances sur les maladies dans la communauté ?	- Il y a eu aussi SANRU et la Croix-Rouge qui ont aussi beaucoup contribué pendant cette période là
[expand this form, as needed]		

Ndjili

FGD details

Date	Wednesday, June 8th 2022			
	Country	Province/ state	District/ county	Town/suburb/village
Location	RDC	KINSHASA	NDJILI/RDC	QUARTIER 3/NDJILI
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Women and men			
Approximate age range (e.g., 16-19; 55-75 etc)	30-60 years old			
# of participants	9 participants			
# of females	4 females			
# of males	5 males			
# with a disability	2 peoples with comorbilities			
Additional comments	Les participants tirés parmi les membres de communauté engagés dans les activités de lutte contre la covid-19 avec l'appui de DG ECHO à travers Save the children.			

Findings of FGD

Evaluation Question (e.g., Q2)	Judgement Criteria	Findings
Questions introductives	**3. Quelles sont les maladies dont on parle le plus dans la communauté ?**	▪ Covid 19 ▪ Fièvre, grippe, diarrhée ▪ Paludisme ▪ Fièvre typhoïde ▪ Rougeole ▪ Tuberculose, VIH, Diabète ▪ Hypertension
	4. Quel a été l'impact de ces maladies dans communauté ?	▪ L'hypertension amène souvent à l'AVC (les paralysies) certaines personnes qui ont fait l'AVC nous les vaccinons à la maison car elles ne savent se déplacer ▪ La pauvreté ▪ Souvent avec le paludisme, on peut acheter même 5 cures de médicaments mais la personne ne guéris pas, ça perturbe l'économie financière du foyer ▪ Toutes ces maladies citées ci haut apportent la pauvreté car on arrive à dépenser l'épargne qui était fait pour autre chose sur la maladie et certaines personnes vont même jusqu'aller s'endetter ▪ Certaines femmes/filles arrivent à se prostituer pour avoir l'argent des soins médicaux d'un membre de la famille ▪ Une personne qui travaillait et devient paralysée à cause de l'hypertension, ses enfants qui étudiaient ne vont plus étudier ▪ Les enfants ne mangent plus bien, ce qui amène la malnutrition ▪ La mendicité ▪ Le divorce
	3. Quelle était la principale méthode de communication ?	▪ Les visites à domiciles, chaque reco a un nombre bien déterminé des ménages dans lesquels il doit sensibiliser, ▪ La sensibilisation de masse

		▪ Les trois radios communautaires des marchés des quartiers 2, 6 et 7
EQ2a. Dans quelle mesure les actions de la riposte au Covid-19 ont assuré la participation des	4**. Comment est-ce que l'organisation, à travers son projet de réponse au Covid-19 a-t-il impliqué la communauté dans la planification des actions ?**	- Avant les membres du projet venaient nous poser certaines questions telles que vous êtes venus le faire : Quelle maladie est en cours actuellement ? Pour ceux qui suivent les traitements, ces derniers sont-ils chers ? - Avant Save était venu pour appuyer les enfants, nous, membres de la communauté avions présenté nos doléances surtout en ce qui concerne Covid, Save avait entendu et après il a réagi - Ils étaient venus faire le diagnostic communautaire et nous l€avons dit que vu que vous êtes venus pour les enfants et maintenant que Covid est là, nous cherchons à savoir comment les gens peuvent vivre en famille, comment se protéger ? Donnez-nous les moyens, si vous pouvez nous former afin qu'on apprenne un plus de cette maladie en question. Et nous on pensait qu'ils étaient partis pour du bon mais nous les avons vus revenir avec le projet - Le partenaire était venu dans tous les Centres de Santé rencontrer les représentants de la communauté, il nous avait dit de ne pas seulement prendre les recos mais toutes les couches sociales pour échanger avec eux, nous avions donné les idées avec lesquelles ils étaient partis. On ne savait même pas qu'il préparait ce projet là
	5. Comment pensez-vous que cette participation/implication devrait être améliorée ?	- Que Save The Children améliore ce qu'il a donné toujours comme motivation aux recos car sur terrain nous rencontrons beaucoup des difficultés, au départ ce n'était pas facile pour que la communauté prenne les vaccins, les cas de résistance lors de la sensibilisation comme dans ce marché pirate là où on vend les mitrailles il y a beaucoup des risques avec les couches des voyous qui sont là-bas,

bénéficiaires du début jusqu'à la fin des projets?		heureusement comme je suis le chef de rue, raison pour laquelle je n'avais connu aucun incident - Impliquer de beaucoup des gens sur terrain car, seule ou à deux, nous ne pouvons pas sensibiliser dans 18 rues de l'aire de santé, donc il faudra impliquer toutes les couches de la population dans la sensibilisation, tous les chefs de rues, les présidents des CEV des catholiques….Il y a eu peu des gens formés rendant difficile l'atteinte de toute la population par le message - Avant la mise en œuvre, j'aurais suggèré qu'ils reviennent vers nous pour voir si nous n'aurons pas encore autre à ajouter sur ce qu'ils auront déjà retenu
	6. **Dans quelle mesure la communauté a-t-elle participé à la mise en œuvre du projet ?**	- La communauté à travers ses leaders a petit à petit commencé à s'approprier la lutte anti-covid quand beaucoup de gens commençaient à tomber malade - Il y eu aussi des volontaires qui ont commencé à sensibiliser les autres personnes - Les radios communautaires avaient laissé beaucoup d'espace pour la sensibilisation ant)covid
	7. Comment pensez-vous que cette participation a contribué à l'atteinte des résultats du projet ?	- Diminution des cas de Covid 19 - Quand le partenaire était venu, nous étions avec toutes les Autorités Politico-Administratives des aires de santé, nous l€avions demandé de payer et d'installer les points de lavage des mains dans les lieux publics pour que lorsque la population lave régulièrement les mains le taux de covid 19 puisse baisser

