Final Report

Mid-term evaluation for Phase 1 of the Community Epidemic and Pandemic Preparedness Programme (CP3)

International Federation of Red Cross and Red Crescent Societies (IFRC)

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Acronyms

Acronym	Definition
AFROHUN	Africa One Health University Network
AIDS	Acquired Immunodeficiency Syndrome
AIHSP	Australia Indonesia Health Security Partnership
BNPB	The National Agency for Disaster Management (Badan Nasional Penanggulangan Bencana)
CAAH	Community Agents for Animal Health
CBS	Community Based Surveillance
CDC	Centres for Disease Control and Prevention
CDRT	Community Disaster Response Teams
CEPSS	Community Epidemic and Pandemic System Strengthening
CGPP	The CORE Group Partners Project
CHISU	Country Health Information Systems and Data Use
CHP	Community Health Promoters
CHV	Community Health Volunteers
CHW	Community Health Workers
COVID	Corona Virus Disease 2019
CSSS	Community Surveillance Systems Strengthening
DFAT	Department of Foreign Affairs and Trade
DHF	Dengue Haemorrhagic Fever
DLM	Data Lifecycle Management
DQA	Data Quality Assurance
DQR	Data Quality Review
DRC	Democratic Republic of the Congo
DRCRC	Democratic Republic of the Congo Red Cross
DVS	Department of Veterinary Services

Acronym	Definition
ECV	Epidemic Control for Volunteers
EMT	Evaluation Management Team
ENAP	École Nationale D'administration Publique (ENAP)
EVD	Ebola Virus Disease
EWAR	Early Warning, Alert and Response
FAO	Food and Agriculture Organization of the United Nations
FGD	Focus Group Discussions
FHI	Family Health International
FIMS	Faculty of Information and Media Studies
FMD	Foot and Mouth Disease
GHSA	Global Health Security Agenda
GPW	General Programmeme of Work
HEPR	Health Emergency Preparedness Readiness and Resilience
HIV	Human Immunodeficiency Virus
IDDS	Infectious Disease Detection and Surveillance
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
INDOHUN	Indonesia One Health University Network
IPC	Infection Prevention and Control
ITT	Indicator Tracking Table
JEE	Joint External Evaluations
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interviews
KOBO	Kobo Toolbox
KRCS	Kenya Red Cross Societies

Acronym	Definition
MEL	Monitoring, Evaluation and Learning
MERL	Monitoring, Evaluation, Research and Learning
MPH	Master of Public Health
MSF	Médecins Sans Frontières
NS	National Society (ies)
ORS	Oral Rehydration Solutions
PER	Preparedness for Effective Response
PHC	Public Health Centres
PMI	Palang Merah Indonesia (Indonesian Red Cross)
PNHF	National Border Hygiene Programmeme
SBCC	Social and Behaviour Change Communication
SDB	Safe and Dignified Burial
SHARP	Strategic HIV/AIDS Response Plan
SOP	Standard Operating Procedure
SPAR	States Parties Self-Assessment Annual Reporting Tool
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States' Agency for International Development
VPD	Vaccine Preventable Diseases
VSF	Vétérinaires Sans Frontières
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WWF	World Wildlife Fund
ZDU	Zoonotic Disease Unit

1 Executive Summary

1.1 Introduction /Background

World Health Organization (WHO) (2024)[1] noted that pandemics and large-scale outbreaks can claim millions of lives, disrupt societies, and devastate economies and livelihoods. Large-scale epidemics and pandemics pose a serious threat to countries, communities, and individuals as well as to global health security. Epidemics and pandemics affect all sectors, impacting routine health services, economic and food security, international trade and travel, education, civil order, communication, and many other facets of human development. In response to this threat, at the end of 2017, the International Federation of Red Cross and Red Crescent Societies (IFRC) received funding from the United States Agency for International Development (USAID) to launch a Programme focusing on Community Epidemic and Pandemic Preparedness (CP3).

In the last decade, disease-related health emergencies have demonstrated that epidemics and pandemics start and end at the community level. As such the CP3 Programme design applies a whole-of-society and all-hazards approach by focusing its interventions on three key workstreams:

1. **Community preparedness**: the first workstream of the CP3 Programme on community preparedness is geared towards strengthening community resilience against the detrimental effects of epidemics and pandemics.
2. **National Society preparedness**: the second workstream on National Society preparedness focuses on strengthening the National Society's capacity to prepare and respond to epidemic and pandemic threats of now and into the future.
3. **Key stakeholders' engagement**: workstream three entails key stakeholder engagement through a One health approach to prepare businesses, communities and society to be more resilient in the face of epidemics and pandemics.

CP3 Phase 1 was a five-year implementation phase from 2017 to 2023 in Cameroon, the Democratic Republic of Congo, Guinea, Indonesia, Kenya, Sierra Leone, and Uganda. The Programme was also implemented in Mali between 2017 and 2020. The IFRC has supported communities, Red Cross and Red Crescent National Societies (NS), and other implementing partners to enhance capacities to prevent, detect, and respond to threats from epidemics and pandemics. The IFRC signed agreements with National Societies in USAID purposively selected countries to implement most of the Programmes at country and community levels with IFRC taking up limited overall oversight and technical support roles (providing technical tools and guidance to National Societies for all 3 workstreams). IFRC and National Societies have several contracted staff to lead and support Programme implementation.

1.2 Evaluation Purpose and Questions

The overall objective of this Mid-term Evaluation is to assess and analyse the delivery of the first phase of the Community Epidemic and Pandemic Preparedness Programme (CP3) covering the period from October 2017 to September 2023 and derive key recommendations from the findings. The findings from this evaluation will inform how the CP3 can better support the WHO-International Health Regulations (IHR), Joint External Evaluations (JEE)/ States Parties Self-Assessment Annual Reporting Tool (SPAR) benchmarks identified priorities, ensuring that efforts to prevent, detect, and respond to public health risks are effective, efficient, and sustainable.

The main purpose of the evaluation is to assess the Programme's effectiveness, relevance, appropriateness, and sustainability. The consultants were expected to review and collect qualitative and quantitative data from

[1] WHO, Preparing for pandemics: https://www.who.int/westernpacific/activities/preparing-for-pandemics

multiple countries and stakeholders, analyse it and generate findings and conclusions based on evidence.

The evaluation questions can be summarized in the three questions below on Table 1:

Table 1. Key Evaluation Questions

CP3 Mid-term Evaluation Questions
1. To what extent was CP3 relevant and appropriate to stakeholders' needs and priorities?
2. To what extent was CP3 effective in achieving assigned objectives?
3. How can the CP3 programme become sustainable beyond donor funding in implemented countries?

The full proposed evaluation questions reframed and reorganized by evaluation criteria are presented in Table 11

1.3 Evaluation Methodology

This evaluation was conducted from August to December 2024. To answer the evaluation questions, the evaluation team utilized a mixed-methods approach. Both quantitative and qualitative data were collected and analysed to evaluate the project trends and accomplishments based on assigned targets and objectives. A desk review was conducted using data generated by the project during implementation from 2017 to 2023. Onsite key informant interviews (KIIs) were conducted during country visits in 3 countries (DR Congo, Indonesia and Kenya) out of 7 to collect the perception of CP3 stakeholders at community, National Society, local stakeholders, and international partners levels.

The evaluation faced a few constraints and limitations, notably:

- **Unavailability of aggregated Programme data**: During the desk review, the evaluation team noted the absence of cumulative aggregated indicators data that track, support, and demonstrate the effectiveness of the CP3 Programme. Although the desk review is intended solely to identify and compile existing Programme data to answer the evaluation questions, the evaluation team went the extra mile to aggregate the available data from the CP3 Programme to help illustrate its effectiveness throughout the implementation timeline. This aggregation does not certify data quality but serves to show the trends of activities reported by stakeholders.

- **Unavailability of Key Informants**: Even though we managed to reach all groups of stakeholders, in some countries we did not always manage to get the representation intended for each group of respondents. The Ministry of Animal Health, the Ministry of Environment, and the Public Health Institute for example in the DR Congo are under-represented because they were not available at the time of our country visit.

- **End of the project in some implementing sites impacted access to respondents**: while we were able to speak to several stakeholders in geographical locations, where the Programme had phased down in 2022, it was challenging to find community households who were willing to be interviewed by the evaluation team in areas where CP3 implementation had stopped.

- **Limited interviews in non-visited countries:** Due to budget constraints, the evaluation team could not visit all countries. As part of the methodology, it was agreed that only three countries would be sampled, which limited access to and the collection of significant data from remote interviews. Therefore, the programme data shared by IFRC alone is sufficient for the evaluation team to establish findings and conclusions regarding non-visited countries. The few remote interviews conducted with IFRC staff are not representative of countries' stakeholders are solely used to identify similarities with the visited countries.

Table 2. Interviews Conducted by Country

Province	Number of interviews	Number of interviewees	Country Status
DR CONGO	31	100	Visited
KENYA	44	80	Visited
INDONESIA	30	41	Visited
CAMEROON	1	3	Remote
GUINEE CONAKRY	1	1	Remote
UGANDA	2	2	Remote
SIERRA LEONE	1	1	Remote
SWITZERLAND	2	3	Remote
United States of America (USA)	2	2	Remote
Total	**115**	**234**	

Despite the above challenges, the evaluation team managed to **conduct 115 KIIs with 234 respondents out of the 152 KIIs intended** as shown on Table 2 above.

1.4 Findings

1.4.1 Over-Arching Findings

Programme Design:

- Stakeholders across all visited countries reported that CP3, like most partner-funded Programmes, comes with a pre-defined framework and objectives, often informed by global and national strategic plans related to public health. Local stakeholders noted that although they were not present when the programme was designed, they were involved in adapting the CP3 Programme to fit the local context, needs, and priorities, reinforcing its relevance and appropriateness.
- Across all countries, IFRC initiated the Programme with a situational analysis and consultative meetings with the National Societies and relevant stakeholders, targeting mainly key partners working in human health, animal health, and the environment.
- Local governments in all countries were involved in the selection of the programme geographic areas of focus informed by the country's epidemic card and led the selection of priority diseases, both human and zoonotic.
- Across most countries visited by the evaluation team, local stakeholders noted that the project design was more focused on human health activities. While this significantly benefited the Ministry of Health, the Ministry of Animal Health and Environment had limited representation and, therefore, was unable to include the scope of work that could strengthen their specific ministries in the CP3 agenda.

Programme implementation and monitoring:

- Stakeholders felt that CP3 phase 1 implementation was more focused on communities' preparedness. National Society' preparedness workstream activities made less progress. This is evidenced by the low or -absence of reporting on indicators of National Society preparedness in all countries except for Kenya.
- For workstream 1, "Community Preparedness":
    - Stakeholders across all countries strongly believe CP3 is relevant and appropriate to their countries as it meets their communities' and local partners' needs and priorities. They argue that CP3 allowed local stakeholders to adapt and align community-based surveillance and

other epidemic preparedness pre-designed activities to concepts and activities that are understood by their population. Beyond that, it allowed to identify and describe local priority diseases using languages that are understandable by local communities and partners.

- Stakeholders across all visited countries strongly believe CP3 was effective in meeting the assigned objectives. The successful stories reported by all stakeholders narrate that their communities have increased knowledge of priority diseases that can spread into epidemics, can detect them, and are aware of channels to report them to local authorities through the National Societies volunteers or local government officers. Beyond that, they observed the adoption of positive attitudes and behaviours that protect the health of the population in their communities. Stakeholders across countries reported improvement in Water, Sanitation and Hygiene (WASH) good practices (hand washing, water purification, safe defecation practice, environmental hygiene, etc), improved positive health-seeking behaviour (reporting and seeking assistance for unvaccinated children and animals, avoiding the consumption of animals that died from unknown causes, etc).
- Stakeholders across all visited countries also noted that the impact of the above CP3 achievements are only effective in areas where CP3 was implemented. They all stressed that CP3's effectiveness was limited by its initial geographical coverage, and inability to provide resources for epidemic response such as WASH infrastructure and equipment for volunteer safety and transportation to complement CP3's efforts as well as its short implementation time.
- Stakeholders' perceptions are corroborated by CP3's Programme data on the Indicator Tracking Table (ITT) data and narrative reports) showing that several epidemic preparedness activities were implemented from 2019 to 2023 across all countries as visualized in Table 3 below.

Keynote. The limitations in the IFRC data management system using none standardized Word documents and Excel spreadsheets for reporting do not allow to assert that the visualized data is exempted from data quality issues such as double counting, missing data, human error (incorrect data capturing), etc. Therefore, all our comments on these visuals are strictly an observation of activities trends; to confirm they were reported at the time of implementation.

Table 3. CP3 workstream 1: Visualization ITT Dashboard trend of people reached with different activities

	2019	2020	2021	2022	2023	All Years
Total	1,220,003	1,930,837	3,068,256	1,994,656	1,685,332	9,899,084
Household visits	672,296	1,556,337	2,255,287	1,482,533	1,146,794	7,113,247
Group information sessions	347,484	266,637	400,985	303,764	370,483	1,689,353
Schools	144,370	71,818	142,106	167,450	146,396	672,140
Mobile Cinema / Street theatre	51,388	29,947	208,023	40,909	21,659	351,926
Other community health activities	4,465	5,742	61,636	0	0	71,843
Campaign with local media	0	356	219	0	0	575
Simulations	0	0	0	0	0	0

- For Workstream 2, "National Society Preparedness" Stakeholders across all countries agree that CP3 was effective in strengthening National Societies 'ability to support epidemic response in host countries. This perception is strong across countries even though we did not find enough quantitative data reporting activities on workstream 2 to triangulate this perception of CP3 effectiveness of National Societies preparedness workstream 2 Table 4 below. The stakeholders argue that CP3 is a holistic Programme therefore by enhancing National Societies' staff and volunteers' capacities through the different trainings, that allowed them to implement workstream 1 effectively, the ripple effect is that this increased the National Societies' human resource capabilities and their relevance in epidemic and pandemic crisis context, making the National Societies and IFRC two ideal key partners organizations in epidemic and pandemic response context for governments and global health partners. They also noted that CP3 has enhanced the National Societies' strategic planning, data management, and reporting capabilities even if more work still needs to be done.

Table 4. CP3 workstream 2: Visualization ITT Dashboard trend of activities

Activities	indicator	value
Epidemic planning	# epidemic simulations in which the ns participated	1
Epidemic planning	# of CP3 branches that have completed a simulation or after-action review	6
Epidemic planning	# of NDRT personnel trained in CBS and ECV	52
Epidemic planning	contingency plans or sops developed by ns	18
Infection prevention & control (IPC)	# of CP3 RC facility frontline staff trained on IPC	56
Infection prevention & control (IPC)	# of CP3 RC health facilities that have conducted an IPC assessment	5
Preparedness for Effective Response (PER)	completed 1+ per exercise of per action plan (specify activity based on country program)	10
Preparedness for Effective Response (PER)	improved score in 1+ per epidemic benchmark areas (specify intended improvement based on country program)	5
Preparedness for Effective Response (PER)	per/epi-ready action plan developed	14
Preparedness for Effective Response (PER)	per/epi-ready orientation and assessment completed	7

*The term value was used because we cannot confirm whether the records found on the ITT represent the number of activities or the number of people reached.

- Workstream 3" Stakeholders engagement": This workstream aims to increase key stakeholders' knowledge or capacity to support epidemic preparedness and response
    - Stakeholders reported that the One Health initiative in most countries started prior to CP3, however, it was all theoretical and partners did not understand the pragmatic way to make the One Health concept a reality. CP3 just came on time and was effective because it provided the first platform where One Health partners could engage in joining outreach activities beyond meetings. In some countries it is reported that CP3 was instrumental in enhancing local stakeholders' understanding of the One Health concept by bringing for the first time all relevant stakeholders together and involving them in activities such as response to rabies alerts from CP3 volunteers bringing the Ministry in charge of animal health and human health to work together; WASH activities unifying Ministry of Human Health and Environment, etc.

- Additionally, the stakeholders reported that CP3 has strengthened the access to community-based surveillance data for all stakeholders by establishing a monitoring and evaluation system that allows early detection, and prompt reporting and stimulates an early response from stakeholders. This system's uniqueness is that it is established within communities, involving community members and National Society volunteers who are also part of the same communities. Their involvement is not as passive observers but as actors in diseases surveillance that have the potential to spread as epidemics in their communities.
- Furthermore, under workstream 3, some countries reported that CP3 was able to reach and involve community leaders who initially represented a strong barrier to communities' epidemics and pandemic preparedness. Stakeholders reported that through awareness activities and observation of National Society volunteers, staff, and partners firsthand handling epidemic crises that affected their communities allowed them to convert these leaders into allies for NS and epidemic preparedness and response.
- Visualized activities data from IFRC ITT data support that several stakeholders' engagement activities were implemented from 2019 to 2023 across all countries as visualized in Table 5 below

Table 5. CP3 workstream 3: Visualization ITT Dashboard trend of activities

Activities	indicators	value
Community leader meetings / Community stakeholders engaged each month	total number of people reached	154437
Data readiness & data literacy training	total number of RC staff, RC volunteers, partners trained	752
Data sets compilation	total number of identified datasets researched and identified	855
Private sector participation	total number of private enterprises reached	16755
data readiness	# of sub-counties/sub-prefectures with epidemic risks mapped and visualised	93
management and coordination	# of monthly partner meetings attended	670
media preparedness	total number of people trained in BBC media sessions	233
media preparedness	total number who scored > 70% on BBC media training courses	32

* The term value was used because we cannot confirm whether the records found on the ITT represent the number of activities or the number of people reached.

1.4.2 Question 1: To what extent was CP3 relevant and appropriate?

The questions on CP3 relevance and appropriateness assessed if CP3 met the needs and priorities of the stakeholders and how much they were involved in the Programme design, implementation monitoring, and evaluation. The stakeholders rated CP3 relevance and appropriateness on a Likert scale of 1-4 where:

- Not at all consistent was a zero score
- Slightly consistent a "1"
- Moderately consistent a "2"
- Very consistent a "3"
- Completely consistent a "4"
- I don't know did not count

With an overall relevance and appropriateness score of 3/4 (76%, N=114) across all partners and countries, CP3 was perceived to be appropriate and relevant to all stakeholders.

Meeting stakeholders' needs and priorities:

- Communities' needs and priorities. Stakeholders' perception is that CP3 was appropriate and relevant in meeting communities' needs and priorities at 77.5% (3.1/4, N=114). They argued that:
    - CP3 allowed local stakeholders to identify priority diseases and develop community case definitions for these diseases, enabling early detection and reporting to the health system.
    - CP3 supported awareness activities have increased community knowledge and enhanced members' understanding of factors that can lead to disease outbreaks.
    - This increase in knowledge has led to the adoption of positive behaviors, practices, and attitudes. Stakeholders reported that the CP3 Programme has successfully promoted behavior change within the communities where it was implemented. They observed safe drinking water habits, good hand hygiene, and sanitation practices such as the use of latrines, active clearing of bushes around homes, and draining stagnant water pools to prevent mosquito breeding and control vector-borne illnesses such as malaria and dengue.
- National Societies' needs and priorities. Stakeholders' perception is that CP3 was appropriate and relevant in meeting NS' needs and priorities at 77.5% (3.1/4, N=48). They supported that:
    - CP3 has contributed to strengthening the National Societies' volunteers' network and community engagement. They noted that, where it was implemented, the National Societies' ' network of volunteers is strengthened through capacity-building activities. Their roles in communities have evolved from first aiders to include community-based surveillance, community awareness activists, and epidemic and pandemic safeguards. CP3 has contributed to strengthening National Societies' institutional capacity through organizational targets and strategic plans, tools development, and enhancing staff skills with capacity building.
    - CP3 has fostered stronger partnerships and coordination between National Societies, Governments, and One Health partners. It is argued that CP3 has positioned NS as the primary partners to their governments for epidemic and pandemic preparedness and response including community-based surveillance.
- Local stakeholders' needs and priorities (this included Government and local partners). Stakeholders' perception is that CP3 was appropriate and relevant in meeting local stakeholders' needs and priorities at 72.5% (3.1/4, N=44). They reported that:
    - Contributed to strengthening collaboration and multisectoral coordination among local stakeholders by raising awareness of the necessity for a multi-sector collaboration approach in epidemic and pandemic preparedness and response.
    - Increased their knowledge and capacity to support epidemic preparedness and response by providing a platform for multi-sectoral collaboration through CP3 meetings and field activities, as well as granting access to community-based surveillance information in real-time through volunteers working in communities.
- International partners' needs and priorities (this includes USAID and IFRC): Stakeholders' perception is that CP3 was appropriate and relevant in meeting local stakeholders' needs and priorities at 87.5% (3.5/4, N=8). They reported that
    - CP3 serves as a valuable learning experiment for international partners. They noted that at the WHO Regional and global levels, there is encouragement for collaborative multisectoral efforts involving the community. CP3 is a project that demonstrates how this can be implemented in practice, going beyond meeting rooms and theories.
    - Preventing pandemics and future outbreaks is the priority of the Global Health Security Agenda (GHSA) mission. Through the CP3 Programme, involving communities in surveillance is crucial, as they play a vital role in the early detection, reporting, and response

to epidemic risks. This engagement is important for international partners.
- CP3 emphasizes the importance of community empowerment, which aligns well with the component of the health workforce of GHSA.
- For IFRC, CP3 has strengthened the organization's epidemic and pandemic preparedness portfolio by enhancing its relationships and coordination with National Societies.
- IFRC had the opportunity to learn from and share experiences with other partners involved in epidemic and pandemic preparedness and response including community-based surveillance.

Involving stakeholders in CP3 Programme design, implementation and Monitoring & Evaluation:

The questions on involvement were asked directly to each stakeholder group to reflect on how much the CP3 Programme involved them throughout the Programme lifespan. The stakeholders scored their involvement in CP3 on a Likert scale of 1-4 same as described previously

With an overall involvement score of 2.6/4 (65%, N=114) across all partners and countries, stakeholders felt involved throughout CP3's different stages when necessary.