		- Nous l€avons demandé de doter les points de lavage des mains en savons pour le lavage correct des mains car la population est pauvre, ils en avaient tenu compte
	8. Quel est le niveau de confiance des communautés bénéficiaires envers l'organisation qui a mis en œuvre les actions de la réponse au COVID ?	- Au début la communauté doutait, disait de laisser ces histoires, les blancs nous mentent, la maladie n'existe pas vraiment ici au Congo mais au fur et à mesure nous l€expliquions et sensibilisons dans quelles mesures elle pouvait vivre les uns avec les autres, directement j'ai vu qu'il y a eu un changement de mentalité, la population a commencé à comprendre que la maladie existe et que nous devons nous protéger pour ne pas être contaminé, pour qu'elle finisse ici chez nous, nous devons nous protéger - L'appropriation par les acteurs de mise en œuvre du projet Save the Children - Ils l€avaient donné certains savons et cela avait beaucoup marqué la communauté ; ainsi elle demandait : « maman, les gens-là qui nous avaient donné les savons ne vont-ils plus revenir ? Donc le fait que l'organisation menait déjà d'autres actions i bénéfiques pour la communauté, quand elle a entendu que c'était Save The Children
	9. Quelles ont été les priorités des communautés en période de Covid-19 ?	- Le respect des gestes barrières - Covid a amené la pauvreté, sortir de la maison est devenu difficile. L€priorité était d'avoir un peu d'argent en mains - L'épargne était devenue une priorité pour beaucoup de foyers, les familles qui ne faisaient des provisions avaient commencé à le faire car elle ne savait pas ce qui pouvait arriver lors du confinement - Les gens ne participaient plus dans les manifestations publiques - Les corps/ Cadavres n'arrivaient plus à domicile

EQ2b. Dans quelle mesure les actions de la riposte au cholera ont tenu compte des besoin et priorités des bénéficiaires ?		- La plupart d'hommes mariés ne sortaient plus pour aller dans les terrasses, la priorité était la vie de famille que d'aller dehors parc qu'ils ne connaissaient pas le lendemain - Le sexe était devenu une priorité car il y n'avait plus d'autres distractions et il y avait eu beaucoup des naissances après.
	10. Ce projet cadrait-il avec les réalités des communautés en termes de besoins et priorités ?	- Le projet n'avait pas tellement cadré avec les priorités de la communauté - Oui, le projet avait adapté sa façon de faire en fonction des besoins prioritaires de la communauté
	11. Comment le projet a-t-il été adapté aux besoins prioritaires des communautés pendant sa mise en œuvre afin de continuer à bénéficier aux groupes bénéficiaires ?	- L a dotation des savons aux points de lavage des mains - La sensibilisation au niveau des carrefours (marchés ; arrêts des bus) pour atteindre plus des gens - Focus sur les personnes âgées
	12. Quelle a été la perception des communautés tout au long du projet ?	- Pour certaines personnes c'était un projet pour exterminer la race noire par la vaccination avec l€maladie imaginaire - Pour d'autres c'était un projet salutaire pour sauver des vies comme ils connaissaient déjà les actions de Save the children par le passé.
	13. Depuis la mise en œuvre des activités de réponses au Covid-19 par SCI, qu'est-ce qui a changé dans votre communauté ?	- Les bonnes pratiques : respect des gestes barrières à la covid 19, le Lavage régulier des mains, port obligatoire du masque - La demande accrue des vaccins par la communauté - Les laves mains sont aujourd'hui dans presque tous les foyers et restaurants
	14. Qui sont les personnes qui ont le plus bénéficié dans la communauté ?	- Les personnes avec les comorbidités - Les personnes âgées

QE6 : Quels résultats ont été obtenus par la réponse aux épidémies de la DG ECHO ?	**15. Quel a été le niveau de transmission et de compréhension des connaissances transmises par le personnel du projet ?**	- L€niveau était très haut, nous avons appris beaucoup des choses venant d'eux avec une participation active
	16. Quel genre de nouveaux comportements avez-vous appris grâce au personnel de l'organisation ?	- Nous sommes devenus les miroirs de la communauté par notre comportement par exemple par le port des cash nez, - Respect des gestes barrières : lavage régulier des mains, pas se serrer les mains en se saluant, tousser dans le coude
	17. Comment est-ce que ce changement a impacté votre communauté ?	- Diminution des cas de covid - La communauté a pris conscience - A partir du lavage des mains pour la lutte contre la covid, certaines maladies des mains sales ont également diminué telle que la diarrhée et la fièvre typhoïde car la communauté se lave fréquemment les mains - Par le port obligatoire des masques, les cas de sinusite et asthme ont diminué
[expand this form, as needed]		

Goma

FGD record form : Group 1

Date	Le 04 juin 2022			
	Country	Province/ state	District/ county	Town/suburb/village
Location	République Démocratique du Congo	Nord-Kivu		Goma, ZS de Nyiragongo, AS de Kiziba
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Hommes, femmes et jeunes membres des cellules d'animation communautaires de l'AS de Kiziba			

Approximate age range (e.g., 16-19; 55-75 etc)	27 – 45 ans
# of participants	10 participants
# of females	6 femmes
# of males	4 hommes
# with a disability	RAS
Additional comments	Participation du président du comité de santé de l'AS Kiziba.