- Communities' Involvement. Communities reported that they were not involved in the design phase, which is why this score was not counted. They rated their involvement at 75% (3/4, N=21) during implementation, as they were frequently approached by CP3 volunteers for awareness activities and invited to CP3 community events (such as mobile cinema, home visits, discussions, and talks). They also reported being involved in Monitoring and Evaluation (M&E) at 62.5% (2.5/4, N=17) by actively reporting risks and cases to volunteers.
- National Societies' involvement. National Societies rated their involvement at 65% (2.6/4, N=18) during the design phase, noting that the CP3 Programme came with a defined framework informed by global and national strategic plans related to public health, and aligned with the strategic plan of the National Society. While they were not directly involved in the design, they assisted countries in adapting the CP3 model to their local context. They rated their involvement at the implementation and M&E stages at 75% (3/4, N=24), as they participated in the implementation of all activities, as well as data collection and reporting with local partners.
- Local stakeholders' involvement. Governments and local partners reported a 62.5% (2.5/4, N=36) involvement in the design phase, as they were responsible for adapting the CP3 Programme to the local context, needs, and priorities of their communities, reinforcing its relevance and appropriateness. They felt involved at 67.5% (2.7/4, N=40) during implementation and 62.5% (2.5/4, N=36) during monitoring and evaluation (M&E). This involvement score was impacted by ministries responsible for animal health and the environment in most countries, which reported insufficient involvement during the implementation and M&E phases, while the Ministry of Health was central to the CP3 Programme.
- International partners. USAID and IFRC believe they provided guidance and support to country stakeholders to adapt the proposed CP3 framework to their local context, as well as to implement and report its effectiveness and impact.

1.4.3 Evaluation Q2: To what extent was CP3 Programme effective?

CP3 effectiveness was assessed against stakeholders' perception of CP3 performance on focused interventions around the three key workstreams: community preparedness, National Society preparedness, and key stakeholders' engagement. The stakeholders were requested to rate CP3 effectiveness out of 4 for CP3 effectiveness in strengthening communities' and National Societies' preparedness, the effectiveness of CP3 knowledge transfer, the effectiveness of CP3 in developing robust partnerships, and the effectiveness of CP3 in reaching stakeholders' engagement.

With an overall effectiveness score of 2.8/4 (69%, N=114) across all partners and countries, CP3 was

perceived as effective in meeting its assigned objectives.

Specific advancements have been made in reaching community preparedness: Stakeholders noted the following advancement in community preparedness where CP3 was implemented:

- Stakeholders estimated that CP3 was effective at 75% (3/4, N=52) in increasing communities' awareness and knowledge of priority diseases
- This enabled communities to detect very early health risks and events that could become epidemics.
- Communities are also aware of the channels to report these events and take the necessary measures to avoid the spread of diseases
- They also noted the adoption of positive behaviours and attitudes that protect population health and avoid the spread of diseases such construction and proper use of pit latrines, adoption of safe WASH habits, and self-reporting of children and animals who need to be vaccinated.

Specific advancements have been made in reaching National Society Preparedness: Stakeholders noted the following advancement in National Society preparedness

- Stakeholders estimated that CP3 was effective at 77.5% (3.1/4, N=30) in enhancing NS volunteers and staff knowledge and capacity in community-based surveillance and epidemic preparedness
- The above increased National Societies' ability to support community-based surveillance and made NS a key partner in the early detection, reporting, and response to epidemic crises as evidenced by CP3 volunteers being responsible for recent alerts on Mpox and other epidemics.
- CP3 also allowed to strengthen National Societies strategic planning for epidemic prevention, preparedness and response, data management and reporting capabilities.

Specific advancements have been made in reaching Key Stakeholder Engagement: Stakeholders perceived the following advancement in stakeholders' engagement:

- CP3 activities aiming to transfer knowledge to local partners were effective at 72.5% (2.9/4; N=41), in this regard, CP3 increased local stakeholders' understanding of the necessity for a multisectoral one health approach to epidemic and pandemic risk management,
- CP3 also provided a space where local stakeholders could exchange and have hands-on experience through field activities.
- CP3 has strengthened the access to community-based surveillance (CBS) data for One Health stakeholders based on an agreed CBS protocol. This allows early detection, and prompt reporting and stimulates an early response from stakeholders.

1.4.4 Evaluation Question 3: CP3 Programme sustainability beyond donor funding?

Key ideas about CP3 sustainability beyond donor funding:

- No sustainability without funding. Stakeholders emphasized that for an epidemic preparedness Programme like CP3, which relies on volunteers' efforts, there would be challenges with sustainability without incentivising the volunteers. This support is essential for them to consistently and comfortably perform their work on the ground, especially in countries that heavily rely on the volunteers of NS.
- Sustainability lesson from Kenya model: Learning from the comparison of the Kenyan implementation model, which utilizes Community Health Promoters (CHP), previously known as Community Health Volunteers, who are now incentivized), with the Indonesian and DR Congo implementation models, which heavily rely on National Society volunteers and staff interfacing between the communities and local stakeholders for activities, in terms of sustainability, the Kenyan model is more likely to be sustainable, considering the following:

- **In the Kenya model**, there is an elaborate Community Health Strategy that outlines how level one (community health) healthcare service is delivered. This is through the Community Health Promoters (CHPs) who are selected by the government under the Ministry of Health in close collaboration with local leaders and community members. These CHPs are then trained on basic packages that includes a host of simple tasks of screening for chronic illnesses, event based/community-based surveillance, screening for routine immunization defaulters etc. Kenya Red Cross complements the government by building the capacity of Community Health Promoters (CHPs) through further training in Epidemic Preparedness and response in Communities (EPiC), including the Community Based Surveillance package for early detection and reporting of outbreak potential diseases. The CHPs are incentivised by the Government, and all partners implementing community-based health interventions are required to implement through the same CHPs. This arrangement ensures that the CHP becomes a community resource available during a Programme's lifespan and way after its completion, thus could likely ensure sustainability of introduced interventions, such as those by CP3.
- **In DR Congo and Indonesia,** the National Societies train their volunteers and staff to act as the interface between communities and local partners (including government officials). The volunteers reach out to government focal points in response to alerts and events. Not all government Ministries have available focal points at the community level, except for the Ministry of Health, which has community nurses (community relays) in DR Congo and heads of Public Health Centres (PHC) in Indonesia. The volunteers bear the significant responsibility of identifying and interfacing with relevant government partners. They receive no equipment or financial support, except when projects like CP3 provide stipends. Despite this weakness in the structure, volunteers in DR Congo and Indonesia have tirelessly supported the implementation of CP3, creating awareness in communities and among One Health government partners. Due to the observed success of the CP3 model, which utilizes community members as volunteers to serve their own communities, these ministries are now considering establishing their own community volunteer programs. This is evident in DR Congo, where the Ministry of Animal Health has begun hiring Community Agents for Animal Health (CAAH).). We also observed some government initiatives supporting and funding activities during outbreaks. For example, we noted that the DRC Red Cross was able to quickly scale up CP3 modalities to respond to the recent Mpox outbreak. In Indonesia the government is effectively involved in mobilizing funds through the Indonesia's village fund and plan to scale up CP3 beyond the pilot regions using the Pandemic fund. However, to sustain the progress made through CP3 beyond donor funding, DR Congo and Indonesia must integrate CP3 acquisitions into their systems. This means addressing the institutionalization of CP3 progress (structure, functions, capabilities, and knowledge) and developing a local sustainable financial model to support communities volunteer incentives. Additionally, they should provide volunteers with equipment not only during outbreaks but also for continuous community epidemic and pandemic preparedness activities.

- Stakeholders also noted the following important sustainability ideas:
  - More implementation time is needed to entrench behavior change at the community level. Sustainability also means that donors and implementing partners should allow sufficient time for communities and countries to internalize and master the acquired knowledge and skills, rather than hastily move on to the next project or country.
  - Cross-Programme collaboration helps increase effectiveness. When possible, CP3 should seek collaboration with complementary initiatives, which can support WASH infrastructure, animal or human vaccination, or NS multi-hazard preparedness. By design, CP3 is a

preparedness Programme that provides knowledge and skills but cannot offer all the resources sometimes needed to apply this knowledge. Therefore, it is important to partner with organizations that provide resources such as WASH infrastructure and equipment for volunteer safety and transportation to complement CP3's efforts.

- Epidemics and pandemics do not respect borders (CP3 covered geographical areas), when the implementation is limited in small areas in the country, this reduces the effectiveness and chance of sustainability. Stakeholders stressed that epidemic and pandemics do not have borders but CP3 coverage is limited. Such a Programme that develops volunteer capacity, teaches communities good practices, promotes safe attitudes, and fosters behaviour change in epidemic and pandemic contexts, will have a better chance of being effective and continuation if implemented on a larger scale across counties, provinces, and countries, reaching a broader population rather than being limited to a small sample of communities.

1.5 CONCLUSIONS & RECOMMENDATIONS

Overall, CP3 was appropriate and relevant for all stakeholders at the international and local levels. Designed using the Global epidemic and pandemic preparedness framework, the Programme was adapted to local context by local stakeholders, proposing strategies and activities that are adapted to local populations.

CP3 has been effective, its health promotion strategies created awareness, and they enable communities to take control of their health by embracing a wide range of locally adapted social and public health interventions across the implementing countries. CP3 led to Epidemic and Pandemic System Strengthening (CEPSS) at the community level by increasing knowledge and good practices; strengthening early warning and response systems; decreasing outbreak frequencies due to surveillance and prompt notification and early action. It strengthened Epidemic and Pandemic Preparedness M&E systems; and supported the development of Epidemic and Pandemic Preparedness guidelines and overall improvement in Community Health.

Additionally, CP3 led to the development of a workforce for epidemic and pandemic preparedness & response – by training Community Health Promoters (CHPs), community health volunteers, and National Society staff and volunteers and training households to prevent, detect and respond to health threats across the implementing countries.

CP3 fostered collaborations and partnerships that facilitated the establishment of the one-health platforms at national and sub-national levels to coordinate with local partners on capacity-building efforts for epidemic and pandemic preparedness and response. Through multi-sectoral collaboration, the partners appreciated the interconnectivity between the environment, animals, and humans in disease transmission, prevention, and control.

CP3 strengthened the National Societies' capacity in epidemic and pandemic preparedness, response, and control - With the limited resources, National Societies in the CP3 countries have supported the detection and containment epidemics in these countries including priority diseases like cholera, chikungunya, anthrax, rabies, kala-azar and lately mpox that affected people or livestock. Table 6 below provides a summary of recommendations.

The CP3 has clearly advanced the priorities and goals of global health security instruments. This includes the JEE V3.0, IHR benchmarks, additional benchmarks for health emergency capacities beyond the IHR, and the strategic objectives 5 and 6 of the WHO General Programme of Work Number 14 (WHO GPW 14). These objectives focus on prevention, preparedness, mitigation, rapid detection, and effective response to health emergencies, aiming to protect 7 billion people.

Table 6. Summary of recommendations

Overarching Recommendations	
Design and implementation	
1.	IFRC and National Societies should advocate and support through CP3 for countries to identify and develop the most efficient and cost-effective structure that allows One H**ealth** Stakeholders to collaborate and support the epidemic and pandemic preparedness effort including community-based surveillance.
2.	To strengthen stakeholders' engagement and participation, IFRC and National Societies should support and advocate and through CP3 the development of procedures for cascading representation of all line Ministries of Health, Animal Health, and Environment to the community level, and establish collaborative frameworks to improve health approach in reporting and service delivery at both community and district levels.
3.	Partners Programmes like CP3 should not operate in silo but rather in collaboration with other Programmes by exploring partnerships with organizations, institutions and agencies to provide clean water to sustain and entrench the gains on public health interventions among community volunteers and community nurses during epidemic response.
4.	As supported by the Food and Agriculture Organization of the United Nations (FAO), to strengthen stakeholders' engagement and participation, IFRC and NS should advocate and support through CP3 to hasten the development of policies and structuring the organogram by the Ministry of agriculture and Livestock in charge of Animal Health to cascade their presence from national to community level to allow them to operate efficiently within the One Health partnership; and advocate for a partner to support the Ministry of Environment to initiate and finalize the same structural re-organization to community level
5.	Advocate for the adoption of the 7-1-7 target to measure the effectiveness of epidemic preparedness and response and generate improvement plans.
6.	Engage local mobile telecommunications partners to support the One Health actors by providing free airtime to community health workers and volunteers for alert notifications as part of their community social responsibility.
7.	Advocate with partners and stakeholders to establish dedicated contingency funds to facilitate logistics for early responses to alerts raised by the community regarding emerging or existing health threats.
8.	Maximize on the acquired knowledge of volunteers trained by CP3 while it is still fresh to replicate the acquired training, good practices, habits and changes in behaviours by using the trained volunteers to train more volunteers an**d** expand epidemic preparedness including CBS activities beyond CP3 covered areas.
Monitoring and Evaluation	
9.	IFRC and National Societies need to strengthen the M&E system and develop a clear M&E framework.
10.	Identify and define objective, quantifiable, measurable, and unambiguous indicators for CBS, community preparedness, National Society preparedness, and stakeholder engagement associated with each activity or intervention. These indicators should enable the measurement and demonstration of CP3 effectiveness and impact. Additionally, determine the baseline, target, data source, frequency of reporting, and assign responsibility for reporting these indicators.
11.	Consult with the countries to design data collection tools that allow for the collection of all necessary data elements to aggregate these indicators. Standardize these tools across all countries by maintaining version control and restricting unnecessary modifications.
12.	Document all M&E tools, structures, functions, capabilities, and procedures in a Standard Operating Procedure (SOP) that highlights all CP3 data management steps. Conduct workshops on the SOP at all levels of data management and ensure it is available to all staff and volunteers involved in the data management process.

A more elaborated table of recommendations proposing leads for potential implementation is available on Table 35

2 INTRODUCTION

2.1 Background to the CP3 Programme

WHO (2024)[2] noted that Pandemics and large-scale outbreaks can claim millions of lives, disrupt societies, and devastate economies and livelihoods. Large-scale epidemics and pandemics pose a serious threat to countries, communities, and individuals as well as to global health security. Epidemics and pandemics affect all sectors of One Health, impacting routine health services, economic and food security, international trade and travel, education, civil order, communication, and many other facets of human development. In response to this threat, at the end of 2017, the International Federation of Red Cross and Red Crescent Societies (IFRC) received funding from the United States Agency for International Development (USAID) to launch a Programme focusing on Community Epidemic and Pandemic Preparedness (CP3).

The CP3 Programme design applies a whole-of-society and all-hazards approach by focusing its interventions on three key workstreams: **community preparedness**, **National Society preparedness,** and **key stakeholders' engagement**. In the last decade, disease-related health emergencies have demonstrated that epidemics and pandemics start at the community and end at the community level. As such, the first workstream of the CP3 Programme on community preparedness is geared toward strengthening community resilience against the detrimental effects of epidemics and pandemics. The second workstream on National Society preparedness focuses on strengthening the National Society's capacity to prepare and respond to epidemic and pandemic threats of now and into the future. Workstream three revolves around key stakeholder engagement to promote and support the key stakeholder engagement in health security-related activities and initiatives in the implementing countries.

Through CP3, the IFRC has supported communities, the NS of the Red Cross and Red Crescent, and other implementing partners to enhance capacities to prepare for, prevent, detect, and respond to threats from epidemics and pandemics. The IFRC signed agreements with NS in the seven USAID purposively selected countries (Red Cross and Red Crescent societies in-country) to implement most of the Programme at country and community levels with IFRC taking up limited overall oversight roles. IFRC and NS have contracted staff to lead and support the implementation.

2.2 CP3 Programme design and implementation

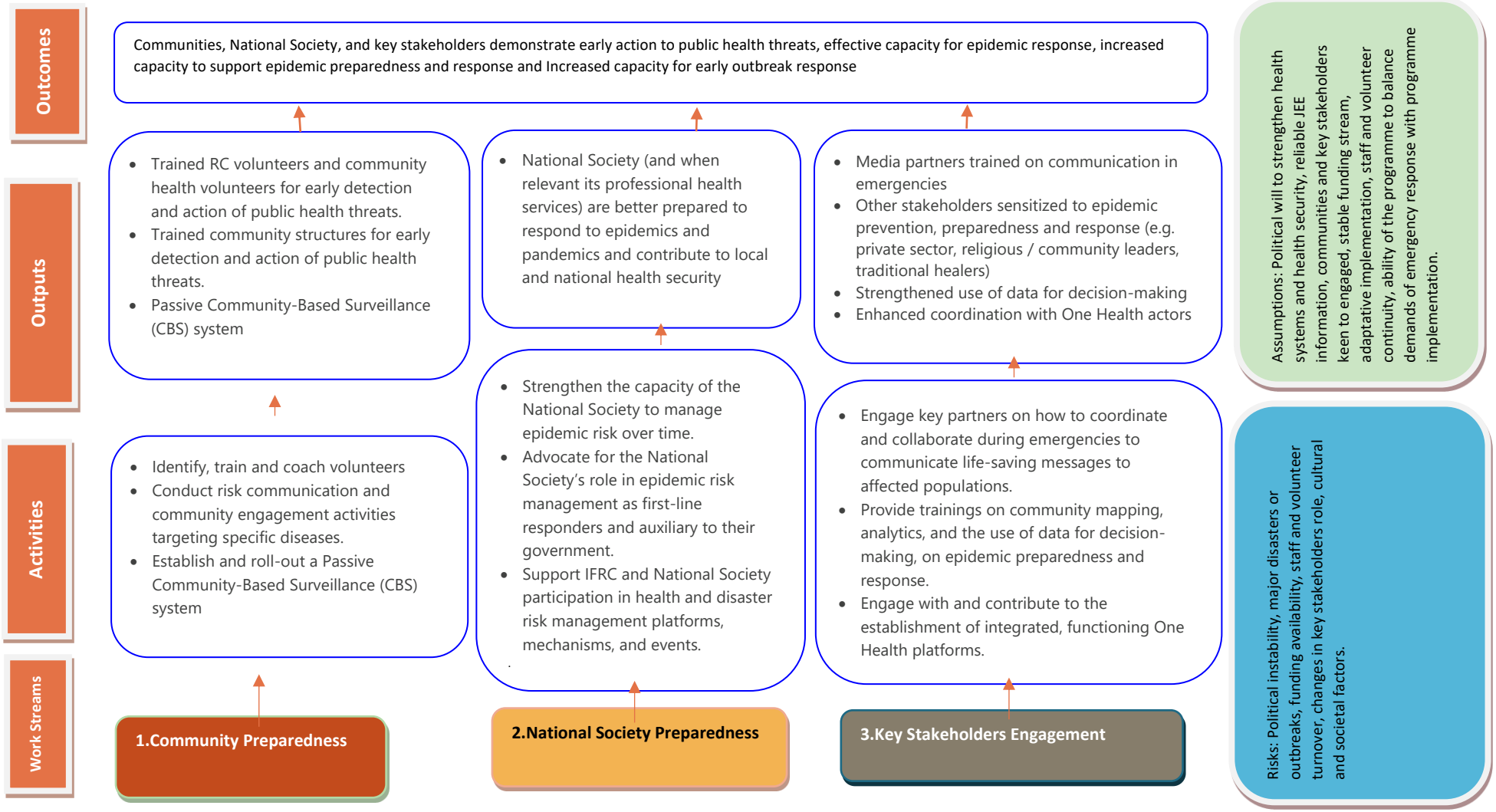
The implementation of the CP3 Programme is ringfenced by a comprehensive Monitoring and Evaluation (M&E) framework that defines the activities that are required to satisfy every workstream embedded in the Programme design. The M&E framework also describes how the activities are built into the expected Programme outputs, outcomes, and finally into the overarching Programme goal. To contribute to global health security through the WHO International Health Regulation (WHO-IHR) benchmarks, the CP3 M&E framework was designed to align the Programme indicators with those of the IHR core capacities both in JEE, SPAR, and USAID GHSA indicators. By meeting the set target indicators within the defined workstreams, the CP3 Programme would have contributed to correlatable improvement in the indicators of the WHO-IHR benchmarks. Although the NS are responsible for implementing the CP3 Programme at the country and community level, the IFRC maintains oversight through Programme coordinators, health coordinators, and delegates who are based at Geneva, regional, cluster, or the country offices.

[2] WHO, Preparing for pandemics: https://www.who.int/westernpacific/activities/preparing-for-pandemics

2.2.1 Theory of Change Description

The simplified Theory of Change Figure 1 below was used for stakeholders' identification and to refine the questions in the evaluation matrix and KII tool.

Figure 1. CP3 Framework for Implementation



2.2.2 DESCRIPTION OF IMPLEMENTATION MODEL – KEY ELEMENTS

The Programme utilizes a whole-of-society, all-hazard approach with several key interventions focusing on three primary workstreams: - **Community Preparedness**: Helping targeted communities around the world gain knowledge and skills on early identification and notification of infectious disease threats, enabling early action. This involves training of community members and volunteers for CBS as well as community health promotion interventions. - **National Society Preparedness**: Engaging Red Cross and Red Crescent volunteers to support governments by training networks of volunteers in early detection of, and early response to, outbreaks so they can be the first responders on the ground. This workstream involves enhancing capacity for effective response, epidemic planning, and National Society-managed health facilities' infection prevention and control-related activities. - **Key Stakeholders Engagement**: Engaging with the private sector, religious leaders, the media, and many more stakeholders in synergising their efforts and leveraging on resources necessary for preparedness, prevention, detection, and supporting communities during disease outbreaks. The interventions in this workstream include community leaders and stakeholder meetings, data readiness for public health decision making, media preparedness and supporting One Health platforms.

2.2.3 IMPLEMENTING COUNTRIES

The Programme primarily targets communities in: Cameroon, the Democratic Republic of Congo, Guinea, Indonesia, Kenya, Sierra Leone, and Uganda.