Findings of FGD

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Q1. Quelles sont les maladies dont on parle le plus dans la communauté ?	RAS	La communauté parle plus de la malaria, le choléra, la covid-19, la rougeole, la malnutrition et la typhoïde.
Q2. Quel a été l'impact de ces maladies dans la communauté ?	RAS	Décès suite au choléra lorsque les malades trainaient à la maison. Dans les structures privées, les soins étaient payants et les familles à faibles moyens financiers étaient affectées. Le manque d'intrants sanitaires dans les structures augmentait le risque de décès, ce qui augmentait le stress des familles touchées. Certaines familles décidaient de déménager lorsqu'il y avait des cas dans l€entourage, ce qui affectait psychologiquement les familles touchées par le choléra. Les rumeurs sur Covid-19 plongeaient les gens dans la p€d'aller à l'hôpital ; ils se cachaient, ce qui alourdissait la chaine de transmission.
Q3. Quelle était la principale méthode de communication	RAS	Des sensibilisations porte-à-porte, des sensibilisations de masse, des causeries éducatives, des jeux-concours, des caravanes et des sensibilisation médiatiques. Le message de sensibilisation portait sur l'hygiène des mains, l'hygiène alimentaire et l'assainissement (gestion des déchets), traitement et conservation de l'eau. Les jeux-concours intéressaient toutes catégories de personnes : enfants, jeunes et vieux participaient. Les CAC faisaient aussi le contrôle de la propreté des parcelles et faisaient des démonstrations sur la gestion des déchets.

EQ2a : Dans quelle mesure les actions de la riposte au choléra ont-elles assuré la participation des bénéficiaires du début jusqu'à la fin ?	2.1 Needs assessments made efforts to identify the most vulnerable individuals or households within the wider affected populations 2.2. Response plans demonstrated a 'do no harm' approach and were sensitive to cultural factors 2.3 Project implementation involved - and demonstrated accountability to - the affected populations	
Q4. Comment est-ce que l'organisation, à travers son projet de réponse au choléra, a-t-il impliqué la communauté dans la planification des actions ?		L'organisation avait utilisé une approche participative mettant les membres de la communauté au centre de la planification à travers les CAC. Bien qu'ayant impliqué seulement 50% de membres des CAC, ce qui a empêché de toucher toute la population de la zone par les activités, l'organisation n'imposait rien. **Quote :** Les CAC participaient à la préparation et donnaient le programme de mise en œuvre. Ils pouvaient influencer la planification. **Note :** Pas d'implication du comité de santé de l'AS Kiziba dans les actions du projet, ce que les participants qualifient d'une err€car ce comité est un act€clé de la santé.
Q5. Comment pensez-vous que cette participation pourrait être améliorée ?		Impliquer le comité de santé et tous les membres des CAC pour plus d'impact. Prévoir une durée raisonnable de mise en œuvre des activités CREC pour toucher tous les membres de la communauté. L'approche utilisée devrait tenir compte de la participation de tous les membres de toutes les CAC afin de toucher toue la population et d'augmenter ainsi l'impact du projet. Note : le projet n'a duré que 2 mois, une durée qui n'a pas permis d'atteindre toute la population de l'AS de Kiziba vu sa grandeur.
Q6. Dans quelle mesure la communauté a-t-elle participé à la mise en œuvre du projet ?		A Kiziba, les CAC et la population étaient au centre de la réalisation ; ECODEDU faisait seulement la supervision. **Quote** : la population appréciait beaucoup la méthodologie participative et chacun voulait pratiquer en public les enseignements reçus. Les enfants et les vieux participaient aussi, ce qui créait une belle ambiance. Les membres des CAC étaient toujours préparés à l'avance et toutes les activités étaient réalisées par eux et les exercices pratiques étaient faits par les participants aux activités.
Q7. Comment pensez-vous que cette participation a		C'est grâce à la participation des CAC que le projet a eu des bons résultats ; ils connaissent mieux leurs communautés car ils en sont membres. Ils connaissent les moments opportuns et les endroits

contribué à l'atteinte des résultats du projet ?		appropriés pour réaliser les activités mais aussi les personnes les plus concernées par tel ou tel autre message de sensibilisation. Ce sont les CAC qui connaissaient les parties de la zone les plus touchées par l'épidémie de choléra. Ils ont l'acceptance de la communauté et la facilité de faire passer des messages liés à la santé car l€rôle est bien connu dans la communauté.
Q8. Quel est le niveau de confiance des communautés bénéficiaires envers l'organisation qui a mis en œuvre les actions de réponse au choléra ?		A Kiziba, la communauté reconnait les efforts de l'organisation dans la réponse au choléra ainsi que les résultats obtenus grâce à ses actions. Elle reconnait qu'ECODEDU lui a appris l'auto prise en charge en termes de prévention. Ils ont beaucoup confiance envers l'organisation, bien que pour eux, le projet aurait dû être mis en œuvre pendant plus de 2 mois car ils avaient beaucoup d'intérêt dans le message apporté par l'organisation. Pour eux, le projet devrait revenir avec une durée plus longue.
EQ8. To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?	8.1. EU-funded actions in response to epidemics were timely, demonstrating an appropriate balance between speed and quality of design 8.2. EU-funded actions in response to epidemics were flexible enough to enable appropriate adaptation at field level	
Q9. Quels ont été les priorités des communautés en période de choléra ?		Dans toute la ZS de Nyiragongo, les besoins prioritaires étaient : - La sensibilisation (communication pour le changement de comportement) en matière d'eau, hygiène et assainissement ; - Le renforcement des capacités des CAC (RECO) pour assurer cette communication ; - Des soins gratuits pour limiter les cas de décès ; et - L'eau.
Q10. Le projet cadrait-il avec les réalités des communautés en termes de priorités ?		Pour les répondants, le fait pour le projet de répondre aux besoins prioritaires des communautés en période de choléra veut dire qu'il cadrait bien avec les réalités de la zone. Les bénéficiaires ont acquis des connaissances sur la prévention et le changement de comportement en termes d'hygiène, ce qui a permis de maitriser l'épidémie.
Q11. Comment le projet a-t-il été adapté aux besoins prioritaires des communautés pendant sa mise en œuvre afin de continuer à bénéficier aux		Pour assurer que la communauté continue à bénéficier du projet, l'organisation avait utilisé la stratégie de transmission des connaissances en assurant la formation des CAC et la dotation des matériels de sensibilisation. Cette stratégie produit des résultats positifs jusqu'à maintenant. Dans toutes les AS, les bénéficiaires continuent à appliquer les connaissances transmises. Les participants affirment qu'ECODEDU avait assuré l'appropriation du projet par les CAC en les mettant au centre de la mise en œuvre. Ils

groupes bénéficiaires ?		soulignent qu'aujourd'hui ils continuent les sensibilisations dans l€communauté, bien que pas avec la même force que pendant le projet.
Q12. Quelle a été la perception des communautés tout au long du projet ?		Les communautés étaient très intéressées par le projet ; ils reconnaissaient que le projet l€avait tiré de l'ignorance et réclamaient la poursuite des activités. La stratégie était très appréciée par la communauté. Les bénéficiaires reconnaissent que c'est grâce aux actions du projet que les cas de choléra ont sensiblement baissé.
QE6. Quels résultats ont été obtenus par la réponse aux épidémies de la DG ECHO ?	6.1. DG ECHO-funded actions and advocacy in response to epidemics mitigated the spread and impact of those epidemics 6.2. Unintended negative consequences of DG ECHO-funded actions were minimal and effectively mitigated when identified	
Q13. Depuis la mise en œuvre des activités de réponse au choléra par l'organisation, qu'est-ce qui a changé dans votre communauté ?		Les cas de contamination ont sensiblement baissé grâce aux sensibilisations. Aujourd'hui on finit même deux semaines sans nouveau cas de choléra car la population connait et pratique désormais le traitement de l'eau et le lavage des récipients mais aussi l€environnement est propre. Même les vendeurs de l'eau refusent de vendre à un client qui a un bidon sale. Les bénéficiaires se lavent régulièrement les mains et savent préparer le SRO pour éviter la déshydratation du malade avant d'arriver au CS. Des ménages qui n'avaient pas de toilettes s'assurent d'en avoir depuis les sensibilisations. Les enfants ne consomment plus de nourriture froide qui les exposait aux microbes.
Q14. Quelles sont les personnes qui ont le plus bénéficié dans la communauté ?		- Les enfants de 0 à 5 ans qui étaient plus vulnérables et ne pouvaient rien faire d'eux-mêmes mais ont subi des résultats directs à travers les enseignements reçus par les parents - Les mères des enfants qui ont reçu directement les messages de sensibilisation - Les femmes enceintes et les femmes allaitantes car elles ont reçu plusieurs enseignements lors des CPN et CPS
Q15. Quel a été le niveau de transmission et de compréhension des connaissances transmises par le personnel du projet ?		Dans l'AS Kiziba, Le niveau de compréhension des messages par les CAC était élevé, bien que les enseignements n'entraient pas en profond€des sujets. Au niveau communautaire, ils ont transmis totalement les connaissances acquises et le message était bien compris car les participants pratiquaient exactement les connaissances reçues.
Q16. Quel genre de nouveau comportement avez-vous appris		A Kiziba, les CAC ont acquis la culture de la sensibilisation. Aujourd'hui ils sensibilisent où qu'ils soient et dès qu'ils se retrouvent avec 5 personnes ou plus. Ils ont compris que le message de prévention du choléra peut être donné partout et à tout moment. Le sens de responsabilité transmis par l'organisation a fait que les CAC s'approprient le projet. Aujourd'hui ils promeuvent les pratiques

grâce au personnel de l'organisation ?		familiales essentielles dans leurs familles. La communauté a pris l'habitude de traiter de l'eau et d'assainir les parcelles.
Q17. Comment est-ce que ce changement a impacté votre communauté ?		Aujourd'hui les cas de choléra sont sensiblement réduits grâce aux nouveaux comportements adoptés depuis le projet. Même les autres maladies des mains telles que la diarrhée ne sont plus aussi fréquentes qu'avant et les familles ont repris le cours normal de leurs vies. Les cas de décès dû aux maladies des mains sales sont réduits.
[expand this form, as needed]		

FGD record form : Group 2

Date	Le 06 juin 2022			
	Country	Province/ state	District/ county	Town/suburb/village
Location	République démocratique du Congo	Nord-Kivu		Goma, ZS de Nyiragongo, AS Kiziba
Characteristic of Group (e.g., women, elderly, displaced persons etc)	Hommes, femmes et jeunes membres des cellules d'animation communautaires des AS Kibati et Rusayo			
Approximate age range (e.g., 16-19; 55-75 etc)	27 – 50 ans			
# of participants	10 participants			
# of females	4 femmes			
# of males	6 hommes			
# with a disability	RAS			
Additional comments	Participation des présidents des comités de santé des AS Kibati et Rusayo			

Findings of FGD

Evaluation Question (e.g., Q2)	**Judgement Criteria (e.g., 2.2)**	**Findings** [Aim to describe the group's response to the question in less than 100 words. Indicate the majority view, but also any significant minority