The 7 selected countries meet one of more of the following[3]:

- They are experiencing a perilous health situation with considerable risks of infectious diseases,
- They are continuously facing several complex health crises and experiencing the world's largest outbreaks,
- They are facing growing insecurity as well as significant deterioration of food security, which predisposes large segments of populations to health risks,
- Many communities are vulnerable to natural hazards and public health emergencies which can trigger disease outbreaks, particularly when affected people are displaced,
- They have the lowest life expectancy in the world in addition to having the highest morbidity and mortality rates for children under five years of age with the main causes of death being related to infectious diseases.
- They are also all part of USAID's GHS programme

2.2.4 CP3 PROGRAMME STRUCTURE, FUNCTIONS AND RESPONSIBILITIES

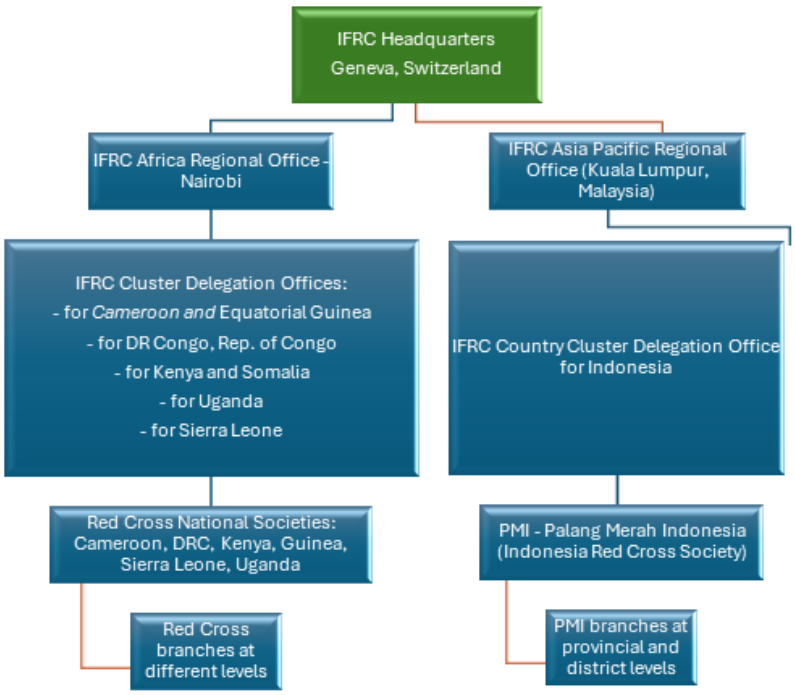
As part of addressing these large-scale pandemics and epidemic outbreaks and preventing them from claiming millions of lives, disrupting societies, and devastating economies and livelihoods, the IFRC was chosen to facilitate the involvement of communities and civil societies in epidemic and pandemic preparedness. This is done to enable early response and mitigate the impact. The selection of IFRC was based on its unique capability to support the implementation of the "whole-of-society" approach to epidemic and pandemic preparedness by leveraging its supporting role to the 191 National Red Cross and Red Crescent Societies.

Figure 2 describes how the IFRC Headquarters through its Health Department, specifically the Community & Emergency Health Unit currently known as "Health Security and Community Resilience Unit" initiated and is

[3] IFRC countries two-pager about activities: https://www.ifrc.org/our-work/health-and-care/emergency-health/epidemic-and-pandemic-preparedness

leading the project management and governance through its regional offices, delegation/cluster offices, and the country project managers to provide support to the National Societies. The CP3 is implemented in-country by Red Cross and Red Crescent National Societies with technical support from IFRC. Even though there is a regional office in the Asia-Pacific region, the Indonesia IFRC office has mainly reported directly to the Headquarters in Switzerland for this Programme. This is because Indonesia is the only country in the region that is implementing the CP3 Programme.

Figure 2. CP3 programme structure (2019 to 2023)



2.2.5 Evolution of the CP3 M&E Framework from 2021 to 2024 and implementation timeline across countries

The CP3 Programme indicators naturally evolved from a planning (projection) perspective (formulation stage) to actual (concretely implemented) accountable deliverables that need to be aggregated and reported. This is shown in the evolution of the CP3 M&E framework where indicators developed from planning indicators[4] also known as Objectively Verifiable Indicators (OVI's) in 2021 to more accountable indicators (Inputs and outcome indicators) in 2024 even if programmatically these are still designated as OVIs.

Overall, we noted the following changes in the framework between 2021 and 2024:

- Some workstreams and indicators were reworded without affecting the meaning defined at the CP3 Programme formulation phase.
- Some indicators were reworded, affecting the meaning defined at the CP3 Programme formulation phase
- Some indicators were dropped or removed from the CP3 Programme (deemed obsolete)

[4] Planning indicators: also known as Objectively Verifiable Indicators (OVI's) are formulated for the Overall Objective(s), the Project Purpose and for the Results. This provides sufficient level of detail for the formulation stage, MDF Tool: Indicators: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sportanddev.org/sites/default/files/2023-01/indicators.pdf

- New indicators were introduced at existing workstreams
- Workstream 4 was introduced

We describe below how each workstream indicators evolved, where applicable. However, for this phase 1 mid-term evaluation and to better use the data collected during the life of the project from 2019 to 2023, if there were any major changes in 2024, we will use the indicators as defined in the 2021 framework.

Workstream 1: Community Preparedness

Table 7. Workstream 1 indicators: Evolution from 2021 to 2024

Ind #	Indicator Code/ Number	GHSA Indicator	Objectively Verifiable Indicators 2021	Objectively Verifiable Indicators 2024	Indicator Level
Workstream 1: Community Preparedness OBJECTIVE 1. To strengthen community resilience against the detrimental effects of epidemics and pandemics					
Enhanced health security through community preparedness and early action to public health threats					**Outcome 1**
1.	WS1.0.0	R.5.4	% of CP3 target communities (i.e. selected villages and towns) that show improvements in key benchmarks part of the KAP by the end of the project	% of CP3 target communities (i.e. selected villages and towns) that show improvements in key benchmarks part of the KAP by the end of the Programme	Outcome
Communities, RCVs and Community Health Volunteers (CHV) are prepared for early detection and early action (Epidemic Control for Volunteers (ECV), CBS) to public health threats					**Output 1.1**
2.	WS1.1.1	R.1.1	Number of contextualised toolkits to train Red Cross staff, RCVs/CHVs	# of contextualised toolkits to train Red Cross staff/volunteers and community health volunteers	Output
3.	WS1.1.2	D.2.1 R.1.1	Number of RCVs/CHVs trained on epidemic and pandemic preparedness	# of volunteers trained on epidemic and pandemic preparedness	Output
4.	WS1.1.3	D.2.1 D.3.2 P.4.1	% of CBS-trained RCVs/CHVs who routinely submit timely CBS reports	% of active volunteers submitting health risk reports and/or activity reports "on time" as determined by the protocol	Output
5.	WS1.1.4	D.2.1 D.3.2 P.4.1	% of CBS alerts verified as 'true' alerts (correctly match the Community Case Definition)	% of CBS alerts cross-checked and accurately matching community case definition	Output
6.	WS1.1.5	D.2.1 D.3.2 P.4.1	% of CBS alerts reports investigated by MoH/MoA within 48 hours	% of CBS true alerts escalated to health authorities in 24 hours	Output
7.	WS1.1.6	P.5.1 D.2.1		% of alerts which were investigated/ reacted to (in under 24 hours)	Output
8.	WS1.1.7	P.5.1 D.2.1		% of true alerts that are confirmed as cases after investigation (clinical and lab testing)	Output
9.	WS1.1.8	P.5.1 D.2.1		% of alerts which were responded to through public health action within 7 days	Output
10.	WS1.1.9	P.5.1		# of animals supported by the RC to receive relevant vaccinations	Output
Communities are prepared for early detection and early action through community-based education campaigns and information sharing.					**Output 1.2**
11.	WS1.2.1	R 5.2	% of community members who know key practices to prevent epidemic disease spread	% of community members who know key practices to prevent epidemic disease spread	Output
12.	WS1.2.2	R 5.2	% of community members who have received RC/RC epidemic awareness information (any channel)	% of community members who have received RC/RC epidemic awareness information (any channel)	Output
13.	WS1.2.3	R 5.2	# of people reached with community health activities (Note: the same people can be counted multiple times)	# of people reached directly with community health activities (Note: the same people can be counted multiple times)	Output
14.	WS1.2.4	R 5.2	# of radio Programmes delivered	# of radio shows delivered	Output
Awareness on risks of epidemics and pandemics is increased in schools					**Output 1.3**
15.	WS1.3.0	R 5.2	# of schools engaged with awareness campaigns	# of schools engaged with awareness campaigns	output

Under workstream 1 as shown in Table 7 above, several indicators were reworded without affecting their initial meanings and four (4) new indicators were added under output 1.1 (preparedness for early detection

and early action to public health threats).

Workstream 2: National Society Preparedness

Table 8. Workstream 2 indicators: Evolution from 2021 to 2024

Ind #	Indicator Code/ Number	GHSA Indicator	Objectively Verifiable Indicators 2021	Objectively Verifiable Indicators 2024	Indicator Level
Workstream 2: National Society Preparedness OBJECTIVE 2. To build National Society capacity to prepare and respond to epidemic and pandemic threat					
Red Cross NS (NS) demonstrate effective capacity for epidemic response					**Outcome 2**
16.	WS2.0.0	R.1.2	# of outbreak simulations/after action review the NS has participated in	# of outbreak simulations/after action review the NS has participated in during the life of the Programme	Outcome
National Society is prepared to respond to epidemics and contributes to local and national health security					**Output 2.1**
17.	WS2.1.1	R.1.2	Preparedness for Effective Response (PER) assessment completed	Number of PER full cycle(s) including epidemic risk completed per country during the life of the Programme	Output
18.	WS2.1.2	R.1.2	Development and implementation of NS capacity building workplan based on PER assessment		Output
19.	WS2.1.2	R.1.2		# of outbreaks responded with the support of the National Society which are documented in a case story	Output
20.	WS2.1.3	R.1.2	NS multihazard contingency plans and SOPs for epidemics are developed/updated	# of contingency/response plans or business continuity plans for epidemics are developed/updated	Output
21.	WS2.1.4	R.1.2	Number of National Response Team members within RC National Society who have been trained to support disease outbreak response	# of National Response Team members within RC National Society who have been trained to support disease outbreak response	Output
National Society health facility services are epidemic ready					**Output 2.2**
22.	WS2.2.1	R.1.2	Number of RC health facilities that have conducted an Infection Prevention and Control (IPC) assessment	# of RC health facilities that have an IPC improvement plan	Output
23.	WS2.2.2	R.1.2	% of target RC facility frontline staff trained on IPC	# of health facility staff who took part in at least an IPC training activity.	Output
24.	WS2.2.3	R.1.2	% of target RC health facilities that develop an epidemic contingency plan	# of RC health facilities that develop a health services continuity plan	Output
25.	WS2.2.4	R.1.2		% of hand hygiene compliance	Output

Under workstream 2 as shown in Table 8 above, several indicators were reworded to give them a more pragmatic, quantifiable meaning, particularly in output 2.1. For instance, indicator WS2.1.2 (R.1.2) changed from "Development and implementation of NS capacity building workplan based on PER assessment "to "Number of PER full cycle(s) including epidemic risk completed per country during the life of the Programme". Additionally, in output 2.2 an indicator was added measuring the percentage (%) of hand hygiene compliance in National Society health facility services as one of the indicators of epidemic readiness.

Workstream 3: Key Stakeholder Engagement

Workstream 3 was reworded "Key Stakeholder Engagement" while it was initially known as "Media, private sector, data readiness, and other stakeholders". As per Table 9 below, it is observed that outcome 3 also was reworded without changing its initial meaning from "External stakeholders are equipped with tools to increase their capacity to support epidemic response" to "Key stakeholders have increased knowledge or capacity to support epidemic preparedness and response". Output 3.3 also was reworded without changing its meaning. The major changes here are:

- The indicator on "Number of people sensitized by type (leader, healer, etc.)" was moved from output

3.4 to output 3.2

- Two indicators were dropped: "% of people trained (National Societies, MoH, partners) on working with media who demonstrate improved ability to disseminate epidemic related information" under output 3.1 and "% of high-priority datasets essential to disaster situations or health emergencies are identified, collected, validated, and disseminated in an open-data environment" under output 3.3.
- One additional indicator was added under output 3.4 "number of NS actively involved in One Health coordination mechanisms"

Table 9. Workstream 3 indicators: Evolution from 2021 to 2024

Ind #	Indicator Code/ Number	GHSA Indicator	Objectively Verifiable Indicators 2021	Objectively Verifiable Indicators 2024	Indicator Level
Workstream 3: Media, private sector, data readiness and other stakeholders OBJECTIVE 3. To promote private sector, media and other key stakeholder engagement in health security					
External stakeholders are equipped with tools to increase their capacity to support epidemic response			**Key stakeholders have increased knowledge or capacity to support epidemic preparedness and response.**		**Outcome 3**
25.	WS3.0.0	R.5.4	% of other stakeholders (disaggregated by type) who have received RC/RC epidemic awareness information (any channel)	% of other stakeholders (disaggregated by type) who have received RC/RC epidemic awareness information (any channel)	Outcome
Media outlets are trained and effective to disseminate epidemic related information					**Output 3.1**
26.	WS3.1.1	R.5.3	# of people trained by type (NS, MoH, local media) on dissemination of epidemic information to affected population	# of people trained by type (NS, MoH, local media) on dissemination of epidemic information to affected population	Output
27.	WS3.1.2	R.5.3	% of people trained (NS, MoH, partners) on working with media who demonstrate improved ability to disseminate epidemic related information		Output
Private sector actors are sensitized on business continuity as well as to support community preparedness.					**Output 3.2**
28.	WS3.2.1	R.5.4	Number of entreprises sensitized about about epidemic preparedness	# of enterprises sensitized about epidemic preparedness	Output
29.	WS3.2.2	R 5.2 R.5.3		# of people sensitized by type (leader, healer, etc.)	Output
Disaster responders have accessible, reliable data prior to a disaster that assists in situational awareness, planning, implementation, monitoring, and reporting.			**RC staff, volunteers, and partners are equipped to use data for decision-making for disaster and emergency risk management**		**Output 3.3**
30.	WS3.3.1	R.1.2	# of RC staff, RC volunteers, partners trained in data readiness and or data literacy	# of RC staff, RC volunteers, partners trained in data readiness and or data literacy	Output
31.	WS3.3.2	R.1.2	% of high-priority datasets essential to a disaster situations or health emergencies are identified, collected, validated, and disseminated in an open-data environment [5]		Output
32.	WS3.3.3	R.1.1		# of evidence-based products developed by NS where they collect their reflexions on the use of data for decision-making.	Output
Other stakeholders (religious/traditional leaders, traditional healer, etc.) are trained to disseminate epidemic related information					**Output 3.4**
33.	WS4.1.0		Number of people sensitized by type (leader, healer, etc.)		Output
34.	WS4.1.0	P.5.1 R.1.1		# of NS actively involved in One Health coordination mechanisms	Output

Workstream 4: Epidemic Response (ONLY UGANDA and GUINEA in fiscal year 2023)

A natural progression from the implementation of the three (3) workstreams required an addition of the fourth workstream on "Epidemic Response". This workstream is reflected in the new framework 2024 and will not be included in this evaluation. Table 10 below is providing more details on the new additional workstream

Table 10. Workstream 4 indicators 2024

Ind #	Indicator Code/ Number	GHSA Indicator	Objectively Verifiable Indicators 2021	Objectively Verifiable Indicators 2024	Indicator Level
Workstream 4: Epidemic Response (ONLY UGANDA and GUINEA) OBJECTIVE 4. To support early outbreak response in Programme districts or in other parts of the country when and as appropriate					
Increased capacity for early outbreak response in Programme districts and other regions.					**Outcome 4**
35.	WS4.0.0	R 5.2 R.5.3		# of people reached with epidemic-related health promotion activities	Outcome
Effective outbreak response actions taken by the National Society to prevent and control the spread of outbreaks.					**Output 4.1**
36.	WS4.1.1	P.5.1 D.2.1		# of community health volunteers newly trained in epidemic control outside of CP3 target areas (it should not count people trained under workstream 1)	Output
37.	WS4.1.2	P.5.1 D.2.1		# of volunteers trained in CBS who are active in case finding during early outbreak response	Output
38.	WS4.1.3	P.5.1 R.1.1 R.5.1 R 5.2 R.5.3		# of people receiving refresher training for epidemic prevention and control	Output
39.	WS4.1.3	P.5.1 R 5.2 R.5.3		# of animals supported by the RC to receive relevant vaccinations during early response outbreak	Output

3 Evaluation Purpose

The overall objective of this Mid-term Evaluation is to assess and analyse the delivery of the first phase of the Community Epidemic and Pandemic Preparedness Programme (CP3) covering the period from October 2017 to September 2023 and derive key recommendations from the findings. The findings from this evaluation will inform how the CP3 can better support the WHO-IHR (JEE/SPAR) benchmark identified priorities, ensuring that efforts to prevent, detect, and respond to public health risks are effective, efficient, and sustainable.

The main purpose of the evaluation is to assess the effectiveness, relevance, appropriateness, and sustainability of the Programme. The consultants are expected to collect multiple countries and stakeholders qualitative and quantitative data, analyse and generate findings and conclusions based on evidence.

4 Evaluation questions

The IFRC's proposed evaluation questions reorganized by evaluation criteria are presented in Table 11 below. The re-framed evaluation questions that were simplified to allow easy understanding by different audiences are available on the Key Informants Interview tool in Annex 3

Table 11. Key evaluation questions linked to proposed data collection method(s)

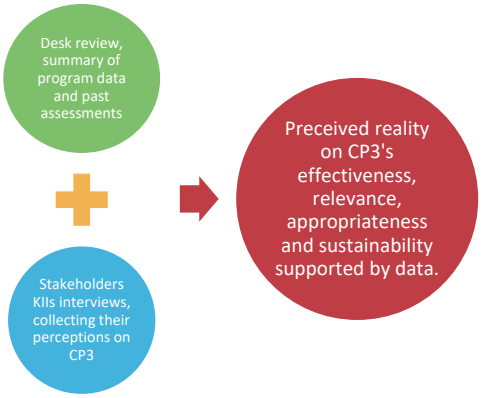
Area of Focus	Research Questions	Data collection method	
		KIIs	Desk Review
1. Relevance/ Appropriateness	1.1. To what extent is the Programme consistent with the needs and priorities of targeted communities, National Societies, and local partners as well as relevant commitments and global health security goals of countries, USAID, IFRC and NS?	X	X
	1.2. To what degree have local country partners, recipients, and target communities been actively involved in the design, implementation, and monitoring/evaluation of the CP3 Programme?	X	X
	1.3. Has there been proactive engagement between the National Societies and partners for initiatives related to Global Health Security beyond the scope of the CP3 Programme? If so, what are the nature and extent of these actions?	X	X
2. Effectiveness	2.1. What specific advancements have been made in reaching the Programme's expected outcomes and impacts, and what are the observed results, both planned and unplanned, at various levels of output, outcome, and impact? *Two KAP surveys in each country will as well inform this question to some extent.	X	X
	2.2. What successes and challenges have been faced by National Societies and the IFRC Secretariat in ensuring effective and efficient epidemic preparedness?	X	X
	2.3. How effective has the knowledge and skill transfer been to local partners and stakeholders, and what improvements are suggested for the next phase?	X	X
	2.4. Are there documented instances where National Societies have effectively responded to epidemics, demonstrating the success of preparedness efforts?	X	X
	2.5. Has the CP3 Programme facilitated the development of a more robust partnership between the National Societies, the Ministry of Health, the Ministry of Agriculture and/or the Ministry of Environment? Please provide examples of how this relationship has evolved.	X	X
	2.6. How significantly has the CP3 Programme enhanced existing partnerships or led to the creation of new ones to bolster Community Epidemic and Pandemic Preparedness (e.g. through One Health platforms, community health units action plans)?	X	X
	2.7. What partnerships or collaborations have been most effective in integrating the Programme with wider health systems?		
3. Sustainability	3.1. How can the Programme's design and strategies be further adapted to anticipate and adapt to future changes in local contexts, resources, and needs?	X	X
	3.2. Regarding the potential for Programme expansion, what initial pitfalls or good practices should be considered when initiating the Programme in new countries or locations?	X	X
	3.3. What could National Societies do to sustain community epidemic preparedness Programming and embed epidemic preparedness in overall disaster preparedness, early action and response mechanisms?	X	X
	3.4. Have the National Societies been able to implement and apply approaches and tools used in the Programme in their emergency response efforts that are not financed by the CP3 Programme (e.g. during the Corona Virus Disease 2019 (COVID) pandemic, Ebola Virus Disease (EVD) or cholera outbreaks)?	X	X

5 Evaluation Methodology

5.1 Evaluation approach

To answer the evaluation questions mentioned above, the evaluation team used a mixed-methods approach. Both quantitative and qualitative data were collected and/or analysed to evaluate the Programme trends and accomplishments in relation to pre-established Programme targets and objectives. Figure 3 below is an illustration of the evaluation approach:

Figure 3. Evaluation Approach



Our strategy for addressing the evaluation questions is outlined in detail in the Evaluation Matrix (Annex 1). This document specifies the original evaluation question, the evaluation team's reframing of the questions, the source of the answer, as well as the proposed methods for data collection and analysis. We employed two primary approaches for data collection to answer the evaluation questions: The desk review and Key Informant Interviews (KIIs).

Inception briefings: Considering the diverse teams and structure of the CP3 Programme, we needed to meet with the IFRC team that is supporting the implementation while preparing our inception report. This allowed us to gain more insight into the Programme design, implementation plan, and data management which, in turn, provided us with crucial information to guide the evaluation design, fieldwork, data analysis, and report writing.