		viewpoints. Try also to record any good 'quotes' by individuals that seem to capture people's feelings]
Q1. Quelles sont les maladies dont on parle le plus dans la communauté ?	RAS	A Kibati et Rusayo, la communauté parle plus de la diarrhée, la malaria, le choléra, la covid-19, la rougeole, la malnutrition la typhoïde, la toux et la tuberculose.
Q2. Quel a été l'impact de ces maladies dans la communauté ?	RAS	Décès suite au choléra lorsque les malades trainaient à la maison. Le manque des moyens financiers augmentait le risque de décès. La stigmatisation des malades. Les rumeurs sur Covid-19 plongeaient les gens dans la p€d'aller à l'hôpital ; ils se cachaient, ce qui alourdissait la chaine de transmission.
Q3. Quelle était la principale méthode de communication	RAS	Des sensibilisations porte-à-porte, des sensibilisations de masse, des causeries éducatives, des débats communautaires, des jeux-concours focalisées sur la prévention et l'élimination de la maladie de choléra à travers des mesures d'hygiène. Le message de sensibilisation portait sur l'hygiène des mains, l'hygiène alimentaire et l'assainissement (gestion des déchets), traitement et conservation de l'eau. **Quote :** des sensibilisations avaient été organisées dans le camp de sinistrés du volcan car il y avait beaucoup de cas de choléra. Les jeux-concours intéressaient toutes catégories de personnes : enfants, jeunes et vieux participaient. Les CAC faisaient aussi le contrôle de la propreté des parcelles et faisaient des démonstrations sur la gestion des déchets.
EQ2a : Dans quelle mesure les actions de la riposte au choléra ont-elles assuré la participation des bénéficiaires du début jusqu'à la fin ?	2.1 Needs assessments made efforts to identify the most vulnerable individuals or households within the wider affected populations 2.2. Response plans demonstrated a 'do no harm' approach and were sensitive to cultural factors 2.3 Project implementation involved - and demonstrated	
Q4. Comment est-ce que l'organisation, à travers son projet de réponse au choléra, a-t-il impliqué la communauté dans la planification des actions ?		A Kibati, l'organisation avait utilisé une approche concentrée sur la mise en œuvre, avec peu de participation de la communauté dans la planification des activités mais également peu de supervision de la part de l'organisation. Cette stratégie s'est avérée moins intéressante pour la communauté.
Q5. Comment pensez-vous que cette participation		La communauté pense que la planification devrait commencer à travers le comité de santé, avec une bonne stratégie de supervision. Pour eux, il

pourrait être améliorée ?	accountability to - the affected populations	serait mieux dans l'avenir de travailler sur base d'un plan d'activité qui devrait être mis à la disposition des CAC dès le début du projet.
Q6. Dans quelle mesure la communauté a-t-elle participé à la mise en œuvre du projet ?		Bien que brutalisés pour la réalisation des activités, les CAC étaient quand-même les acteurs principaux de la mise en œuvre des activités sur terrain. Ils signalent que certains d'entre eux pouvaient pas participer à la réalisation car ils étaient dans leurs activités au moment de la réalisation.
Q7. Comment pensez-vous que cette participation a contribué à l'atteinte des résultats du projet ?		Dans le camp des sinistrés du volcan Nyiragongo, la participation des CAC avait beaucoup aidé à éradiquer le choléra. C'est grâce à la participation des CAC que le projet a eu des bons résultats ; ils connaissent mieux leurs communautés car ils en sont membres. Ils connaissent les moments opportuns et les endroits appropriés pour réaliser les activités mais aussi les personnes les plus concernées par tel ou tel autre message de sensibilisation. Ce sont les CAC qui connaissaient les parties de la zone les plus touchées par l'épidémie de choléra. Ils ont l'acceptance de la communauté et la facilité de faire passer des messages liés à la santé car l€rôle est bien connu dans la communauté.
Q8. Quel est le niveau de confiance des communautés bénéficiaires envers l'organisation qui a mis en œuvre les actions de réponse au choléra ?		La communauté fait confiance à l'organisation car elle reconnait son apport dans l'éradication de l'épidémie de choléra. Les CAC eux n'ont pas confiance car pour eux, l'organisation était négligente et manquait d'expérience de travail avec la communauté : des activités brusquées, faible supervision et très courte période du projet. Pour eux, les activités n'ont durée qu'1 mois.
EQ8. To what extent were DG ECHO's interventions in response to epidemics timely and flexible, thereby allowing partners to have adapted responses?	8.1. EU-funded actions in response to epidemics were timely, demonstrating an appropriate balance between speed and quality of design 8.2. EU-funded actions in response to epidemics were flexible enough to enable appropriate adaptation at field level	
Q9. Quels ont été les priorités des communautés en période de choléra ?		Dans toute la ZS de Nyiragongo, les besoins prioritaires étaient : - La sensibilisation (communication pour le changement de comportement) en matière d'eau, hygiène et assainissement ; - Le renforcement des capacités des CAC (RECO) pour assurer cette communication ; - Des soins gratuits pour limiter les cas de décès ; et - L'eau.
Q10. Le projet cadrait-il avec les réalités des		Pour les répondants, le fait pour le projet de répondre aux besoins prioritaires des communautés en période de choléra veut dire qu'il cadrait bien avec les réalités de la zone. « Dans le camp des sinistrés du

communautés en termes de priorités ?		volcan à Kibati par exemple, il y avait beaucoup de cas de choléra et grâce à la sensibilisation nous avons pu couper la chaine de transmission », déclare le président du comité de santé de l'AS Kibati.
Q11. Comment le projet a-t-il été adapté aux besoins prioritaires des communautés pendant sa mise en œuvre afin de continuer à bénéficier aux groupes bénéficiaires ?		Pour assurer que la communauté continue à bénéficier du projet, l'organisation avait utilisé la stratégie de transmission des connaissances en assurant la formation des CAC et la dotation des matériels de sensibilisation. Cette stratégie produit des résultats positifs jusqu'à maintenant. Dans toutes les AS, les bénéficiaires continuent à appliquer les connaissances transmises. Les sensibilisations de masse ont permis à la population de continuer à mettre en pratique les connaissances.
Q12. Quelle a été la perception des communautés tout au long du projet ?		La communauté reconnaissait que le projet l€avait tiré de l'ignorance et réclamaient la poursuite des activités. La stratégie était très appréciée par la communauté. Les membres des CAC de Kibati quant à eux avaient l'impression de ne pas être pris au sérieux par l'organisation car celle-ci ne tenait pas compte de leurs responsabilités familiales et l€emploi du temps. Pour eux il n'y avait pas de partage d'information et ils étaient obligés de se soumettre au programme du superviseur.
QE6. Quels résultats ont été obtenus par la réponse aux épidémies de la DG ECHO ?	6.1. DG ECHO-funded actions and advocacy in response to epidemics mitigated the spread and impact of those epidemics 6.2. Unintended negative consequences of DG ECHO-funded actions were minimal and effectively mitigated when identified	
Q13. Depuis la mise en œuvre des activités de réponse au choléra par l'organisation, qu'est-ce qui a changé dans votre communauté ?		Les cas de contamination ont sensiblement baissé grâce aux sensibilisations. Aujourd'hui on finit même deux semaines sans nouveau cas de choléra car la population connait et pratique désormais le traitement de l'eau et le lavage des récipients mais aussi l€environnement est propre. Même les vendeurs de l'eau refusent de vendre à un client qui a un bidon sale. Les bénéficiaires se lavent régulièrement les mains et savent préparer le SRO pour éviter la déshydratation du malade avant d'arriver au CS. Des ménages qui n'avaient pas de toilettes s'assurent d'en avoir depuis les sensibilisations. L'environnement est plus propre qu'avant car la population ne laisse plus trainer les ordures.
Q14. Quelles sont les personnes qui ont le plus bénéficié dans la communauté ?		- Les enfants de 0 à 5 ans qui étaient plus vulnérables et ne pouvaient rien faire d'eux-mêmes mais ont subi des résultats directs à travers les enseignements reçus par les parents - Les femmes enceintes et les femmes allaitantes car elles ont reçu plusieurs enseignements lors des CPN et CPS A Kibati particulièrement, les sinistrés vivants dans le camp, les élèves et écoliers ont aussi plus bénéficié du projet car plusieurs activités avaient été organisées en l€faveur.

Q15. Quel a été le niveau de transmission et de compréhension des connaissances transmises par le personnel du projet ?		A Kibati et Rusayo, le niveau de transmission dans la communauté était moyen car le temps de mise en œuvre ne permettait pas de tout transmettre. Pour les membres des CAC, il était difficile de transmettre en 1 heure une matière reçue en 2 jours. Ils ne donnaient que la synthèse des messages qui était bien compris et pratiqué.
Q16. Quel genre de nouveau comportement avez-vous appris grâce au personnel de l'organisation ?		A Kibati et Rusayo, la communauté a pris l'habitude d'assainir les parcelles, le traitement de l'eau et la bonne conservation de la nourriture. Ils ont pris l'habitude de fabriquer du SRO et limitent les cas de décès dans la communauté.
Q17. Comment est-ce que ce changement a impacté votre communauté ?		Aujourd'hui les cas de choléra sont sensiblement réduits grâce aux nouveaux comportements adoptés depuis le projet. Même les autres maladies des mains telles que la diarrhée ne sont plus aussi fréquentes qu'avant et les familles ont repris le cours normal de leurs vies. Les cas de décès dû aux maladies des mains sales sont réduits.
[expand this form, as needed]		

Annexe 6 – Online Survey

E-Survey Design

Purpose

The overall purpose of this e-survey is to collect and add another layer of data to the evidence base of the evaluation. This method will enable the evaluation team to gather data from a larger number of stakeholders than through the field visits alone, and can extend the geographic reach beyond the sample of five countries. It will also be able to reach a more diverse samples of stakeholders within a given target key informant category (e.g., EC/WHO/IP staff).

Target population and sampling strategy

The target respondent population groups for the survey are:

- DG ECHO staff, other EU/EC staff
- Implementing partner staff (both HQ and field level staff)
- Staff of other ECHO 'collaborators' e.g., UN, gov, donors, Heath Cluster members
- WHO officials

The evaluation team kindly request support from DG ECHO/ WHO/ Implementing partners on identifying relevant individuals and email contact lists for distribution of the survey. Snowball sampling (onward sharing of the survey to relevant contacts by existing survey respondents) will be encouraged. The evaluation team estimate an expected response rate of 40%, and an estimate target number of invited respondents of 150. The actual target number will be dependent on the total number of possible respondents/ contacts identified with the assistance of ECHO/ WHO/ IPs.

The ET shall maximise the response rate by allowing a sufficient time frame and follow-up, ideally supported by DG ECHO's Field Offices when appropriate.

Confidentiality

The data collected through the survey will be anonymous, and will not require an individual to give their name. This will be stated to the respondent in the invitation email and opening preamble. However, there will be an option included at the end of the survey for respondents to volunteer their name and contact details if they would be willing to be contacted by the evaluation team for follow-up questions/interview. Respondents will be informed that providing these details is optional, and any feedback they provide will remain confidential and will not be attributed directly to an individual/organisation.

Design of survey questions

Where appropriate, the survey questions utilises closed questions (e.g., likert scales) to allow for aggregation and quantitative analysis of responses. To a lesser frequency in the survey, open (free text) questions are included, where topic areas require more in-depth descriptive detail or original suggestions from respondents. An assessment of the evaluation questions and judgement criteria was carried out by the evaluation team to identify where survey data could be appropriate and useful to generate insight and/ or to triangulate with other sources. This was further compared to the evaluation questions for which the evaluation team found a low strength of evidence during the desk report. The table below details the EQs which were identified for targeting through the survey (EQ 4, 5, 8, 9 for part A, and EQ 10, 11, and 12 for part B) and specifies which sub-population group are relevant respondents for the EQ.

Table 22 EQs selected for survey targeting

Survey Qs as per IR	Low strength of evidence in DR	Suggested common Qs (good for quantitative analysis)	Suggested sub-populations				
			DG ECHO officials	Other EU/EC officials	DG ECHO Implementing Partners (excluding WHO)	Other DG ECHO 'collaborators' e.g., UN, gov, donors, Heath Cluster	WHO officials
		X-cutting Qs Part A	X	X	X	X	X
3			X	X	X	X	
4	4		X	X			
5	5		X	X	X	X	
8	8		X	X	X	X	
9			X	X	X	X	

10	10		X	X			X
11	11		X	X			X
12	12		X	X			X

Length

Respondents will be asked between 20-30 questions. The actual number of questions asked to a respondent will depend on the filtering pathways followed. The survey has been designed to take approximately 15 minutes to complete.