5.1.1 DESK REVIEW APPROACH

The evaluation team members conducted a desk review of all 7 countries' Programme documents shared by IFRC. This included the following CP3 implementation Programme data sources:

- Performance indicators data: Quantitative data from countries indicators Tracking Table (ITT), and Knowledge, Attitude, and Practice (KAP) survey) from the project's key indicators of success described in Tables 1, 2 and 3 were mined and analysed.
- Activities delivered and narratively reported: Qualitative data from progress reports, that show the degree or extent to which a successful outcome was reached were also mined and analysed.

The purpose of the desk review was to identify relevant data sources and gather information from existing Programme generated data and use it to establish a correlation/triangulation with stakeholders' perceptions to learn and support how much the CP3 Programme was effective, relevant and appropriate to stakeholders and explore their ideas around how sustainable CP3 can be beyond USAID funding.

5.1.2 KEY INFORMANT INTERVIEWS APPROACH (KIIS)

KIIs were conducted with individuals or groups, depending on the availability of the respondents as scheduled by IFRC team. Considering the urgent nature of humanitarian epidemic and pandemic work, the evaluation team was as flexible as possible in conducting these meetings. The KIIs targeted key stakeholders of the CP3 Programme at the USAID and IFRC level (headquarters, regional offices in Africa and Asia-Pacific, and country cluster delegations), as well as local stakeholders in the selected countries that we visited for fieldwork: DR Congo, Kenya, and Indonesia. A KII tool was developed and used to assess the relevance/appropriateness, effectiveness, and sustainability of the CP3 Programme. The KII tool we used (see Annex 3) is a semi-structured interview guide largely qualitative, however, we have also incorporated quantitative measures in the tools in the form of Likert scales (e.g. Strongly Agree to Strongly Disagree) to allow for comparisons between respondent groups.

5.1.3 Sampling Approach

Desk Review data sampling: All relevant and available data from the seven countries, covering the evaluation period (October 2019 to September 2023) is included in the desk review. Indicators values that have zero for the lifetime of the project, were only considered if they held a significant meaning like the number or percentage of alerts. We excluded from aggregation and analysis all indicators that have zero value during the lifetime of the project, which could mean one of the following:

- The activities did not take place (was not funded)
- The activities did not take place (the implementation did not happen)
- The indicator was not applicable to the country and that is the reason why it was not reported.

Countries selection: IFRC support is focused on communities in seven (7) countries and twenty-five (25) regions/countries/provinces, as described in Table 6 below. The evaluation team visited three (3) selected countries Programme. Two countries in Africa (DR Congo is a French-speaking country while Kenya is English-speaking) were selected, while Indonesia, the only country in the Asia Pacific region, was specifically included.

Counties/regions/provinces and villages selection: These counties/regions/provinces and villages were mainly chosen to achieve a balance between rural and urban areas. Where possible USAID priority provinces were included as well. Activity sites in communities within the selected counties/regions/provinces were selected to strike a balance between high-activity sites and low-activity sites based on reported indicators.

In the DR Congo, out of the three CP3 implementing provinces, we selected the province of Kongo Central and the Capital city province of Kinshasa. In Indonesia, out of the six CP3 provinces, we selected: West Java, Banten, and the USAID priority region of South Sulawesi while in Kenya out of the four CP3 provinces, we selected Tharaka Nithi which is a peri urban region, and Narok which is a pastoralist county bordering Tanzania and frequently experiences transboundary zoonotic diseases.

The selected countries, counties/regions/provinces, and villages/areas are highlighted in green below (Table 12).

Table 12. Implementing countries and counties/regions/provinces

Country	Counties/Districts/Provinces	Targeted Village/ Area	Selected for Fieldwork visit
1. Cameroon	North Cameroon		No
	East Cameroon		No
2. Democratic Republic of Congo	Kinshasa	Maluku and Mbinza Meteo	Yes
	Kongo Central	Madimba, Seke Banza and Nsona Mpangu	Yes
	Equateur		No
3. Guinea	Dinguiraye		No
	Dabola		No
	Faranah		No
	Kissidougou		No
4. Indonesia	West Kalimantan		No
	Central Java		No
	West Java	Bogor Timur (Katulampa), Tanah Sareal (Mekarwangi)	Yes
	Banten	Pandeglang (Saruni and Juhut)	Yes
	Bali	Kediri (Belalang), Tabanan (Delod Peken)	No
	South Sulawesi	Simbang (Samangki)	Yes
5. Kenya	Bomet		No
	Narok		Yes
	Tharaka-Nithi		Yes
	West Pokot		No
6. Sierra Leone	Kailahun		No
	Kambia		No
7. Uganda	Kabale		No
	Kamwenge		No
	Kitagwenda		No
	Bundibugyo		No

KIIs targeted vs. actual: Table 13 below is showing the targeted KIIs vs actual KIIs conducted.

Table 13. Targeted KIIs VS actual

Targeted

Type of Respondent	Number of Targeted interviews
International partnerships and organizations (KIIs)	**32**
IFRC Headquarters	4
IFRC Regional Offices for Africa and Asia-Pacific	4
IFRC Country Cluster Delegations covering the target countries	8
USAIDPoint of Contact	8
Country Manager	8
Local stakeholders (KIIs or FGD)	
DR Congo	40
Kenya	40
Indonesia	40
All KIIs	**152**

Actual

Province	Nbr of interviews	Nbr of interviewees	Country status
DR CONGO	**31**	**100**	**Visited**
Kinshasa	16	25	
Kongo Central	15	75	
KENYA	**44**	**80**	**Visited**
Tharaka-Nithi	21	22	
Narok	15	50	
Nairobi	9	9	
INDONESIA	**30**	**41**	**Visited**
West Java	18	23	
South Sulawesi	6	10	
Banten	6	8	
CAMEROON	**1**	**3**	**Remote**
Littoral	1	3	
GUINEE CONAKRY	**1**	**1**	**Remote**
Conakry	1	1	
UGANDA	**2**	**2**	**Remote**
Kampala	2	2	
SIERRA LEONE	**1**	**1**	**Remote**
Freetown	1	1	
SWITZERLAND	**2**	**3**	**Remote**
Geneva	2	3	
USA	**2**	**2**	**Remote**
Washington	2	2	
Total	**115**	**234**	

We intended to conduct 152 KIIs, we successfully conducted 115 KIIs with 234 respondents. Due to some respondents' limited availability, we agreed to have several group interviews instead of individual KIIs. While 115 KIIs represent a 75.6% success rate of our initial target, the benefit of having 234 respondents outweighs the number of interviews we did manage to have separately.

5.1.4 Data management and analysis Approach

Desk Review

We conducted the desk review of all Programme data submitted by IFRC, using the Data Mining Approach described below.:

- Extracting and transforming quantitative data (indicators) from different countries' spreadsheets available data sets into a single master dataset.
- Extracting, coding, and capturing qualitative data for the data mining exercise involves extracting or generating the following information from reports and documentation:
    - Theory of change description
    - Description of implementation model – key elements
    - M&E system
    - Partner mapping at different levels- by location and activities/focus area (Annex 2)
    - Key successes and challenges noted by implementing partners
    - Contribution to JEE indicators

Desk Review Challenge. While we were able to use the mined qualitative data to inform the background section of this report, we struggled to extract and make sense of the quantitative programme data presented

by IFRC M&E tools. Our team had to restructure the IFRC ITT data into a new database to make it usable. To facilitate a deep exploration of the data from 2019 to 2023, we developed a dashboard visualization of the CP3 Programme implementation data. The dashboard allows us to visualize the entire dataset, observe trends and data quality limitations, and extract an overall report consolidating activities data from all countries, as well as seven individual countries reports for each country, which we gave access to IFRC team in a form of dashboard platform that can be edited and adapted.

Dashboard development as a solution for IFRC data management limitations. The completed ITTs from all countries were standardized and integrated into a master dataset, encompassing all indicators per workstream across the Evaluation period (2019-2023). Yearly and monthly trends were explored using the dashboard at the country level, while in-depth analyses of key indicators were conducted per activities within the workstreams. The dashboard trends are used to establish a correlation between the stakeholders' KIIs narratives and CP3-reported activities.

The KAP survey results were also used as a triangulation source to support KIIs analysis.

Quantitative data was summarized using descriptive statistics, such as frequencies, proportions, means, and medians. This will effectively characterize respondent demographics and other key variables. The Likert scale scores were averaged by area of focus, and individual items within each domain were presented using frequencies and proportions. Qualitative data was systematically coded into thematic areas. Emerging themes were quantified using descriptive statistics to capture and convey the depth and breadth of the insights.

Key Informant Interviews

The KIIs data collection tool (Annex 3): is a semi-structured interview guide that was used to collect data from key informants. The guide was digitized using Kobo Toolbox (KOBO). This allowed the team to collect data using their computers or tablets. Once submitted to the secured KOBO's cloud, we were able to download the data as an Excel file, create the master dataset of all interviews from different levels, and start the data analysis.

We asked for permission from the respondents to record the interviews. In the DR Congo interviews were conducted in French and Lingala. In Indonesia, interviews were conducted in Indonesian (Bahasa) and English. In Kenya, interviews were conducted in English. Interviews were transcribed and translated into English to allow their incorporation into the master dataset.
KII data management, cleaning, and analysis were performed using Stata version 18 and R version 4.4.0. Duplicates were identified using the "validation status column". For interviews with multiple entries, those marked "approved" for analysis, while duplicates labelled "not approved" or "on hold" were excluded. For unique interviews, this field was left blank.

Stakeholder Categorization. To simplify the analysis, stakeholder types were recategorized into four main categories (see Table 14):

Table 14. Stakeholder Categorization

Stakeholder type for analysis	Stakeholder type in the tool
International partners	USAID Points of Contact *
	IFRC Head Quarter
	IFRC Regional Office for Africa
	IFRC Country Delegations
Local stakeholders	Disaster management authorities
	Local government representatives
	One Health partners at the national and sub-national levels
	Education authorities
	Private sector entities
	Media
National Society	Red Cross/Red Crescent NS

Community	Other local stakeholder
	Community leaders

* In Indonesia, the KII actively collaborated with the USAID-GHS team, FAO, and WHO to amplify impact and foster strong partnerships. Other stakeholders include divers' community members.

Local government representatives included administrative personnel, personnel from various ministries (Health, Development, Coordination, Livestock and Fisheries and Environment) as well as staff from human and animal health facilities. Volunteers from the Red Cross were categorized under the "Community" stakeholder group, given their role in supporting the community and their limited strategic knowledge of the CP3 Programme.

Standardization and Scale Adjustments Interview counts were verified and cleaned using the person_1_name column. Country, province, and interviewer names were standardized for consistency. The scale for relevance and appropriateness questions was modified from 1-5 to 0-4 by subtracting 1 from each score to make the result understanding intuitive. Responses marked "99" or "I don't know" were set to missing. Frequencies were used to summarise the number of interviews and people interviewed by countries and stakeholder types.

Statistical analysis

Frequency Counts: The number of interviews and total participants were summarized by country and stakeholder type.

- Mean Scores: Average scores for relevance and appropriateness; and effectiveness were calculated and stratified by stakeholder type and country, with further breakdowns for relevance (design, implementation, monitoring/evaluation) and effectiveness (advancement in stakeholder engagement, partnership). In calculating means, the Likert rating scale of 0-4 (where 0=Not consistent; 1=slightly consistent; 2=moderately consistent; 3=very consistent; 4=completely consistent) was used to assess opinions, attitudes, and behaviors of respondents.

Community Adjustments: As community members were generally not involved in project design and showed variability in understanding, responses to design questions from community members were set to missing.

6 Fieldwork

In-country Fieldwork:

The fieldwork for DR Congo was conducted between September 9 – 18, 2024, allowing the tool to be tested before the other countries were visited. Indonesia and Kenya fieldwork was conducted between September 16-30. The KIIs for countries not physically visited were planned for September 23-27, 2024, but were extended until mid-October.

1) Pre-fieldwork briefing where possible, pre-fieldwork PowerPoint presentation was shared/presented to the National Societies, explaining the purpose, objectives, methodology, and approach of the evaluation, as well as the ethical rules and regulations that would guide the fieldwork. It also included the proposed timeline and itinerary.

2) Fieldwork debriefing: This PowerPoint debrief served as a debriefing to the National Societies after the completion of fieldwork. It included the main ideas that emerged from the fieldwork, such as challenges and opportunities, as well as the main ideas that emerged from participants' responses which provide insight into what the findings could be.

3) Remote Fieldwork: KIIs were conducted with the IFRC headquarters team, regional offices, delegates, and country Programme managers using virtual communication platforms such as Teams or Zoom. In cases where physical meetings were possible, such as at the Nairobi Regional Office or during country visits, our assigned team member met with IFRC staff to conduct these interviews.

6.1 Evaluation Constraints and Limitations

The evaluation team faced a few constraints and limitations in carrying out this evaluation, namely:

1. Rushed and extended fieldwork due to delegates' availability in country.
2. Unavailability of some key Informants in some countries
3. End of the project in some implementing sites impacted accessibility to respondents.
4. Data quality issues:
    a. **missing data**: while countries narrative monthly reports consistently report on the three workstream in countries activities, the data management system does not allow these narrated activities to be captured into quantifiable inputs and reflected on the ITT, leading to none reporting of entire workstream data while several activities took place.
    b. **double counting of participants involved in countries activities**: The data management system does not allow to identify and avoid double or furthermore counting of a single individual or household, leading to inaccurate aggregation of number of individuals and household reached by activities.
    c. **Absence of overall aggregated indicator data**: The evaluation team did not receive annual or overall aggregated program progress data that demonstrates the CP3 program's impact and effectiveness, such as the total number of people reached, communities impacted, activities implemented, volunteers trained, and strategic plans developed. Consequently, the evaluation team had to create this data using the available information from the ITT records.

7 FINDINGS

7.1 Fieldwork findings visited countries: Democratic Republic of Congo, Indonesia, and Kenya

7.1.1 CP3 PROGRAMME DESIGN, IMPLEMENTATION, MONITORING, AND EVALUATION

CP3 objective as viewed by stakeholders.

USAID and IFRC agreed purpose of the CP3 Programme aims to strengthen and expand community-based health measures to mitigate infectious diseases and sustain and grow community-based health services, while concurrently fostering community and health sector resilience to prepare for and respond to health emergencies.

During fieldwork, we spoke to local stakeholders in DR Congo, Indonesia, and Kenya. Table 15 below describes their understanding of the CP3 objective in their specific countries:

Table 15. CP3 objective as viewed by local stakeholders

CP3 objective as viewed by local stakeholders		
Democratic Republic of the Congo (DRC)	**Kenya**	**Indonesia**
CP3 objectives as interpreted by DR Congo stakeholders are: 1. strengthening communities' capacities so they can contribute to their own health security through prevention, early detection, and allow early response to public health threats. 2. strengthening the National Society's capacities so it can contribute to communities' health security by coordinating and supporting communities so they can be able to detect, report, and activate early responses to public health threats. 3. Strengthening civil society's capacities to actively contribute to health security by improving their abilities to mobilize communities and support measures taken to respond to public health threats.	CP3 objectives as interpreted by the Kenya stakeholders as: 1. A Programme that considers the holistic health of animals, humans, and the environment brings together environment, animal and human health partners, strengthening their capacity to collaborate and effectively respond to epidemic and pandemic crises. 2. The Programme prepares partners and the community to be better equipped for epidemics and pandemics.	CP3 objectives as interpreted by Indonesia stakeholders are: • Strengthening health promotion activities in the communities and advocating for health literacy on epidemic/pandemic, infectious disease, zoonotic, and EIDs prevention and control • Coordinating activities at the community level so that they can be able to detect, report in real-time, and respond early to public health threats like the recent increasing cases of dog bites. • Train and increase the capacity of the communities and stakeholders to actively contribute to health security, and support strategies put in place to respond to public health threats.

There is an alignment in the understanding of CP3 objectives across stakeholders.

CP3 inception and implementation

Inception work and consultations:

Stakeholders across all visited countries reported that IFRC and National Societies conducted inception work (situational analysis and consultations) with local stakeholders to incorporate their contributions into the design and strategies of the initial concept of CP3, adapting it to each country's context. In some instances, these consultations were cascaded from the national level to provinces selected by the national leadership to further adapt the CP3 model to local community contexts. These consultations resulted in the identification of specific geographical areas of focus and the priority diseases to be targeted by CP3 in each country. They also informed the types of activities that could be implemented and would interest local communities.

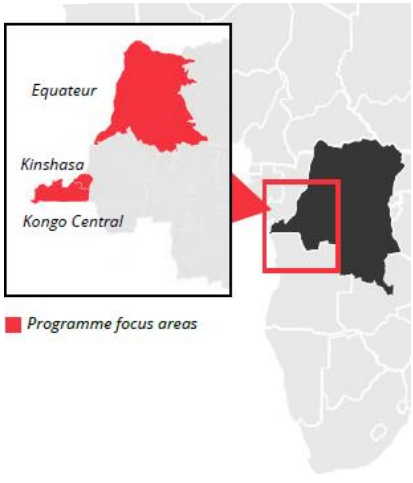
> *" As a project coordinator, we coordinated with stakeholders such as the health department, livestock/food security, and agriculture offices. Together with PMI management, we determined priority diseases and then carried out sensitization to the selected sub-districts based on input from the departments of health and agriculture. We defined the activity-based guidance from PMI national headquarters." –* ***PMI District office, Bogor, West Java, Indonesia***

> *"We had initial discussions with the National Society (NS) based on a situational analysis of the capacity of the NS, we also had a preliminary phase of exchange with stakeholders in human health, animal health, and environmental health. We then organized a national planning workshop for the CP3 project with all national stakeholders, which made it possible to determine the areas of intervention, targets, and strategies. This national consultation process was duplicated at the provincial level with a participatory planning approach for all provincial health system stakeholders and local branches of the Red Cross."-****A CP3 IFRC leader in Kinshasa, DR Congo***

As a result in the DR Congo, the consultations with local stakeholders led to the agreement to implement the Programme in two provinces (Figure 4) Kinshasa (Binza Meteo and Maluku 1 Health Zones), Kongo Central (Nsona-Pangu and Kimpese Health Zones) and expanded to Equateur (Wangata, Bikoro, and Mbandaka Health Zones) and in 2 other health zones in Kongo Central (Kisantu and Seke-Banza) since 2023 .

Figure 4. CP3 programme implementation map in DR Congo

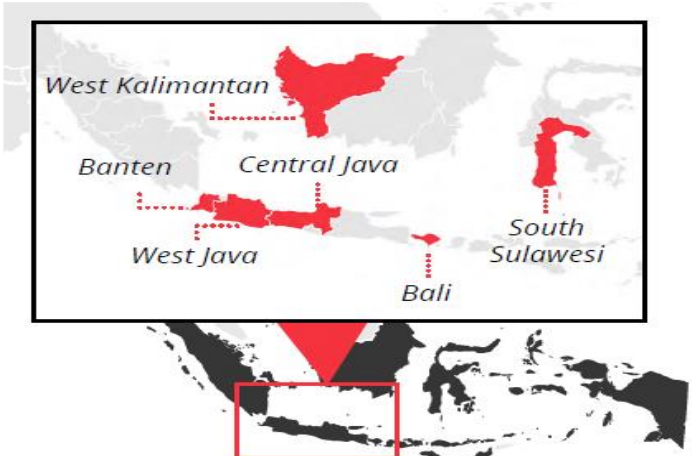
Map source IFRC: DR Congo Community Epidemic and Pandemic Preparedness program brochure



In Indonesia Banten, Bali, Central and West Java, West Kalimantan and South Sulawesi were selected (Figure 5). The priority diseases identified under CP3 in Indonesia include avian influenza, TB, COVID-19, Foot and Mouth Disease (FMD), anthrax and dengue.

Figure 5. CP3 programme implementation map in Indonesia

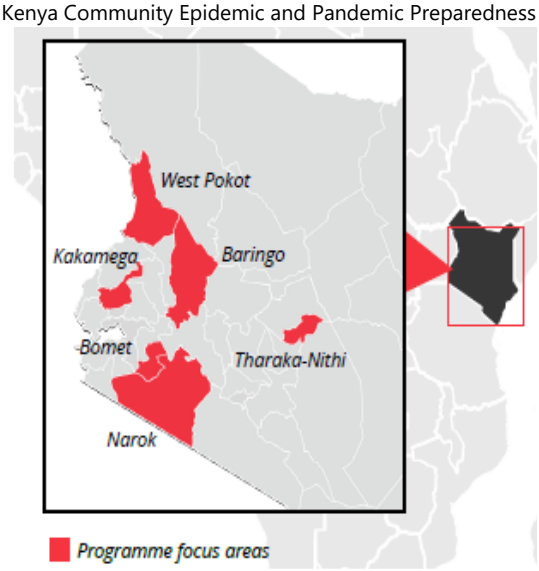
Map source IFRC: Indonesia Community Epidemic and Pandemic Preparedness program brochure



In Kenya, the Kenya Red Cross Societies (KRCS) team, with the support of the IFRC, met with the Ministry of Health to discuss the modalities of collaboration in establishing a One Health platform in early 2017. This was followed by an invitation from the Ministry of Health to the Ministry of agriculture and Livestock, the Department of Veterinary Services (DVS), and other partners to join the national One Health platform known as the Zoonotic Disease Unit (ZDU). Subsequently, One Health platforms were established at the county and sub-county levels as the implementation structures on the ground, forming the basis for the multisectoral approach to CP3.

Figure 6. CP3 programme implementation map in Kenya

Map source IFRC: Kenya Community Epidemic and Pandemic Preparedness program brochure.



CP3 Implementation in Kenya targets 6 counties: West Pokot, Baringo, Tharaka Nithi, Narok, Bomet, and Kakamega as illustrated on Figure 6 above.

CP3 implemented activities:

Workforce development. After the consultations, the National Societies moved on to recruiting volunteers and specialized staff required for the CP3 implementation. Naturally the next sets of activities focused on

workforce development and capacity building such as Training of Trainers (ToT) in all necessary curricula related to epidemic and pandemic preparedness and management. The trainers trained volunteers in all targeted geographical areas so they could be ready to work within their communities. Table 16 below highlights stakeholders' description of some workforce development activities implemented during CP3 Phase 1.

Table 16. CP3's workforce development and capacity-building activities as described by stakeholders

CP3's workforce development and capacity-building activities as described by stakeholders		
DRC	**Indonesia**	**Kenya**
- Training of Community Disaster Response Teams (CDRT) - Training Volunteers on Oral Rehydration Therapy (ORT) - Training of volunteers on safe and dignified burials (SDB) and Management of the Dead (MotD) - Training of volunteers in information management and feedback system, communication in public health emergencies - Training in Infection Prevention & Control (IPC)	- CP3 initially organized training of trainers (TOT), in all necessary curricula related to epidemic and pandemic preparedness and management. - PMI's volunteers training to equip them with knowledge on community-based epidemic and pandemic preparedness and empower them to become local voices. - Workshop and training with national and government stakeholders in epidemics preparedness and management. - PMI also developed and workshopped guidelines for training on data monitoring for CBS, coordinating with other divisions such as IT, and resource mobilization to ensure we respond.	- Training and piloting, One Health partners consisting of Ministries of health, agriculture & livestock, Education, Environment, and Red Cross - Meetings quarterly to discuss and review the progress of CP3 countrywide. - Community Health Promoters (CHP) Training: CHPs are at the heart of community preparedness. They are trained on how to identify threats and use the Community Based Surveillance System (CBS) to report the alerts, which go to sub-county, county, and local Red Cross branch for action. CHPs also submit weekly and monthly progress reports.

*"We have benefited from several training courses that have helped us as a Red Cross, but also helped the community when we share our knowledge with them. We have taken training courses such as CBS, SDB, , cholera, journalism, and others. Before CP3 volunteers were just first aid"-**Volunteers' Team leader in Maluku, DR Congo***

"The volunteers are getting more active, not only in the targeted area but also in their own community. They also do go to the school to educate the students about disease..." – ***PMI staff of health service division, CP3 coordinator, Banten***

CP3 is a significant contribution as it brings in human resources with the necessary capacity and expertise. However, other PMI districts raised questions about obtaining the same program. ***National Surveillance officer, West Java, Indonesia***

Photo credit IFRC Indonesia: Photos: Capacity building/Knowledge transfer activities in Indonesia

"We have attended training organized by the county and Red Cross severally and during these meetings, we get information on how to identify, report, and manage disease threats." ***CU Lead, Tharaka-Nithi, Kenya***

Photo credit IFRC Kenya: Left Kenya: CHP training, right Kenya: One Health meeting

Communities' Public Health Intervention activities. After the workforce development and capacity-building activities, NS teams and local partners started implementing community Public Health Intervention activities. This ranged from active interactions with communities through awareness activities during household home visits, and schools' activities to the development of guidelines and strategic plans to support community epidemics and pandemics preparedness including community-based surveillance implementation. Table 17 below lists some of the activities mentioned by stakeholders in each country.

Table 17. CP3's Communities' Public Health Intervention activities as described by stakeholders

CP3's Communities' Public Health Intervention activities as described by stakeholders		
DRC	**Indonesia**	**Kenya**
- Home visit: action which allowed us to educate communities and identify alerts hidden in households. - Mobile awareness raising this allows to reach people in homes and neighbourhoods - Mobile cinema awareness session: this allows mass education on good practices and provide the community with knowledge on diseases symptoms adapted to communities - Hand washing demonstration in schools and other public places: this allows cultivate good practices to families of young children - Point of entry (hand washing and screening) in ports: action which allowed us to control the entry of potential Ebola cases into Kinshasa - Water, Hygiene and sanitation education and Aquatab distribution to the community to help with water purification - Support during epidemics and pandemics: Installation of Oral Rehydration station points - Systematic recovery of children lost to the vaccination Programme or zero dose children	- Communities' awareness activities: • Household visits • Schools' health promotion activities • Community Group information sessions - Mass community clean up campaigns - Mosquito larvae monitoring to prevent dengue fever outbreaks - Mapping disease hot spots and Community risk - Community-based surveillance and active case-finding which included Avian influenza, TB, COVID-19, and dengue. - Baseline KAP survey - Development of guidelines for disaster management on making community risk mapping for health, community engagement, and accountability. - Support during infectious disease outbreaks	- Information dissemination by CHPs in communities and households o CHPs awareness activities of Households: o Awareness in women group meetings o Public awareness campaigns in the community - Use of Events to create Awareness: o World Rabies Day o school CP3 challenge organised by KRCS known as the Chanuka challenge - development and designing of the guidelines and Strategic plan - Meetings and dialogues o One Health Partners monthly review meetings with One Health to take stock of the emerging situations and disease threats o CP3 community dialogues - Mobile cinemas and sensitization and community-based surveillance CBS - Support during epidemics and pandemics

*"We conduct home visits, identification of children late with their vaccination schedule, we raise awareness in the community regarding water purification, environmental sanitation, cinema screening to raise awareness among the population."- **21 Volunteers' Yanga Dia Songa, Kongo Central, DR Congo***

Photo credit IFRC DR Congo: left: Mobile awareness raising (Binza-Meteo – Kinshasa) Center: Radio broadcast with the collaboration of Radio Bangu in Kimpese and Right: Outdoor video awareness session (Ngomba Kikusa), DR Congo

*"We conduct mosquito breeding site monitoring, health promotion, routine monthly meeting with the public health office, CBS through SatuSBM alert, …We are involved in clean up Saturday and Tuesday."- **Mixed quotes CP3 coordinator, Volunteer, West Java, Indonesia***

Photo credit IFRC Indonesia: Photos: Epidemic and pandemic preparedness and management activities in Indonesia

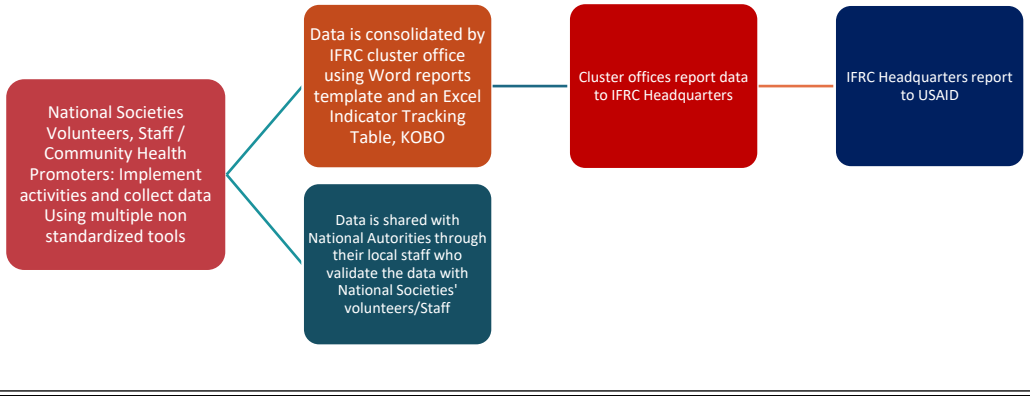
*"Information dissemination is done by CHPs in communities and households...We also work in the development and designing of the County Health Strategic plan, CHPs visit schools and offer talks in health clubs where information is given to children and cascaded to their homes"- **Mixed quotes Household and volunteers, Tharaka-Nithi. Kenya***

Photo source IFRC Kenya: Rabies Awareness Events, Kenya

CP3 Monitoring and Evaluation system

To facilitate reporting on Programme effectiveness and impact, CP3 activities are linked to indicators, such as the number of alerts, the number of people trained, and the number of home visits conducted. (See the list of all CP3 indicators in Table 7, Table 8, Table 9 and Table 10.) These indicators must be reported to the IFRC and the funding partner. National Societies 'volunteers, staff and/or CHPs are not only implementing these activities but are also responsible for data collection (Figure 7).

Figure 7. CP3 programme M&E Data flow chart overview



IFRC and National Societies M&E staff reported that the data collected by volunteers/CHPs is validated by the relevant government official at the local level before it is reported to the next level. IFRC as the technical support partner provided guidance on the reporting requirements and tools to ensure National Societies can collect and report CP3 data in a way that is effective to communicate the Programme impact.

"The Red Cross is the one working on the ground in CP3 through our volunteers, all the data is collected by us from the services we provide to the community. These data are sent to our hierarchy but also to partner ministries."-**Red Cross Leader, Kongo Central, DR Congo**

"Every month, CHPs aggregate reports and share them with me in hard copies which I upload in Kobo collect and this cascaded to the higher levels. Through the partnership, the report goes to the Red Cross. In case of a disease like anthrax, the alerts goes to the Animal Health Assistant." -***Community Health Assistant, Tharaka-Nithi, Kenya***

"PMI collect the data and analyse that, IFRC and BNPB as a team formulate a policy brief which further bring to other national stakeholders." -***Steering Committee, national disaster management agency, West Java, Indonesia***

"We support the CP3 programme monitoring and evaluation, and we have contributed to planning, implementation, monitoring and reporting. My role is to ensure that all the data that comes from the field is ready for use. My job is to make sure CP3 adapt to new technologies and that all information from the field come up through to our system for reporting."-***IFRC M&E staff, Kinshasa, DR Congo***

Limitations of the M&E system: stakeholders reported some challenges:

- **Data not equally accessible to all partners**: Data collected by NS volunteers M&E system are not always equally accessible to all One Health partners.
    - The Ministries of Health are the only Ministries that have full access to CP3 data in all visited countries except for Kenya where it was reported that CHPs being government-appointed community representatives, have the responsibility to share the data with all One Health partners Ministries.
    - In DR Congo and Indonesia, the Ministries of Environment and Ministries in charge of Animal Disease Control have weak or non-existent community-level staff that can interface in real-time with National Societies volunteers to communicate risks and alerts.

The data is collected by volunteers who are implementing activities on the ground, the ministry of health naturally gets all the data because they have a system that is connected to ours and that requires accountability to the project. This is also by design as they were the most involved during consultations and they see CP3 as a health project. While with other partners (Ministry of environment and Ministry of Fisheries and Livestock National Secretariat Directorate of Animal Disease Control), they do not see CP3 as a project that should be accountable to them, so they do not ask any data, we are the one approaching them. For example, when we see case of rabies in community, we call them to involve them, what they do with the data and how they use it we do not know, we work with the vets at community level not sure if they report this to higher levels but the ministry of health has a reporting system that takes our data to national level for response. The ministry of health is even asking to integrate our data into their system DHIS2 because they understand its importance."-***Leader at Red Cross-National level, Kinshasa, DR Congo***

"Multisectoral meetings in the village are held twice a year. Routine monitoring and evaluation activities are not conducted intentionally. PMI plays a role in preparing the supporting aspects of service delivery.". ***Head of animal health centre, South Sulawesi, Indonesia***

- **Data quality issues**:
  - Data sources: Data reported by the IFRC is aggregated from information collected by National Societies ' volunteers and the M&E team using various non-standardized sources, including volunteers' registers, training reports, district reports, supervisors' reports, research reports (KAP surveys, case studies), and data submitted from volunteers' cell phones and aggregated into Kobo by supervisors and other databases. Such a system, which relies on different independent secondary data sources for report aggregation, presents numerous data quality challenges, such as:
    - Secondary data are not intentionally collected for CP3's Programme reporting, and IFRC does not have control over the quality of the reported data.
    - The data elements collected by these sources are not specifically tailored to capture CP3 indicators with precision. This challenge is compounded in a multi-country and multi-sector project like CP3, making it difficult to verify if countries are reporting comparable indicators.
  - Data collectors and supervisors are not aware of the CP3 indicators requirements; therefore, they cannot collect data that is suitable for CP3 purposes. For instance, during the desk review exercise, our team visualized the ITT data on a dashboard, revealing inflated numbers far exceeding the total population of the communities. This discrepancy may suggest that data collectors do not understand the purpose of data collection, for each household visit, they reported the same family multiple times as if they were different individuals reached. Similarly, when training the same volunteers across different modules or sessions recorded in the register, they count each volunteer multiple times during aggregation. The same issue arises with meetings attended; each signature for different sessions from the same person is counted as a separate individual. All these practices lead to the multiple counting of single events, individuals, and services, resulting in a disproportionate amount of the data.
  - The lack of understanding of the reporting requirements also resulted in missing data. The National Society and IFRC M&E team did not fully grasp the indicator definitions for the activities to be reported. For instance, this could have led to narrative reports documenting workstream 2 activities that could not be translated into quantifiable units to capture in the ITT (the Programme Excel database that accounts for all events, populations reached, and services). This oversight affects the ability to reflect the effectiveness and impact of the CP3 Programme across all workstreams and hinders our ability to fully use the desk review data for triangulation.

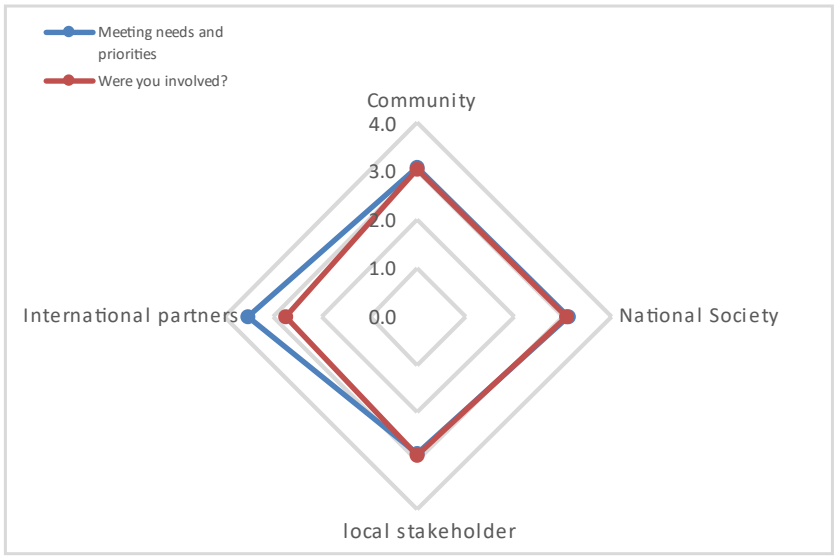
7.1.2 WAS CP3 RELEVANT AND APPROPRIATE IN THE COUNTRIES' CONTEXT?

The questions on CP3 relevance and appropriateness assessed if:

1. CP3 met the needs and priorities of the stakeholders and
2. how much they were involved in the Programme design, implementation and Monitoring, and evaluation of CP3?

The stakeholders rated CP3 relevance and appropriateness based on the Likert scale of 0-4 as described previously and the results are reflected in (Figure 8) below:

Figure 8. CP3 programme relevance and appropriateness



RELEVANCE AND APPROPRIATENESS						
Stakeholders	**Meeting needs and priorities**	**N**	**Were you involved?**	**N**	**Average**	**Percentage**
Community	3.1	114	3.0	21	3.1	76.7
National Society	3.1	48	3.1	24	3.1	77.6
local stakeholder	2.9	44	2.9	41	2.9	71.8
International partners	3.5	8	2.8	4	3.1	78.1
Average	**3.1**		**2.9**		**3.0**	**76.0**

With an overall relevance and appropriateness score of 3/4 (76%, N=115) across all partners and countries, CP3 was perceived as very appropriate and relevant to all stakeholders.

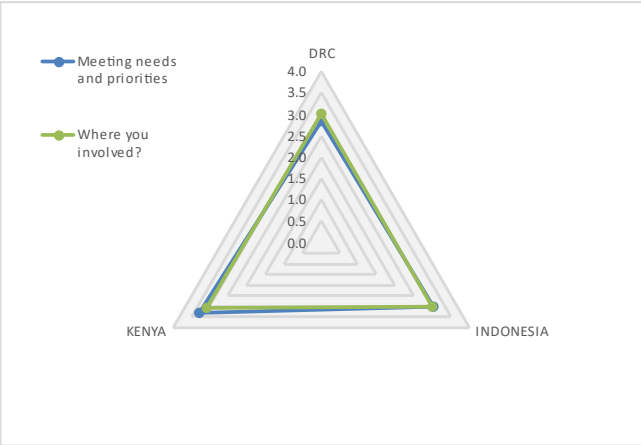
7.1.2.1 MEETING COMMUNITIES' NEEDS AND PRIORITIES AND INVOLVING THEM IN CP3 STAGES

Stakeholders' across countries perception is that CP3 was appropriate and relevant in meeting communities' needs and priorities and involved them in CP3 activities at 76% (3/4, N=105) as reflected in Figure 9.

Communities' needs and priorities

Kenya recorded the highest rating where stakeholders believed CP3 met their communities' needs and priorities at 82.5% (3.3/4, N=44), followed by Indonesia rating 75% (3/4, N=30) and DRC stakeholders believed CP3 met their communities' needs at 70% (2.8/4, N=31).

Figure 9. CP3 programme relevance and appropriateness for communities



	Relevance and appropriateness					
Countries	**Meeting needs and priorities**	**N**	**Where you involved?**	**N**	**Average**	**Percentage**
DRC	2.8	31	3.0	2	**2.9**	**73.0**
INDONESIA	3.0	30	3.0	5	**3.0**	**75.4**
KENYA	3.3	44	3.1	14	**3.2**	**79.3**
All countries	**3.0**	**105**	**3.0**	**21**	**3.0**	**75.9**

Table 18 below are the reasons justifying these scores.

Table 18. Community-level reasons justifying the rating

Needs and priorities met, or weakness identified	Feedback on Positive CP3 Effects and bottlenecks
CP3 has a strong presence in the community	• **CP3 has a strong close presence in the community through volunteers** this makes it a relevant and appropriate community project because the key actors are the CHVs and NS volunteers who are part of the community and know their communities' needs and priorities and are available to help meet them.
Community Surveillance Systems Strengthening (CSSS)	• **Increased Knowledge and good practices:** community awareness activities led to an increase in knowledge of diseases that can spread into epidemics and pandemics and the communities adopt good practices that protect and reduce the risk of exposure to CP3 priority diseases. o **Communities have constructed latrines and are aware of handwashing practices.** o Communities monitoring and mapping of diseases and risk of epidemics by NS and CHVs o **Communities are keeping food clean, and no more eating dead animals** o **The community started to vaccinate their animals (dogs and cows at regular intervals, and the animals would be certified, a practice not previously done** • **Strengthened Early alerts and response system:** through early detection of risk, notification of events and risk, and early response o Identification of priority diseases and development of case definitions for priority diseases in the community o **Detection of public health threats:** community disease reporters know how to detect and report public health threats to village elders or CHVs. o **Reporting of public health threats** CHVs know how to report cases of disease outbreaks and suspected zoonotic diseases using mobile phones alert system • **Decrease of disease burden:** Stakeholders reported that before CP3 there were rampant cases of Cholera and diseases like measles, rabies, and anthrax but now it has reduced because the surveillance and case definition are accurate, there is now public health interventions courtesy of CP3 • **Strengthening Epidemic and Pandemic Preparedness M&E system.** The CP3 Programme provided the first platform that can link up the human health and animal health data collective from the community into one and allow multisectoral partners to have access to commonly defined indicators and make use of them for effective response in communities, and therefore people would be able to respond to those

	• **Development of Epidemic and Pandemic Preparedness guidelines**. A guideline in line with community preparedness to be launched to acts as the link between the stakeholders for coordination • **Improvement in Community Overall Health.** There has been an improvement in the general health of the community
CP3 has strengthened Multisectoral Partnership work at the community level	• **Multisectoral synergy is taking shape at the community level.** Multisectoral synergy is developing slowly at the community level. All stakeholders were consulted in the preparation for a Strategic Plan, involving all One-health stakeholders in the local government. As well as local community leaders who are now are allies to the CP3 Programme.
The factors that affected the score negatively	· **CP3 Programme geographical coverage is limited-** proportionally, the CP3 coverage in host countries is very limited to a few communities. · **The CP3 timeline was limited to enable communities in some host countries to integrate the acquired knowledge into consistent habits.** · **CP3 is a preparedness Programme,** it does not provide resources for response or to support communities to encourage the implementation of the learning from awareness activities. · **Economic protection:** Livestock losses by farming or pastoral communities through epizootics lead to a complete loss of livelihoods although CP3 was not designed to address this scope of work. · **Insufficient Resources for Implementation:** Expenses required for implementation of CBS are insufficient for example airtime and transportation for response by Vets and CHVs.

Here a few quotes by stakeholders on how CP3 met the communities' needs and priorities by strengthening Community Surveillance Systems and noting bottlenecks that need to be improved:

*CP3 is helping because it gives me ideas on how to keep cleanness and help my customer stay healthy when eating at the restaurant, clean space, clean food and hand washing. We learned how to call volunteers and take children to hospital when we see diarrhoea in children, they also told us how to make Oral Rehydration Solutions (ORS), they also taught us how to purify water before drinking it. Now we have that knowledge, and we get involved in informing volunteers and they inform the hospital to help us..."-**Community members in Lufu, DR Congo***

*"So far, there has been significant improvement in communities regarding awareness of the epidemic and pandemic preparedness, particularly in areas such as water hygiene, sanitation, and environmental cleanliness. In urban areas, most houses have their own toilets, whereas in villages, not everyone has access to one. Thankfully, this situation is improving, and more people are gaining access to toilets. In poorer communities, understanding of these issues remains low among some individuals; however, most members of urban housing communities have a good grasp of the importance of sanitation and hygiene". **Volunteers, Saruni and Juhut, Banten, Indonesia***

*There are fewer disease outbreaks now because of the CP3 program. We have been trained on handwashing practices at critical times and on keeping food clean and healthy. As a result, no one eats wild meat or dead animals anymore. Most people who previously did not have latrines now have them. We also know how to report cases of disease outbreaks and when to suspect rabies in dogs. – **Female Household Head – Tharka Nithi, Kenya***

*When we report a threat in the community, such as a suspected rabid dog or sick livestock, some veterinary officers request funds for transportation to the location. However, because the money is often not available in a timely manner, the threat persists and exacerbates problems within the community. This has made us reluctant to report incidents at times. To better manage the communities assigned to them, the number of Community Health Practitioners (CHPs) should be increased, as we cannot be everywhere at the same time. Additionally, we sometimes lack sufficient airtime to make calls, and the distances within the community are significant, further increasing response times. The expansive road network also poses a challenge. **Community Health Unit Lead – Tharaka Nithi, Kenya***

Communities' involvement in CP3: The questions on CP3 involvement were asked specifically to each group of stakeholders as "Were you involved in CP3 Programme design, implementation and monitoring, and evaluation?". Respondents had to score their involvement in each phase using the Likert scale out of 4 as previously described, reflecting the scores below in Table 19:

Table 19. CP3 programme communities' involvement per phase

	Involvement stage							
Countries	**Design**	**N**	**Implementation**	**N**	**M&E**	**N**	**Average**	**Percentage**
DRC	0.0	0	3.5	2	4.0	1	**3.8**	**93.8**
INDONESIA	0.0	0	3.0	5	2.6	5	**2.8**	**70.0**
KENYA	0.0	0	3.0	14	2.4	11	**2.7**	**67.0**
All countries	**0.0**	**0**	**3.2**	**21**	**3.0**	**17**	**3.1**	**76.9**

Overall, across all stages and all countries, communities felt involved at 76.9%. They all reported that they did not know if someone in the community was involved in the design phase hence the score of zero nullifying all involvement at the design phase scores.