Translation

We propose to provide the e-survey in options of English, French, Spanish, Arabic and Dari. We would be grateful for DG ECHO's feedback on this.

Analysis of results

The survey questionnaire has been designed with the analysis stage in mind, to allow for the effective and useful analysis of results. The evaluation team will conduct quantitative analysis of closed questions, and qualitative coding of free text against the evidence matrix. As discussed, if deemed useful by the evaluation team, follow-up questions/ interviews may be pursued with individuals who volunteer to be contacted for this.

Timeframe

Table 23 Survey timeframe

Step	Proposed dates
Finalisation of survey questionnaire	Friday 27th May
Translation into different languages required	By Friday 3rd June
Proof-reading of translations/ Final testing of online survey	Monday 6th June
Launching survey	Tuesday 7th June
Follow up reminder 1	Friday 10th June
Follow up reminder 2	Wednesday 14th June
Close survey	Friday 17th June
Analysis/ reporting	Monday 20th June onwards

Draft Survey Design (Part A Epidemics – excluding Part B WHO)

Opening Preamble

Dear respondent,

Thank you for agreeing to take part in this e-survey. Your answers will be used to inform the independent, external evaluation of **DG ECHO's humanitarian response to epidemics and DG ECHO's partnership with the World Health Organization (WHO) between 2017 and 2021**. The evaluation has been commissioned by DG ECHO's evaluation unit and is being implemented by the external consultancy Landell Mills.

The evaluation will assess achievements in terms of relevance, coherence, added-value, efficiency, effectiveness and resilience/connectedness. It will produce recommendations to inform future planning and implementation of DG ECHO's response to epidemics, and DG ECHO's partnership with the WHO.

Your responses are completely anonymous and will help the evaluation team to gather perceptions on the results and impact of DG ECHO's humanitarian response to epidemics, and partnership with WHO. For more information on DG ECHO's data protection policy, please review the following Privacy Statement [LINK TO PRIVACY STATEMENT]

[For respondents not working for the EU/EC, DG ECHO is sometimes better known as 'ECHO']

The survey results will be aggregated and analysed, so your contribution will feed into the recommendations for the future. We encourage you to be honest and open in your confidential responses.

The survey contains X questions, and it should take approximately 15 minutes to complete. If you have any questions on this survey, please email the evaluation team contact point Ellie McGovern, elliem@landell-mills.com.

Your opinion and experience are greatly valued, and we thank you again for your contribution.

Question : Do you agree with the terms raised in DG ECHO's Privacy Statement? By clicking 'Yes' you consent that you are willing to answer the questions in this survey.

Section 1: Respondent profile questions

1. What organization do you work for?
   - DG ECHO
   - Other EC/EU institution
   - WHO
   - Implementing Partner which received DG ECHO funding for an epidemic response 2017-2021
   - Other DG ECHO collaborator (UN agency, Government, donor, health cluster member)
   - Other (please specify) _____

2. Are you an employee of your organisation or a consultant/contractor?
   - Employee
   - Consultant/ contractor

3. What is your specific role title?
   - Open _____

4. What is your gender
   - Male
   - Female
   - Prefer not to answer
   - Other (___)

5. Where do you work?
   - Headquarters level
   - Regional level (filter to q5a)
   - Country level (filter to q5B)

5a. Please specify which region you work in

   - Region choices, or open

5b. Please specify which country/ies you cover in your work

   - Afghanistan

- Venezuela
- South Sudan
- Syria
- Democratic Republic of Congo
- Other country/ies level (please specify)____

Section 2: Common questions (Part A)

When answering the following questions please think about

- Your experience from 2017 until present
- being honest and open in your confidential responses

6. How would you rate DG ECHO's response to epidemics in terms of the following criteria?

	Excellent	Good	Fair	Poor	Very poor	Do not know
Appropriateness						
Accountability to affected populations						
Coherence with other actors						
Results						
Timeliness						
Flexibility						
Added value (meaning the unique strengths/contribution of DG ECHO over other donors)						
Sustainability						
Overall assessment						

7. What, in your opinion, was the best aspect of DG ECHO's response to epidemics?

8. What could DG ECHO do better in their response to epidemics?

9. Compared with other donors, how does DG ECHO add value in responses to epidemics? Please pick three [indicate your selection with an 'X']:

Quick response	
Scale of response	
Flexibility as a donor	
Less paperwork	

Convening other actors	
Taking risks/ supporting innovation	
Field presence	
Technical expertise	
Influence with Government	
Other (fill in the blank)	

Section 3: Evaluation Questions (Part A)

10. (EQ3) How would you rate DG ECHO's involvement in the following aspects of coordination and advocacy?

	Excellent	Good	Fair	Poor	Very poor	Do not know
Response coordination						
Donor coordination						
Advocacy (on behalf of affected populations)						

11. What would help DG ECHO to improve donor and/or response coordination?

12. What advantages and/or constraints does DG ECHO face in conducting advocacy?

For EU staff only:

13. (EQ4) In terms of DG ECHO's role in global health security within the EU/EC, how do you assess DG ECHO's performance in the aspects below:

	Excellent	Good	Fair	Poor	Very poor	Do not know
Leadership and coordination						
Analysis and information sharing						
Linking with other						

EC services and Member States						
Specialist deployments						
Logistics						
Clarity of role/ mandate						
Clarity of direction/ plans						

14. (EQ4) Thinking about the future, what are the opportunities and constraints relating to DG ECHO playing a greater role in global health security within the EC?
Open text _____

For all respondent groups:

15. (EQ4) DG ECHO could strengthen its role in relation to potential epidemics by [choose a maximum of 3 responses]:
- Having a bigger budget
- Supporting other EU/EC Services
- Having a clear policy position/strategy
- Working more on prevention in humanitarian contexts
- Having stronger logistical capacity
- Responding more quickly
- Have more technical capacities in the field
- Reinforcing technical capacity at HQ in dealing with health policy
- Having a stronger voice in EC Global Health meetings
- Coordinating more with the UN and other actors
- Deploying Emergency Medical Teams
- Conducting research on outbreaks
- Having a stronger partnership with WHO
- Other (_____)

16. (EQ5) Which dimensions of DG ECHO's capacity in relation to epidemics do you value the most [choose a maximum of 2 responses]:
- Flexibility as a donor
- The scale of its funding
- Technical knowledge and understanding
- Strong voice in advocacy
- Linking humanitarian action and developmentQuick response
- Logistical capacity and support
- Other (_____)

17. (EQ8) How would you rate DG ECHO's ability to balance speed of response with quality of response?