Country level:

- In DR Congo two community groups interviewed reported that they were highly involved (93.8%, N=2) in the implementation with activities and reporting of the risk and cases to volunteers who relayed the information to relevant local authorities and partners to trigger the response interventions.

- Indonesia came next reporting an involvement of 70% (2.8/4, N=5) noting that community members are actively engaging in the programme's activities, which reflects a sense of ownership and responsibility among community members in the planning and execution of health initiatives.

- Kenya communities scored a moderate involvement 67% (2.7/4, N=14), they felt they were very involved in the implementation (75%, N=14) and moderately involved in reporting (60%, N=11) the risk and cases this is probably because in Kenya the CHPs take more responsibility in the detection and reporting and community members feel less involved in the generation and reporting of the information that is relayed to relevant local authorities and partners to trigger the response interventions.

Here are a few quotes on communities' involvement in the CP3 Programme:

"In the design, we were not involved, if they involved us in the design, we were going to add local ideas from the volunteers. –
Volunteers Team Leader at Red Cross, Kongo Central, DR Congo

*"The communities themselves detect and report cases in relation to the information that the volunteers gave them, these volunteers being from the community it is very consistent because they train their people themselves get involved in doing the surveillance, the sanitation and they transfer the information to the next level for reporting that informs the data we transmit.."- **Volunteers Team Leader at Red Cross, Kinshasa, DR Congo***

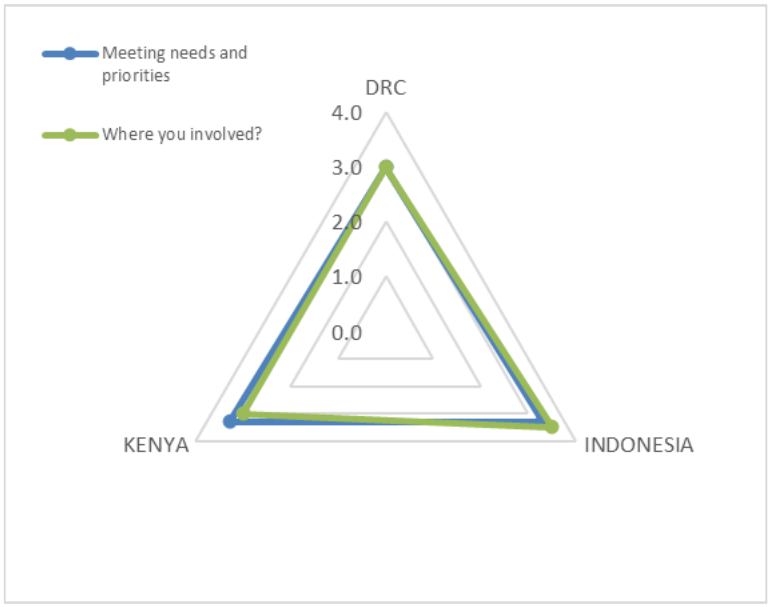
*"The community is very much involved because this program not only provides what they need but also builds human resources in the village to raise awareness of their health and the health of their animals. While the CP3 volunteers and the animal health center vaccinate the cattle, the community participates by directing their animals into the clamp cage that they built." **Head of a village, South Sulawesi, Indonesia***

*"Everyone knows how and who to report an alert. Before they could report to the chief and it was not effective as there was no clarity on who to take action. After CP3 everyone in the community, including the leadership knows that they should report to the CHP who would then issue an alert using the USSD code and there would be a response from the relevant authorities". **CHP, Narok, Kenya***

7.1.2.2 MEETING NATIONAL SOCIETIES' NEEDS AND PRIORITIES AND THEIR INVOLVEMENT IN CP3 STAGES

Stakeholders across countries perception is that CP3 was very appropriate and relevant for NS'and they were involved in the project at 80 % (3.2/4, N=39) as reflected in Figure 10 below:

Figure 10. CP3 programme relevance and appropriateness for National Societies



	Relevance and appropriateness					
Countries	**Meeting needs and priorities**	**N**	**Where you involved?**	**N**	**Average**	**Percentage**
DRC	3.0	19	3.0	13	**3.0**	**75.0**
INDONESIA	3.3	13	3.5	6	**3.4**	**85.1**
KENYA	3.3	7	3.0	4	**3.1**	**78.6**
All countries	**3.2**	**39**	**3.2**	**23**	**3.2**	**79.6**

National Societies' needs and priorities:

With the highest score, Indonesian stakeholders believe, CP3 met PMI's needs and priorities at at 85% (3.4/4, N=13), Kenya was next in the score, and stakeholders noted that CP3 met KRCS's needs and priorities at at 78.6% (3.1/4, N=7). The DR Congo stakeholders believe CP3 met the DR Congo Red Cross's needs and priorities at 75% (3.0/4, N=19) Table 20 below are the reasons justifying this score.

Table 20. National Societies level reasons justifying the rating

Needs and priorities met, or weakness identified	Feedback on Positive CP3 Effects
Strengthening National Society positioning at country level as an auxiliary to public authorities	• **CP3 improved the community perception on National Societies' volunteers** – the volunteers noted that before CP3 they were perceived as first aiders, blood donation teams and dead bodies retrievers; now they are appreciated and viewed as the protectors of their communities against disease outbreaks. • CP3 has successfully bridged gaps between National Societies' disaster response and health teams, bringing attention to disease outbreaks and non-natural health crises, and raising National Societies' profile in epidemic and pandemic preparedness. CP3 provides an opportunity for National Societies' health division to demonstrate its competency in managing non-natural disasters, in line with new regulations emphasizing infectious disease prevention and health promotion.

Strengthening **National capability, skills, competency and resources**	**CP3 strengthened National Societies' capabilities** including National Societies' volunteers' skills development and knowledge transfer in the context of Epidemic and Pandemic Preparedness, and development of tools, processes, strategies, policies and frameworks guiding community epidemic preparedness • **CP3 improved NS resources.** In addition to National Societies' access to equipment, materials for their work in epidemic and pandemic preparedness, the NS public health and emergencies department is now structured and has a framework for response, identification of volunteers, and training. This has strengthened the CBS reporting system. • National Societies have conducted skills transfer to NS staff and volunteers as per National Societies' strategic goals, enabling volunteers to act as CBS agents, which strengthens community health monitoring and response efforts while other National Societies' staff have been strengthened on Programme management and M&E. • This Programme enables National Societies to meet community health demands in areas not directly targeted by CP3, as volunteers from neighbouring villages often assist where additional human resource support is needed. • CP3 supports National Societies' broader goals by institutionalizing health promotion and infectious disease prevention in both National Societies and government regulations.
Strengthened Multisectoral Partnership with NS at national level	· CP3 positioned the National Societies as a key partner in CBS and epidemics and pandemics preparedness and response by unlocking a strategic partnership with the host government that places National Societies at the heart of the CBS. · National Societies collaborates consistently with district health offices, environmental health offices, and other local agencies for all activities, not just CP3. These partnerships help align health and disaster response strategies, bolstering community health. · Government agencies recognize National Societies' capacity, leveraging its network to improve early detection and response to health crises. CP3 has raised awareness of PMI's role as an auxiliary health support arm to the government in times of health emergencies. · CP3 fills crucial gaps in community health, such as linking community needs with public health centers for disease reporting, strengthening local health responses. · **CP3 strengthening the local partnerships where National Societies are the unifying partner.** Multisectoral synergy is developing with NS involving all the stakeholders in the human, animal, and environmental sectors. This has made partners appreciate the interconnectedness between the environment, animals, and humans in disease transmission and control.
The factors that affected the score negatively	· CP3's limited coverage reduces its positive impact. The reach of CP3 is constrained to only the districts where the Programme has been implemented. · Limited funding impacts Programme implementation and volunteer motivation and has hindered the recruitment of skilled personnel for disease detection and pandemic preparedness roles within CP3 coordination committees, affecting the Programme's capacity to fully meet community health needs.

Here are a few quotes by stakeholders on CP3 met National Societies' needs and priorities:

"Before CP3 we were only considered as first aiders, we were only there to help with the deceased in communities. With CP3, we volunteers are valued by the population, we are recognized thanks to our training as important personnel in supporting the population against epidemics, pandemics and other diseases. The population turns to us for guidance when needed. We have better visibility and recognition from the community ***Volunteers at Red Cross community level, Yanga Dia Songa, Kongo Central, DR Congo***

"The Red Cross has gained legitimacy and is recognized by the government when it comes to epidemic and pandemic preparedness and control, this is because CP3 has strengthened the National Society capacity with training of staff where many travelled overseas in Nairobi for training in epidemic and pandemic management but also WASH and many other trainings on data management and so on. CP3 allowed the DR Congo Red Cross to strengthen its resources and ability to operate effectively as a key partner in the epidemic and pandemic preparedness and control to a point where even the Congolese government acknowledges it. CP3 also allowed the inclusion of epidemic and pandemic management and preparedness in Red Cross nursing school training curriculum which is possibly going to trickle down to the national program- ***IFRC program staff, Kinshasa, DR Congo***

CP3 has a significant contribution as it brings in human resources with the necessary capacity and expertise. However, other PMI districts raised questions about obtaining the same programme. ***National Surveillance officer, West Java, Indonesia***

"In general, the consistency is only about 70% because it is not evenly distributed. In the two villages we visit every month for health promotion, the demand in Maros is not limited to just these villages; Maros has 15 sub-districts. Our focus is only on one sub-district with two villages, which means we cannot reach the entire area. Sometimes, people in villages without CP3 volunteers ask volunteers in neighbouring villages for assistance. We are also limited by our funding, while colleagues in other sub-districts are requesting help as well. Despite these challenges, the impact of this program is significant. ***PMI CP3 coordinator, South Sulawesi, Indonesia***

"Through the CP3, the Preparedness for Effective Response initiative is currently progressing. The CP3 program has advanced KRCS in its auxiliary role for epidemic and pandemic preparedness and response, enabling them to establish a strategic partnership with the government. In some cases, this may also allow them to secure funding from national sources, which is advantageous in countries where this is happening". ***KRCS Staff at the Nairobi office, Kenya***

"With the available resources, we have successfully contained epidemics in these priority counties, including anthrax, rabies, and kalaazar, which previously affected both people and animals. Our mandate is to eradicate threats through early detection and response. CP3 has brought this approach together in one package, collaborating with the relevant ministries... ***National Society Community Based Surveillance Officer- Nairobi, Kenya***

National Societies' involvement in CP3:

In overall across all stages and all countries, National Societies noted they were involved at 78 % in CP3 design, implementation and M&E. This score was affected by the perception of involvement of different respondents at different level and stage. For example, a volunteer will score low in design and very high in implementation and M&E while a Senior Manager at National Societies will score high in design if he/she was involved and low in M&E as they feel their involvement was limited. Table 21 below reflects the scores.

Table 21. CP3 programme National Societies' involvement per phase

	Involvement stage							
Countries	**Design**	**N**	**Implementation**	**N**	**M&E**	**N**	**Average**	**Percentage**
DRC	2.0	7	2.9	13	3.1	14	**3.0**	**75.8**
INDONESIA	3.0	6	3.2	6	3.0	6	**3.1**	**77.1**
KENYA	3.3	4	3.5	4	3.0	4	**3.3**	**81.3**
All countries	**2.8**	**17**	**3.2**	**23**	**3.0**	**24**	**3.1**	**78.1**

Country level:

KRCS reported the highest involvement (81%, N=4). Indonesia PMI reported an involvement of 77% (3.1/4, N=6) and the DR Congo Red Cross reported an involvement of 75.8% (3/4, N=14) throughout CP3 Programme design, implementation, and M&E.

National Societies' respondents indicated that internationally funded Programmes come with pre-defined frameworks, which are often informed by global and national strategic plans related to public health and are also aligned with the strategic plan of the National Societies. The National Societies' respondents reported that they were responsible for engaging other local stakeholders and involving them throughout the CP3 planning, implementation and M&E. They also noted that they were involved in the situational analysis, consultations, and adaptation of the CP3 Programme to the local contexts.

Here are a few quotes on National Societies' involvement in the CP3 Programme:

"Among the projects where we have good coordination with partners and come together for workshops and activities, CP3 stands out as one where we are actively involved with our partners. Of course, partner projects do not start from scratch; they are already designed beforehand. I am primarily referring to the first phase, not the second. In the second phase, there were two workshops and various preparations, allowing for corrections to be made. However, in the first phase, a framework was already in place. The reality is that the partners also understood the significance of the country's strategic plan in terms of public health and the strategic plan of the national society. With this understanding, we began to move forward gradually. Thus, the first phase is very different from the second."-. ***National leader at Red Cross, National level, Kinshasa, DR Congo***

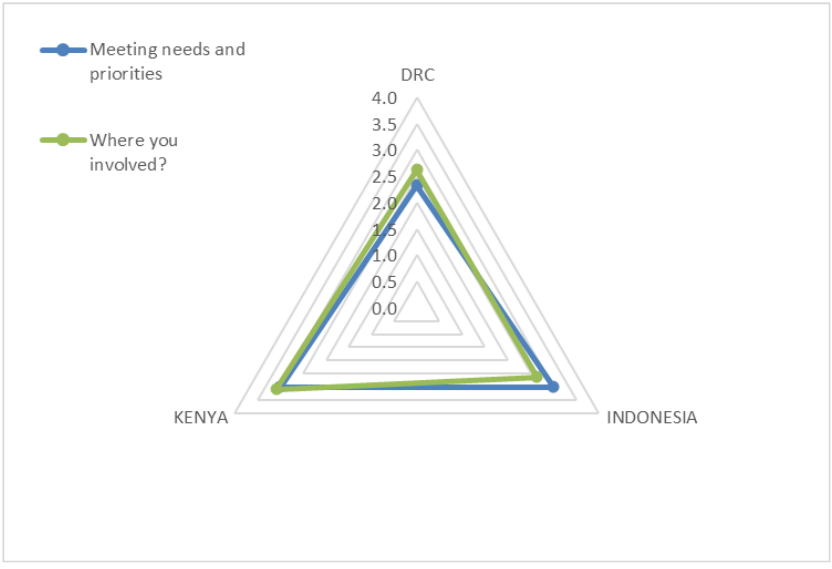
"We have trained CHPs in community-based surveillance as we were meant to equip the community technical people to know the community-based surveillance approaches. This targeted county and sub-county supervisors. The communities can adopt practices that are now not exposing them to the priority diseases under the program.
National Society Programme Coordinator, Kenya

"We are deeply involved in developing and coordinating partners, working closely with them to emphasize cross-sector cooperation. We actively participate in sub-district Musrembang (subnational/village annual local authorities' planning meeting) . We are consistently engaged in joint health promotion and field visits, maintaining strong coordination among PMI, local government, and religious leaders to encourage immunization.
- ***Mixed quote from PMI staff, West Java, Indonesia***

7.1.2.3 MEETING LOCAL STAKEHOLDERS' NEEDS AND PRIORITIES AND THEIR INVOLVEMENT IN CP3 STAGES

Stakeholders' across countries perception is that CP3 was appropriate and relevant for Local Stakeholders (Government ministries and local partners) and they were involved in the project at 69.5 % (2.8/4, N=44) as reflected on Figure 11 below.

Figure 11. CP3 programme relevance and appropriateness for local stakeholders



	Relevance and appropriateness					
Countries	**Meeting needs and priorities**	**N**	**Where you involved?**	**N**	**Average**	**Percentage**
DRC	2.3	9	2.6	8	**2.5**	**62.0**
INDONESIA	3.0	12	2.6	11	**2.8**	**70.5**
KENYA	3.0	23	3.1	22	**3.0**	**76.1**
All countries	**2.8**	**44**	**2.8**	**41**	**2.8**	**69.5**

Local Stakeholders' needs and priorities:

With the highest score, Kenya's stakeholders believe, CP3 met Kenya's local stakeholders' needs and priorities at 76% (3.0/4, N=23), Indonesia was next in the score, stakeholders noted that CP3 met Indonesian local stakeholders' needs and priorities at 70% (2.8/4, N=12). The DR Congo stakeholders believe CP3 met the DR Congo local stakeholders' needs and priorities at 62% (2.5/4, N=9)**.** Table 22 below are the reasons justifying this score.

Table 22. Local stakeholders' reasons justifying the score

Needs and priorities met, or weakness identified	Feedback on Positive CP3 Effects
CP3 Strengthened Multisectoral Collaborations and Local Partnerships	• CP3 contributed to improving local stakeholders' understanding of the necessity for a multi-sector collaboration approach in epidemic and pandemic surveillance preparedness and response bringing together the ministries of health, environment, Fisheries and Livestock (Animal health) to work toward an effective collaboration in tackling epidemic and pandemics. • CP3 strengthening the local partnerships with strong coordination and collaboration leading to effective results. o The monthly meetings provide feedback that the CP3 is responding to the needs and priorities of local partners, who appreciate the assistance provided by the Red Cross. The partners come together to share experiences and replicate good practices. This collaborative effort has effectively reduced the disease burden and ensured timely responses to emerging threats. o Partners share responsibilities and consolidate efforts for example during Kalazar outbreak in Kenya, **Find Kenya** was on the ground, **Caritas** provided nutritional support, and **Médecins Sans Frontières (MSF)** assisted with general aid events in collaboration with NS. **Village Hopecore** contributed to the eradication of sandflies in Tharaka North. • Engagement with local partners, including the local religious leaders, traditional healers, midwives, private doctors, and other health authorities improves health outcomes. • Coordination with multiple ministries (e.g., Ministry of Health, Ministry of Home Affairs, National Coordinating Ministry and Ministry of Village Development) for initiatives like the development of the CBS roadmap and pocketbook for village heads to sustain the Programme. ● Efforts to bridge the Ministry of Health with the community, creating substantial opportunities for engagement and shared responsibilities in health initiatives
Support of CP3 Volunteers	• CP3 volunteers provide essential support to public health centers by encouraging community members to attend mobile health centers for checkups. ● CP3 volunteers serve as an additional information source, complementing the existing support from CHVs and enhancing community health monitoring and awareness.
Youth Involvement and Community Engagement	• The Youth NS volunteers play a critical role in community health, stepping in as first responders during school events, monitoring mosquito larvae at household level, and promoting vector control measures.
Strengthening the Capacity of local stakeholders in epidemics and pandemics preparedness and response	· **CP3 contributed to strengthening capacity of local stakeholders by:** o **Providing access to communities-based surveillance information in real time** Each line ministry receives alerts pertinent to their sector and can access real-time information from the volunteers. o **CP3 provided a platform for multi-sectorial collaboration:** CP3 activities provided an opportunity for different ministries to collaborate. Respondents mentioned the rabies crisis, where alerts were sent to both the ministries responsible for human health and animal health. · **Capacity building of local stakeholders increasing participation, collaboration, and synergy:** o Under CP3, trainings are organized for all stakeholders, including individuals from education, public health, the environment, and local administration. This approach has effectively prepared them for action and helped mitigate disease outbreaks.

The factors that affected the score negatively	· **Inadequate implementation period is some countries:** Respondents felt that it was important to give stakeholders time to understand and internalize the CP3 concepts before concluding activities. · **CP3 activities were more focused on human health.** The Ministries of Environment and Fisheries and Livestock (Animal Health) felt that while CP3 invited them to meetings, it did not include activities that strengthened their respective sectors. · **The Ministry of Environment and the Ministry of Fisheries and Livestock do not have community staff to integrate with CP3 at the community level.** This impacted the score as these ministries felt they did not have a connection with CP3 CBS but more with the One Health initiative. · Some significant partners in countries are not involved- such as Forest Department, World Vision and WWF (World Wildlife Fund) have not been very involved. The Forest Department can help prevent livestock from grazing in the forests and reduce the risk of zoonotic disease emergence.

Here are a few quotes by stakeholders that explain their perceptions of how CP3 met the needs and priorities of local stakeholders:

*"Our ministry's role is to address the environmental crisis, disaster management, global warming, and related issues. The CP3 project included us by inviting us to all meetings. From the beginning, the Red Cross involved us in every aspect of the project. This is the first health-related program that has truly engaged us, and that means a lot to us even if we did not have fieldwork activities planned for our ministry in CP3 we are happy we been exposed to such project…. The Ministry of Health is well-structured and operates independently of political influences, which is a reality we must acknowledge. Unfortunately, our ministry does not receive the same priority unless an environmental crisis results in human casualties. Preparedness is not prioritized and is not included in the budget. The administration is cumbersome, but the Red Cross is making significant efforts to unite us and help everyone understand the necessity"- **Ministry of Environment, Matadi, Kongo Central, DR Congo***

*"Firstly, when we developed the coordinating ministry regulation, we also created the roadmap for CBS. In that process, we coordinated with all the ministries, including the Ministry of Health as the main counterpart for this activity. Once the Ministry of Health confirmed their interest in expanding this initiative, we developed both the roadmap and the regulation. Recently, we held multisectoral meetings with the Ministry of Home Affairs to develop a pocketbook for village heads, guiding them on how to use grant funding for CBS activities in their villages."- **Local Stakeholder, West Java Indonesia***

*"The CP3 program is special; it has never been done before. Bringing together the Ministry of Health and the Ministry of Livestock and Veterinary Affairs was a significant achievement, as they had never collaborated in this way before. Several factors, including the involvement of community volunteers and the Community Health Promoters (CHPs), contributed positively to the initiative and are part of the reason for the program's positive impact. However, we also face challenges that we will discuss along the way". **NGO Head Narok, Kenya***

Local Stakeholders' Involvement in CP3:

In overall across all stages and all countries, respondents noted that local stakeholders were involved at 63% (2.5/4, N=40) in CP3 design, implementation, and M&E (Table 23).

Table 23. CP3 programme Local Stakeholders' involvement per phase

	Involvement stage							
Countries	Design	N	Implementation	N	M&E	N	Average	Percentage
DRC	2.2	6	2.5	8	2.5	6	**2.5**	**62.5**
INDONESIA	2.8	10	2.6	11	2.0	11	**2.3**	**58.0**
KENYA	2.5	20	2.8	21	2.8	19	**2.8**	**69.4**
All countries	**2.5**	**36**	**2.6**	**40**	**2.4**	**36**	**2.5**	**63.3**

Country level:

Kenya reported the highest involvement of local stakeholders (69%, N=21). DR Congo reported involvement

of 62.5% (2.5/4, N=8) and Indonesian local respondents reported local stakeholders' involvement of 58% (3/4, N=14) throughout CP3 Programme design, implementation, and M&E.

Respondents noted the need for multisectoral synergy to allow more effective collaboration. They also highlighted local stakeholders struggling with competing priorities with other health and non-health Programmes. Unequal partner involvement was also noted as an obstacle to strong partnership stressing that there has been more emphasis on public health and animal health and less focus on the environment and wildlife. Partners in Ministries of environments felt they were not much involved.

Here are a few quotes on local stakeholders' involvement in the CP3 Programme:

" We participated in outreach and project presentation sessions with CP3. While we took part in the training module, and development, we were not involved in the activities.". - ***National coordination, One Health, Kinshasa, DR Congo***

"My directorate, we were informed of the project only in 2023. If anyone was contacted for inception in 2019 it was probably people at ministry administration at higher level. The ministry was invited from the start, but the right department was only assigned in 2023. We were only engaged actively in 2023".
- ***Ministry of Fisheries and Livestock, National division of Animal Health, Kinshasa, DR Congo***

"The government is involved in the selection of area of focus, monitoring, and evaluation, the MoH facilitates and determines the direction of development, particularly when identifying CP3 designated implementation areas." ***Ministry of Health respondent, national level, West Java, Indonesia***

"We engaged extensively with various local partners, including the local religious office to connect with future brides for stunting prevention. We also collaborated with the rabies center and established networks with other health authorities, such as midwives and independent doctors. However, these networks are not aware of the CP3 projects. CP3 is actively involved in mapping TB patients to improve tracking and care." ***Surveillance officer, West Java, Indonesia***

"Designing is the collaborative effort of all the partners and it is something that gets fine-tuned every time to better respond to epidemics and pandemics. The departments that get involved are the health, animal health, education, veterinary services, legal, environment, and private sector. All these play a role in the design stages of CP3." ***County Director of Health – Tharaka Nithi, Kenya***

7.1.3 Was CP3 Effective in Reaching Assigned Objectives?

To assess the effectiveness of the CP3 Programme, we gathered stakeholders' perceptions regarding the Programme's success in achieving the three main assigned objectives, known as workstreams.:

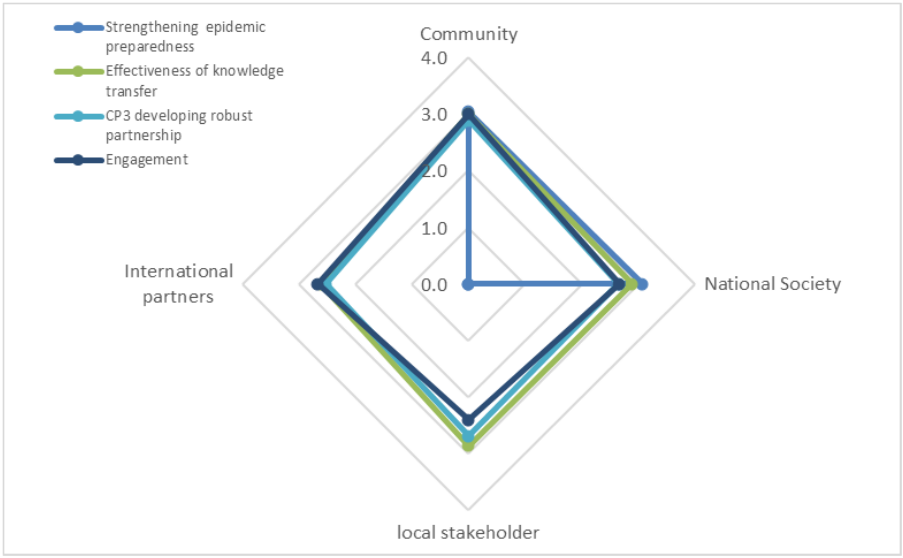
1. Reaching communities' preparedness
2. Reaching National Society Preparedness
3. Reaching the key stakeholders engagement

In other words, we asked stakeholders whether CP3 activities contributed to strengthening epidemic and pandemic preparedness, effectively transferred knowledge to local stakeholders, and developed a robust partnership among local partners.

The evaluation team required respondents to rate their perception of CP3 activities' effectiveness out of 4 using a Likert scale as previously described.

Overall: Stakeholders' perception is that CP3 activities are effective at 69% (2.8/4, N=115) Figure 12.

Figure 12. CP3 effectiveness across stakeholders (all countries)



	EFFECTIVENESS									
Stakeholders	**Strengthening epidemic preparedness**	**N**	**Effectiveness of knowledge transfer**	**N**	**CP3 developing robust partnership**	**N**	**Engagement**	**N**	**Average**	**Percentage**
Community	3.0	52	3.0	23	2.9	18	3.0	8	3.0	74.5
National Society	3.1	30	2.9	27	2.7	23	2.7	24	2.8	70.5
local stakeholder			2.9	41	2.7	41	2.4	15	2.6	66.1
International partners			2.6	21	2.5	19	2.7	3	2.6	65.1
Average	**3.1**	**82**	**2.8**	**112**	**2.7**	**101**	**2.7**	**50**	**2.8**	**69.1**

With a score of 75% (3.0/4, N=52) for community preparedness, stakeholders strongly believe that CP3 enhanced the capacity of communities to detect, report, and adopt behaviours and attitudes that protect public health in the areas where the Programme was implemented.

Similarly, in regard to National Societies' preparedness, they believe CP3 has strengthened their capabilities through workforce development and capacity-building activities. They argue that this reflects their increasing contributions to supporting epidemic and pandemic preparedness and responses in their respective countries since CP3 inception in 2017-2018, making NS strong partners for their respective governments and, consequently, making the IFRC a major global partner supporting epidemic and pandemic preparedness and response.

Stakeholders also noted that there was a highly effective knowledge transfer at the community level (75%

effective, N=52) and a good transfer of knowledge at the NS and local stakeholders' level (72.5% effective, N=68). Additionally, they reported good stakeholder engagement (67.5% effective, N=50) and the development of several strong partnerships (67.5% effective, N=112), acknowledging that this is still a work in progress.

7.1.3.1 CP3 EFFECTIVENESS IN WORKSTREAM 1: STRENGTHENING COMMUNITIES PREPAREDNESS

Advancements have been made in reaching Community Preparedness.

In overall across all countries, local stakeholders believe CP3 was very effective at 75% (N=50) in reaching community preparedness. They noted that thanks to CP3's awareness and health promotion activities, the communities can detect very early risks and symptoms of diseases that can potentially become epidemics, they are aware of the channels to report these events and take the necessary measures to suppress the spread before a response intervention arrives. They also noted the adoption of positive behaviours, practices, and attitudes that protect population health and suppress the spread of diseases including the use of latrines, adoption of safe WASH habits, self-reporting of children and animals who need to be vaccinated, and awareness of the importance of not consuming animals that died of unknown causes.

> *"When a project starts, it is important to give the community time to understand it. CP3 stopped very quickly; although the communities were reached, the project was so short that it did not provide them with enough time to mature and integrate that new knowledge into their habits and routines. Now that they have stopped too early, I doubt this will have a long-lasting effect. –*
> ***National coordination, One Health, Kinshasa, DR Congo***

Table 24. CP3 programme community effectiveness

	Effectiveness					
Countries	**Preparedness**	**N**	**Knowledge**	**N**	**Average**	**Percentage**
DRC	2.9	18	3.5	2	**3.2**	**79.9**
INDONESIA	3.1	11	2.2	6	**2.6**	**65.7**
KENYA	3.2	21	3.3	15	**3.2**	**80.7**
All countries	**3.1**	**50**	**3.0**	**23**	**3.0**	**75.4**

Country level:

Table 24 above shows that, Kenya reported the highest CP3 community preparedness effectiveness at 80.7 % (3.2/4, N=21), noting that knowledge transfer (effective at 82.5%, N=15) was almost equally high as the community preparedness (80%, N=21). DR Congo reported CP3 community preparedness effectiveness of 79.9% (3.2/4, N=18), while knowledge transfer in communities was perceived as very high (87.5%, N=2), and community preparedness scored 72.5% (N=18). Indonesia recorded the lowest reporting of CP3 community preparedness effectiveness at 65.7 % (2.6/4, N=11). Indonesian stakeholders noted a very good community preparedness 77.5 % (3.1/4, N=11) but stressed low knowledge transfer in communities (55% effective, N=6). Stakeholders argue that the low success of knowledge transfer in Indonesia is due to community engagement and accessibility challenges, such as remote locations and limited transportation, rejection during outreach efforts where resistance and difficulties in fostering community engagement were reported as well as cultural barriers, which made it difficult for community health volunteers to promote healthier behaviours and advocate for change in risky behaviours and attitude related to health habits in communities.

Below on Table 25 are the overarching reasons that affected the CP3 community preparedness effectiveness score across countries:

Table 25. Communities'reasons justifying the score

Objective	Feedback on Positive CP3 Effects and bottlenecks
Strengthening Community Epidemic and Pandemic Preparedness	• **Increase knowledge and awareness of priority diseases and how to handle them** • **Strengthening early detection, reporting, and response** • **Adoption of good practices that protect population health:** o Adoption of Animal Health regulations and good practices such as routine vaccination of animals, meat inspections, no eating of dead animals o Improve in health-seeking behavior, more mothers are attending Public Health Clinics, less home delivery and more children are being vaccinated. o Adoption of good Water, Hygiene, and Sanitation (WASH) practices: handwashing, drinking water treatment and boiling practices have improved as well as home cleaning, latrine building and reduction of open defecation • **Reduction of disease burden:** due to increased knowledge and raising of alerts as well as action being taken on the alerts, there is a reduction of outbreaks in the past 7 years. • **Strengthening of surveillance system:** CP3 has implemented CBS to detect and escalate alerts about selected priority diseases, feeding into existing systems..
The factors that affected the score negatively	· **CP3 limited coverage:** all above achievements have been made only where CP3 was implemented, there is a need to make it a nationwide operable system. · **Constant population migration**, particularly in border cities requires a continuous communities awareness activity as people are leaving and new people are coming · **CP3's preparedness focus nature does not provide resources to support development of promoted good practices**: Communities often complained how they cannot apply CP3 teaching in WASH for example if they live in areas where water is not accessible. · **Cultural and religious leadership barriers**. Leading to rejection during outreach efforts with resistance and difficulty in fostering community engagement. · **Community accessibility challenges**, such as remote locations and limited transportation.

Here are a few quotes on CP3 community preparedness effectiveness:

"When it comes to community preparedness a good progress was made, particularly regarding community-based surveillance, epidemic control, and mobilization, I believe that CP3 has played a significant role. Today, when there is an alert about a potential epidemic, the community takes charge by informing the Red Cross and knowing whom to contact. Before CP3, they were unaware of this process, but I think it has made a major contribution.....
*- **Red Cross-national leader, national office, Kinshasa, DR Congo***

*"There's been good progress. Before our awareness activities on water sanitation, there was a lot of diarrhea among children. Now, they can boil water before drinking, even if they don't have purifying products. People are now aware of the need to clean up their environment, build toilets, and boil and purify water. Before CP3, people used to defecate in public, and the environment was very unhealthy. We were able to bring a diarrheal epidemic under control thanks to the involvement of the communities, who understood the awareness-raising efforts of the volunteers. We had people seeking treatment for diarrhea, and we used oral rehydration solution (ORS) to help many. They saw how effective the results were, and the communities trust us a lot. " **-12 Red Cross volunteers-Lufu, Kongo Central. Dr Congo***

*"Initially the community was typically ignorant of environmental health, volunteers always educated the community. Since there was COVID-19, the community has become more concerned, especially in the aspect of washing hands properly. The community is also included in the action, namely "gotong royong" or community gathering to clean the environment and carry out monitoring of larvae. In each village there are advantages and disadvantages, in Saruni village there is already community concern, for Citereup village it is a bit difficult because the distance is far from the village when health promotion is far away with difficult access and signal." .- – **Local community stakeholder- West Java, Indonesia***

*Many people are now not dying from the priority diseases. Vaccination drives are there and all meat is inspected. Not many mothers were going to the clinic not like long ago. Pregnant mothers no longer deliver at home. have reduced disease index there is early detection and alerts are done. One health is active and infant diseases are reduced. Handwashing practices have improved and drinking water treatment and boiling. They also go to schools for training of children at school. No reported or suspected cholera case in 7 years. **CHU Lead - Tharaka Nithi, Kenya***

7.1.3.2 CP3 EFFECTIVENESS IN WORKSTREAM 2: STRENGTHENING NATIONAL SOCIETY PREPAREDNESS

Specific advancements have been made in reaching National Society Preparedness.

Across all countries, National Societies stakeholders believe CP3 was very effective at 76.7% (N=28) in reaching National Societies' preparedness. Stakeholders noted that CP3 strengthened National Societies' capacity in Epidemic and Pandemic Preparedness and response by:

Strengthening National Societies' community presence. The workforce strengthening and capacity building that targeted National Societies' volunteers increased their commitment, engagement, and responsiveness, respondents argue that volunteers are acting independently, which is seen as a successful epidemic and pandemic preparedness effort. Respondents have also noted that volunteers are more present at the community and have demonstrated a quick response in epidemic and pandemic emergencies which allowed an increase of communities' recognition of the role that the NS are playing beyond blood donation or first aid work they have been known for. This highlights the improved community awareness and volunteer involvement supporting effective early detection, reporting, and response to epidemic and pandemic crises.

> *"In Kenya, we often say that during any disaster, the government and the Kenya Red Cross are the primary responders. It is important to recognize this is a great reputation for the National Society. When it comes specifically to epidemics, the capacity built through CP3 plays a crucial role. We have the relevant trainers who can provide all the necessary training for both preparing for and responding to outbreaks."* – ***IFRC program staff Nairobi***

- **Strengthening National Societies' capability, skills, competency, and resources:**
  - *National Societies' capability, skills and competency:* stakeholders reported that beyond the volunteers, CP3 improved NS staff capabilities this includes through skills development and knowledge transfer in the context of Epidemic and Pandemic Preparedness, they support that this improved National Societies' staff and volunteers' behaviours (motivation), work ethic and competencies demonstrated in the pride they take in the performance of their task in their communities
  - *Resources*: It is also noted that CP3 developed tools, processes, strategies, policies, and frameworks. CP3 also improved NS access to equipment, and materials for their work in epidemic and pandemic preparedness, this includes vehicles, broadcasting and awareness activities materials, volunteer fieldwork equipment, and branded products displaying Red Cross and IFRC logos from national to community level thanks to CP3, as well as the development of M&E electronic tools for community-based surveillance used by volunteers to report alerts and events to the next level in real-time increase the number of alerts and response**.** CP3 has also enhanced the National Societies' strategic planning by developing strategic epidemic and pandemic preparedness and response frameworks and guidelines.
- **Strengthening National Societies' strategic position at the national level.** Stakeholders also reported that CP3 contributed to strengthening the National Societies' reputation as a major epidemic and pandemic preparedness and response partner at the country level. Through community-based surveillance, National Societies' volunteers and staff allowed early detection of diseases that could spread into epidemics and pandemics in their communities in the past 7 years. The most recent epidemics in the DR Congo, Indonesia, and Kenya from chikungunya, cholera, rabies, and dengue fever including the current Mpox have all been detected and reported by National Societies' volunteers.

Table 26. CP3 programme National Societies' effectiveness

	Effectiveness					
Countries	**Preparedness**	**N**	**Knowledge**	**N**	**Average**	**Percentage**
DRC	2.9	16	2.8	16	**2.9**	**71.9**
INDONESIA	3.2	5	3.2	6	**3.2**	**79.6**
KENYA	3.3	7	3.0	4	**3.1**	**78.6**
All countries	**3.1**	**28**	**3.0**	**26**	**3.1**	**76.7**

Country level:

Table 26 above shows that, Indonesia reported the highest CP3 National Society preparedness effectiveness at 79.6 % (3.2/4, N=6), noting that the PMI epidemic and pandemic preparedness matched the knowledge transfer (effective at 80%, N=6). Kenya reported CP3 community preparedness effectiveness similarly very high at 78.6% (3.1/4, N=7), while knowledge transfer in KRCS was perceived as very effective at 75% (N=4), KRCS preparedness scored 82.5% (N=7). DR Congo recorded a good reporting of CP3 National Society preparedness effectiveness at 79.9 % (N=16). DR Congo National Society respondents noted that DR Congo Red Cross preparedness 72.5 % (N=16) almost matched the knowledge transfer 70% (N=16).

Challenges to National Societies' preparedness: Stakeholders noted the following challenges to communities' preparedness:

- **CP3's National Society preparedness strengthening has not been prioritized**, National Societies' respondents noted that priority was given to community preparedness activities, there is still a lot of work to be done to strengthen the capacity of National Societies to prepare and respond to epidemics and pandemics.
- **The National Societies Preparedness is limited to the geographical area covered by CP3**: Respondents reported that CP3 had a very small coverage, therefore the impact of this amazing achievement in NS preparedness is limited to the areas CP3 covered. If a disease that has the potential to spread into a large-scale epidemic strikes far from CP3-covered areas it could go undetected, and the NS will run out of resources and will be understaffed.
- **Limited access to data and information**. Countries reported that National Societies have limited access to data and information, which hinders adequate response to a new threat with no proper case definition.

Here are a few quotes on CP3 National Societies' preparedness effectiveness:

"At the national level, only the development of a health emergency and natural disaster response plan has been completed. While there has been significant progress, much work remains on our workstream. Teams have received training, which has strengthened their capacity at the national, provincial, and community levels. Additionally, we have implemented various tools and normative documents, including response plans and the development of strategic documents. At the community level, the Red Cross performed better; the training of volunteers enhanced the capacity of the national society and improved its visibility nationwide." - ***Red Cross CP3 coordinator-Nsona Mpangu, Kongo Central, DR Congo***

"In some communities village, many did not know there was a PMI. They came to know what PMI is and what it does through CP3. The people who knew about PMI only knew about blood donation, now they understand that PMI help with epidemic and pandemics." ***local stakeholder, West Java, Indonesia***

Working with the CHPs has made the community preparedness more robust. The communities are prepared through community dialogues and community-based surveillance that has made their knowledge and skills on how to respond at times of epidemic. ***National Society Program Manager, Nairobi, Kenya***

7.1.3.3 CP3 EFFECTIVENESS IN WORKSTREAM 3: REACHING KEY STAKEHOLDER ENGAGEMENT.

Key Stakeholder Engagement is part of CP3 workstream 3. The targeted objective here is to increase key stakeholders' knowledge or capacity to support epidemic preparedness and response. We asked stakeholders' perceptions of how much CP3 contributed to reaching key stakeholders' engagement by increasing local stakeholders' (Governments and local partners) knowledge of epidemic and pandemic preparedness and response and building robust partnerships. Table 20 below presents the result of their Likert scale score out of 4.

> *One health approach included members from all sectors including wildlife, animal health, veterinary, environment, education, and public health. Working had to convert religious extremist groups to change and adopt conventional ways of life. CHPs are being recruited into conventional health systems and getting trained by Redcross and the county. All county departments were actively involved and trained almost 70% during the design and inception.* ***County Director of Health – Tharaka Nithi, Kenya***

KNOWLEDGE TRANSFER

Overall, across all countries, local stakeholders believe CP3 was very effective at 66.5 % (N=41) in reaching stakeholder engagement. They noted that even though the One Health initiative started prior to CP3 implementation in most visited countries, it was not very clear to One Health partners how that partnership could be implemented. CP3 offered the first platform where the One Health partnership could be demonstrated. From the CP3 consultations bringing together all local leadership (national and provincial) from different ministries to reflect together how they can work in protecting population health through an epidemic and pandemic preparedness Programme, to the National Societies' volunteers reaching out and inviting different ministries available local agents to join their surveillance effort at community level and stimulating the ministries to think about their contribution in epidemic response activities during crisis.