- Excellent
- Good
- Fair
- Poor
- Very poor
- Do not know

18. (EQ8) Please explain why you believe DG ECHO is able to/ unable to balance the speed of response with quality of response?

19. (EQ9) How would you rate DG ECHO's performance in linking short-term epidemic response to longer-term prevention and preparedness?
    - Excellent
    - Good
    - Fair
    - Poor
    - Very poor
    - Do not know

20. (EQ9) In your opinion, how could DG ECHO perform better in linking short-term epidemic response to longer-term prevention and preparedness?

Section 4: Evaluation Questions (Part B)

Filtering questions:

21. Have you been involved in implementing DG ECHO funded WHO projects and/or been involved in other DG ECHO-WHO partnership collaborations since 2017?
    - Yes – continues
    - No - ends

The following questions cover aspects of the DG ECHO and WHO partnership. When answering the following questions please think about your perspective and observations of the DG ECHO and WHO partnership from 2017 until the present.

For respondents who answered 'Yes' to Q21

22. (Q10) On a scale of 1 to 5, where 5 is "completely" and 1 is "not at all", please rate the DG-ECHO and WHO partnership in terms of:

	5 (completely)	4	3	2	1 (not at all)	Do not know
The extent to which you feel DG ECHO and WHO are aligned on the partnership's…						
Mandate						
Goals and objectives						
Strategic priorities						
Operational program areas/tools						

	5 (completely)	4	3	2	1 (not at all)	Do not know
Health advocacy efforts						
The extent to which you understand the WHO-ECHO partnership's						
Vision						
Goals and objectives						
Strategic priorities						
Operational structures and processes						

23. (Q10) In your opinion, in relation to all aspects of health emergencies (i.e., preparedness, immediate response and post-acute phase), which of WHO's strengths bring the most value to the DG ECHO-WHO partnership? Please pick five options from below and/or specify additional options in 'Other' [indicate your selection with an "X"].

Providing logistics support during response	
Developing norms and guidelines	
Surveillance of new and ongoing public health events	
Close relationship with Ministry of Health	
Functioning effectively as the health cluster coordinator	
Coordinating partners across multiple sectors during response phase	
Technical expertise	
Providing rapid funds to Ministry of Health during emergencies	
Developing preparedness plans	
Coordinating partners across multiple sectors during development of preparedness plans	
Field response	
Capacity building of the humanitarian system	
Work with implementing partners	
Other (fill in the blank)	

24. (Q10) Do you feel that the DG ECHO-WHO partnership extends beyond a donor-recipient relationship?
    a. If yes, in what way?
    b. If no, what is missing?
25. (Q10) Do you feel the DG ECHO-WHO partnership is a strategic partnership?
    a. If yes, what characteristics make it strategic?
    b. If no, what is missing?
26. (EQ11) At your working level, have you participated in any formal dialogue between DG ECHO and WHO? If 'yes', go to Q27, if 'no', go to Q28
27. (EQ11) On a scale of 1 to 5, where 5 is "completely" and 1 is "not at all", please rate the DG-ECHO and WHO partnership in terms of the extent to which the dialogue between DG-ECHO and WHO

	5 (completely)	4	3	2	1 (not at all)	Do not know	Not relevant
was strategic							
was structured							
equally addressed the interests and needs of both DG-ECHO and WHO							
identified mutual priorities							
provided the forum to discuss challenges and issues							
was transparent by sharing outcomes of the dialogue to relevant stakeholders							
led to concrete actions							

28. (EQ11 & EQ12) On a scale of 1 to 5, where 5 is "completely" and 1 is "not at all", please rate the DG-ECHO and WHO partnership in terms of

	5 (completely)	4	3	2	1 (not at all)	Do not know
having in place joint processes for						
decision making						
planning						
implementation						
Decreasing administrative and management costs/burdens						
Demonstrating mutual accountability (each partner's commitment to deliver to each other)						
Demonstrating collective accountability (the partnership's commitment as a whole to deliver)						

	5 (completely)	4	3	2	1 (not at all)	Do not know
Providing timely and flexible support to health emergencies						
Providing timely and flexible response to COVID-19						
Strengthening the exchange of information between DG ECHO and WHO						
strengthening the exchange of information between						
the two partners						
the two partners and other humanitarian actors						

29. (EQ12) Compared to other bilateral health partnerships you are involved in , to what extent has the DG-ECHO/WHO partnership contributed to the following:

	Contributed the most	Contributed more	Contributed same	Contributed less	Did not contribute	Do not know/I'm not involved in other such partnerships
Strengthening collaborations with other partners working in humanitarian health						
Enhancing advocacy efforts on health in humanitarian settings						
Addressing the needs of the most vulnerable in health emergency settings						
Strengthening resilient health systems to respond to health emergencies						
Strengthening the links between the responses of humanitarian and development actors (bridging the humanitarian and health development nexus)						

30. What are the top three ways the DG-ECHO and WHO partnership could be strengthened to achieve greater impact in health emergencies:

Thank you for completing the survey.

If you would be willing to be contacted for possible follow-up questions, please add your name and contact email below. Please note that providing these details is optional, and any feedback you provide will remain confidential and will not be attributed to you as an individual/organisation.

Name:

Email address:

Organisation:

Role:

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Annexe 8 – Terms of Reference (TOR)

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