Table 27. CP3 programme stakeholders engagement effectiveness

	Effectiveness							
Countries	**Knowledge**	**N**	**Partnership**	**N**	**Engagement**	**N**	**Average**	**Percentage**
DRC	2.4	9	2.2	9	1.7	3	**2.1**	**52.8**
INDONESIA	2.8	10	2.5	11	4.0	1	**3.1**	**77.1**
KENYA	3.0	22	3.0	21	2.5	11	**2.8**	**70.8**
All countries	**2.8**	**41**	**2.6**	**41**	**2.7**	**15**	**2.7**	**66.5**

Country level:

Transferring knowledge, building partnerships, and engagement of One Health Partners Ministries:

Table 27 above shows that, Indonesia reported the highest CP3 stakeholders' effectiveness at 77 % (3.1/4, N=11), rating stakeholder engagement activities' effectiveness at a maximum of 100%. The respondents argued that CP3's awareness activities, and strongly engaged local partners raised their knowledge (70%, N=10) compared to before CP3 where One Health Partners Ministries did not have a strong no interaction between them. Kenya's local partners rated CP3 stakeholders' engagement effectiveness at 70.8% (N=22). While knowledge transfer and partnership between local stakeholders was rated very high at 75%, engagement was rated low at 62.5%. DR Congo reported CP3's lowest stakeholder engagement effectiveness at 52.8 % (N=9). Respondents reported that knowledge transfer was considered good at 70% noting that learning and awareness have happened among One Health partners Ministries who are now ready to get involved, however in CP3 phase 1, except for the Ministry of Health which took ownership of the CP3 Programme from the beginning and understood how CP3 fits within its objectives, it was a learning process for other Ministries (Ministries in charge of Animal Health and Ministries of environment) to start understanding where they should fit into the whole process. The partnership score (55%, N=11) and the stakeholder engagement very low score (42.5%, N=3) highlight the feeling of the Ministries in charge of Animal Health and Ministries of the environment in DR Congo stressing that they were invited but not included considering the CP3 consultations did not allow their budgets to develop activities that could

strengthen the scopes of their line ministries.

At the community partners level, stakeholders noted that while in some areas like Indonesia and DR Congo they were still rejection and cultural barriers during outreach efforts there is an improvement in relationships with religious leaders and traditional healers who perceived the government public health system as a threat before, but their perceptions were improved by CP3 volunteers who approached them with awareness activities during the epidemic crisis and demonstrated the effectiveness of their activities such as ORS with Rehydration points during cholera outbreak (DR Congo) and larvae monitoring and mapping epidemic and pandemic zones based on the suspected threat. Now religious leaders and traditional healers are more open to collaboration and participate actively in community-based surveillance and alert efforts.

"The resistance of religious and traditional medicine actors is decreasing because we have integrated some of their members among our volunteers and these volunteers are better listened to and raise internal awareness. There is still an improvement to make but we made a good progress....

Traditional healers and religious leaders have better awareness in epidemics and pandemics preparedness as they speak to their members and communicate to influence their follower attitude... Traditional healers, we visit their sites and speak to them, the results is now if they struggle with cases, they call us to help take their patients to the hospital.
There is a church called Bundu Dia Kongo they were resisting to our call for vaccination and work with the health centers but now slowly they are allowing us to work with them and are more open since they see how much contribution we bring during epidemics and pandemics crisis." - ***Mixed quotes from Red Cross volunteers and staff, community level, DR Congo***

DEVELOPING ROBUST PARTNERSHIP

All partners across all countries agree that the CP3 Programme's strongest partnership was with the Ministry of Health, many believe this is because the Red Cross's vocation has always been primarily dedicated to human health and the institution itself is working under the umbrella of the Ministry of Health in all countries. It was also noted that Ministries of Health are better structured and have better capacity from the national level to the community level enabling this strong partnership compared to the other two One Health partners Ministries. This unbalanced partnership is less compounding in Kenya where the CHPs are communities' government representatives with the mandate to serve all One Health Ministries partners equally as possible.

Kenya documented some robust local partnerships, stakeholders reported that through continuous meetings and training local partners increased their capacity to support Epidemic and Pandemic Preparedness and response in Kenya. For example, media partners were involved in the training of CHPs and provided support allowing CHPs to use their platforms. This allowed the media partners to play an important role in preparedness and response and work as part of the One Health team. Another example is a private communication company partner, who provided support to strengthen the reporting system with a phone tree system that targets the higher authority, and the information cascaded to the next level. The CHPs report the incidents using a toll-free number with a call centre that runs 24 hours allowing the county also to respond within the hour. Other training such as private veterinarians, offered necessary information and materials needed to support CP3. There was also a training for all stakeholders and community farmers, teachers, and chiefs and this enhanced good collaboration among the stakeholders. They are all tailor-made and specific and the content is adapted to a specific audience.

We are very proud that our capacity is being acknowledged. Volunteers at city and village levels are being included in important events both in national and local level. Before we only had concern for natural disaster, now we are also included in health emergencies." ***– local stakeholder, West Java Indonesia***

7.2 Data from none visited countries: Cameroon, Guinea Conakry, Uganda, and Sierra Leone

Five remote interviews were conducted with IFRC delegates in countries that were not visited by the evaluation team. In Cameroon and Uganda, we were able to include representatives from National Societies in these interviews, as shown in Table 28 below. The purpose of these interviews was not to obtain a representative sample like in the visited countries, but rather to explore their views and identify any similarities or notable ideas. These interviews aimed to gather their perceptions of CP3's relevance and appropriateness, effectiveness, and ideas for sustainability beyond donor funding. The data collected from these interviews are already incorporated into the evaluation of all partner analyses. This summary aims to give the reader a sense of their input.

Table 28. Remote fieldwork interviews

Province	Nbr of interviews	Nbr of interviewees	Country status
CAMEROON	**1**	**3**	**Remote**
Littoral	1	3	
GUINEE CONAKRY	**1**	**1**	**Remote**
Conakry	1	1	
UGANDA	**2**	**2**	**Remote**
Kampala	2	2	
SIERRA LEONE	**1**	**1**	**Remote**
Freetown	1	1	
Total	**5**	**7**	

Inception and Implementation

All respondents described a very similar approach to the visited countries for CP3's inception and implementation. They began with a country situational analysis and stakeholder consultation to adapt the CP3 design to the local context and propose tailored activities.

For implementation, the proposed and reported activities were strikingly similar. Respondents also highlighted comparable strengths, contributions, challenges, and bottlenecks related to community preparedness, National Societies Preparedness, and stakeholder engagement. Below, we have selected a few quotes to share their perceptions.

Inception

"The project started in 2018 but for both countries, I've been involved in site selection. You know the coordination between the national side, the national and sub-national authorities in-country to decide which areas within the country are probably eligible or in need of the interventions that we needed to implement. I've participated in activities around training of volunteers in the different packages, epidemic preparedness and response in communities, community-based surveillance, components of community engagement and accountability." ***– IFRC delegate, Uganda and Kenya***

We had consultations with the local government and selected the targeted communities. We recruited the team here for IFRC and volunteers, trained this team and then launched the implementation ***– IFRC delegate, Guinea Conakry***

Communities Preparedness

"The project was closely aligned with the needs of the populations, who often lack adequate information about epidemics and pandemics. They tend to rely on media coverage, which is often distant from their realities. In contrast, our fieldwork allows us to listen to and understand their concerns, helping to clarify any misunderstandings they may have.

For instance, in the northern region where I work, certain socio-cultural habits can contribute to epidemics and pandemics, such as cholera. Many people in this area are not accustomed to using toilets and often defecate in the open. Since the implementation of CP3, meetings with religious and traditional authorities have helped us explain the importance of using toilets, which can protect the community from certain epidemics.

Moreover, CP3 has established a platform for dialogue with the population, enabling the dissemination of information that fosters behavioral change and socio-cultural progress. This initiative is beneficial and helps safeguard them against epidemics and pandemics. ."

– CP3 coordinator, Cameroon Red Cross, Cameroon

"CP3 was not funded to create an enabling environment. Yes, CP3 was very effective in meeting so many communities' needs but, some communities had significant needs that the program could not meet. One of the things we were trying to promote was encouraging people to adopt handwashing and ensure it becomes part of their routine. However, one limitation of the program was that some people lacked the necessary materials to practice proper handwashing. Some of these communities even lacked access to water. For example, when our volunteers visited schools to encourage handwashing, they realized that adopting this behavior requires having water. Often, the available equipment was insufficient, and even the water itself was inadequate. Consequently, they would request support to establish a water source at the school, but we were unable to provide that assistance. In CP3 programme, behavior change is a priority, focus point, however, creating an enabling environment for people to adopt that behavior a crucial component.".
Uganda Red Cross Representative, Manager of Epidemic and pandemic Preparedness and Response URCS Headquarters, Uganda

National Societies Preparedness

"I will rate this one as very consistent. To explain this. I've engaged the National Society leadership on the addition that CP3 brought to them since the program began and they are more open to saying that before the CP3 program, they were not recognized by the government. Thanks to the CP3 program, they can now participate in national-level meetings that are related to epidemic preparedness, and they are recognized. The government can easily reach out to them. For example, on the 28th of September, we'll be celebrating World Rabies Day, and the Department of Agriculture is leading the celebration in Sierra Leone to the Red Cross movement in general and the Red Cross through the CP3 program to request support. ." ***– IFRC delegate, Sierra Leone***

"The CP3 program supported the National Society in establishing a functional department for epidemic preparedness and pandemic response, aligning with their strategic plan for 2017 to 2020. They aimed to create a dedicated function for managing epidemics and pandemics under the Health and Social Services framework; however, funding constraints hindered this initiative. When the CP3 program was introduced, it enabled the establishment of this function…

The reason I selected "moderately consistent" is that there were some gaps. The National Society had certain requirements that the program initially did not accept. For example, during an outbreak in 2019, we wanted to utilize the National Society's funds to support the response. However, there was a perception that this program was solely a preparedness initiative and not a response program. Although the program had its successes, it was primarily focused on preparedness, which created confusion regarding the use of funds for response efforts. This led to some discord for several years until the program eventually evolved to allow for response activities. However, this evolution took time and required negotiation between the Uganda Red Cross management and the IFRC management". ***Uganda Red Cross Representative, Manager of Epidemic and pandemic Preparedness and Response URCS Headquarters, Uganda***

Key Stakeholder Engagement

"The Ministry of Public Health is the strongest partner for obvious reasons. They have experience in the community and are well-structured. We cannot see many people from the environment and agriculture sectors at the community level where we work, which makes it challenging to involve them." ***– IFRC delegate, Sierra Leone***

"For Uganda, a lot still needs to be done because we are not completely in sync with the local authorities, the Minister of Health, the Ministry of Agriculture, and the Ministry of Environment. They have not refined the process, so we still have a long way to go…

The coordination among the district One Health teams is not very cohesive, as they are not yet adequately trained. This has resulted in a fragmented approach to coordination. Typically, collaboration only occurs in response to an outbreak, prompting people to come together. However, there should be routine preparedness planning, where teams discuss the seasonal calendar and recognize the approaching rainy season. This would allow them to focus activities on educating communities about relevant issues through volunteers. Unfortunately, this proactive engagement does not happen until a crisis arises or a donor visits the area to mobilize the teams for a meeting. I believe Uganda needs to learn more from Kenya to follow that process effectively.". ***IFRC delegate, Uganda and Kenya***

"*In Uganda, we have the Village Health Task Force mechanism, which is led by the village Head and then we have the community volunteers for the government and also the Red Cross volunteers and then key leaders so that whenever there's a problem, these village health task force are the ones who discuss the problem and what needs to be done and then they mobilize the community for an action day****.". IFRC delegate, Uganda and Kenya***

7.3 Desk Review Data Triangulation with Evaluation Data: How Does the Programme Data Support CP3 Relevance, Appropriateness, and Effectiveness?

The evaluation team reviewed the monthly reports (2018-2023) and the Indicator Tracking Tables (2019-2023). Below we are describing what the desk Review revealed.

7.3.1 WHAT PROGRAMME DATA REVEAL ABOUT CP3'S RELEVANCE AND APPROPRIATENESS

Reporting activities began in 2018, prior to the evaluation period. Early reports, corroborated by local stakeholders and the IFRC team, indicate that situational analyses and consultations were conducted with local stakeholders to tailor the CP3 Programme to each country's specific context. The reports document the participating stakeholders' organizations, their contributions to identifying priority diseases, and the areas of focus and input they provided for Programme design and implementation.

7.3.2 WHAT THE PROGRAMME DATA REVEAL ABOUT CP3'S EFFECTIVENESS

7.3.2.1 DATA MANAGEMENT LIMITATIONS

The evaluation team noted that the narrative reports contain diverse information on activities by country reported under all workstreams. However, it is unclear if or how these activities are quantified to account for and support CP3's effectiveness and to give CP3 the credit it deserves for funding and supporting these activities. For instance, in workstream 2, while there is no data captured for all countries in the ITT, except for small records for Kenya (160), Guinea (10), and Cameroon (4), the countries' monthly reports provided important information on activities conducted under workstream 2, but this information was not quantified or accounted for. Here are a few examples from the sampled reports of many in these reports:

1. DR Congo, June 2018 report, noted that the country team worked on the Integration of « One

Health» modules in the training curriculum of nurses and veterinary nurses; they also reported that they conducted a pre-evaluation of the Infection and Prevention Control (IPC) in the Democratic Republic Of Congo Red Cross (DRCRC) health facilities and they developed a methodology to evaluate the IPC component in the health facilities of the DRCRC. In November 2020, the DR Congo team reported under workstream 2 that they organized a two-day workshop both in Nsona-Mpangu, Kongo Central, and Mbinza Meteo in Kinshasa to update the existing Community Disaster Response Teams plans developed during the previous quarter of 2019.

2. In Indonesia, the IFRC team reported that in April 2018, with CP3 support PMI team participated in The International SBCC (Social Behaviour Change Communication) summit in Bali, 16-20 April 2018.; later the same month, PMI participated in the celebration of National Preparedness Day by conducting disaster simulations at the office. In August 2018, the team worked on the development of a Guideline for the Communication Strategy (including Information Education and Communication material) has been started, the same month they distributed Epidemic Control for Volunteers booklets to 4 pilot districts.

From the above, it is clear that throughout the narrative monthly reports, countries are communicating the activities undertaken for each workstream. It is the responsibility of the IFRC M&E team to provide clear guidance on how, when, and who should record, account, aggregate, and report these activities. The purpose of M&E is to account for the Programme's success; this can only be achieved if the M&E team establishes measurable indicators and trains the country and cluster data management team on when, how, and who should carry out specific tasks in the data management process. For example, it is important to explain to countries using the examples of DR Congo and Indonesia.:

1. How to count the development of a guideline, policy, or strategy document? When does it qualify as an accountable quantity (From the inception or when it is completed?),
2. How and when do you count training or conference participation? (Such as the one IFRC-supported PMI team to participate, when it is run by another organization or a workshop organized by IFRC like in DR Congo)
3. How and when do you count system-strengthening activities such as DRC Red Cross Health Facilities strengthening activity like in the DR Congo example?

There are several of these activities reported as narratives in the monthly reports throughout the CP3 Programme lifespan that were not accounted for. All the above demonstrates that the IFRC country teams do not have clear guidance from the M&E team regarding CP3 indicator reporting requirements. This highlights the need to develop clear definitions for indicators, create comprehensive guidelines, and ensure that those responsible for data collection, aggregation, and reporting are well-trained and have access to these resources. Additionally, it is important to develop standardized data collection tools that are not reformatted by each country, allowing for effective reporting on CP3 effectiveness, progress, and success.

Evaluators 'keynote: The IFRC Team does not need to develop additional indicators but should provide clear guidance on its SOP regarding which activities correspond to each indicator. This will enable countries to translate their activities into quantifiable elements that can be used to inform the indicators.

7.3.2.2 WHAT DOES THE ITT'S DATA REVIEW REVEAL ABOUT CP3?

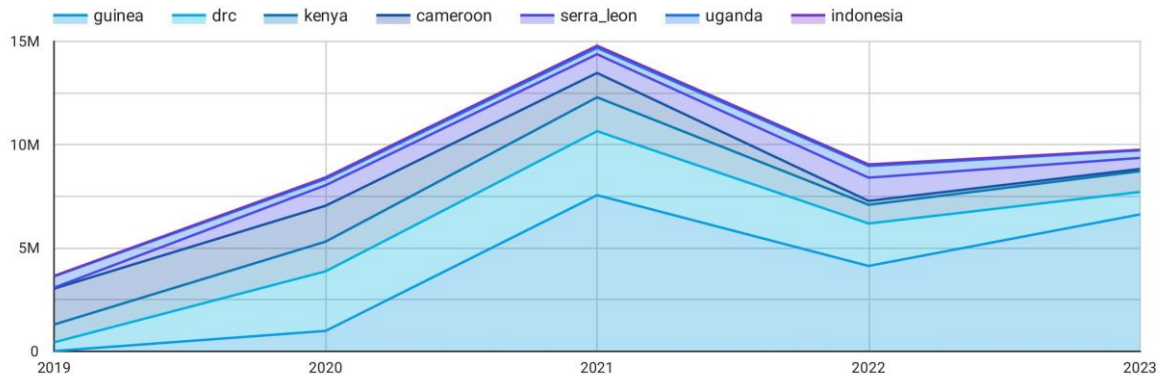
Evaluators' keynote. The limitations in the IFRC data management system highlighted previously, using none non-standardized source documents for reporting does not allow to assert the visualized data is exempted from data quality issues such as double counting, missing data, human error (incorrect data capturing), etc. Therefore, our comments on these visuals are strictly an observation of activities; to confirm they were reported at the time of implementation.

All countries and all workstreams

Figure 13 below shows all CP3 data trends as reported on the ITT from 2019 to 2023. We used number of records as it is not clearly established if the captured inputs are activities conducted, or people reached.

Figure 13. CP3 Implementation activities report ITT data dashboard (all countries)

Workstream	Number of records captured on ITT throughout the project
Community Preparedness	45,192,596
Media, private sector, data readiness and other stakeholders activities	484,006
Epidemic Response (Only Uganda and Guinea)	266
National Society Preparedness	174



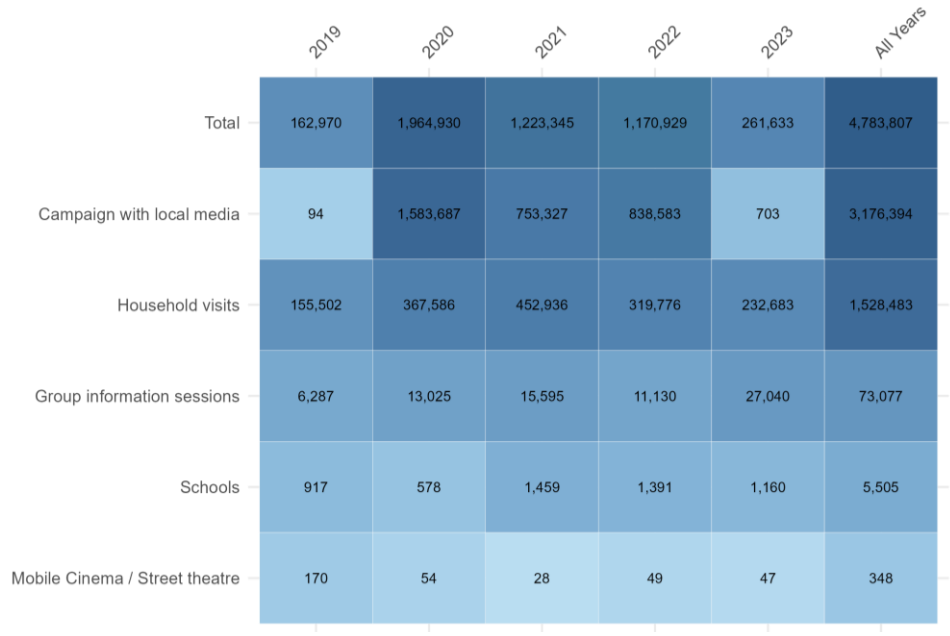
All countries' ITT data visualization (Figure 13) reveals the following:

- Reporting in ITT started in 2019, reached the peak in 2021 dropped in 2022 coinciding with the end of phase 1 in some sites and COVID-19 as reported by several stakeholders. The trends show an increase in data reporting starting again in 2023.
- As reported by stakeholders' interviews, workstream 1 "community preparedness" received more attention, therefore reported the most data. Workstream 3 "Key Stakeholders engagement" was the second highest reporting workstream. As pointed out by local stakeholders, workstream 2 "National Societies preparedness data reflects that it did not receive much attention with only 174 records from Kenya (160), Guinea (10), and Cameroon (4). This could also be the lack of understanding of the connection between this workstream's objectives, the activities that are being implemented, how they are linked to the indicators, and the data elements that should inform these indicators' aggregation and reporting, leading to the workstream activities not being accounted for.

Workstream 1" Community Preparedness"

Table 29 below shows CP3 community preparedness activities as reported on the ITT from 2019 to 2023.

Table 29. CP3 workstream 1" Community Preparedness" ITT data dashboard, number records (all countries)



The community preparedness ITT data visualization (Table 29) reveals that the reporting of workstream 1 in ITT started in 2019, reached the peak in 2021 dropped in 2022 coinciding with the end of phase 1 in some sites as reported by several stakeholders or possible COVID-19 effect. The trends show an increase in data reporting starting again in 2023.

Workstream 2" National Societies Preparedness"

Table 30 below shows all CP3 National Societies' preparedness activities as reported on the ITT from 2019 to 2023.

Table 30. CP3 workstream 2" National Societies Preparedness" ITT data dashboard (all countries)

Activities	indicator	value
Epidemic planning	# epidemic simulations in which the ns participated	1
Epidemic planning	# of CP3 branches that have completed a simulation or after-action review	6
Epidemic planning	# of NDRT personnel trained in CBS and ECV	52
Epidemic planning	contingency plans or sops developed by ns	18
Infection prevention & control (IPC)	# of CP3 RC facility frontline staff trained on IPC	56
Infection prevention & control (IPC)	# of CP3 RC health facilities that have conducted an IPC assessment	5
Preparedness for Effective Response (PER)	completed 1+ per exercise of per action plan (specify activity based on country program)	10
Preparedness for Effective Response (PER)	improved score in 1+ per epidemic benchmark areas (specify intended improvement based on country program)	5
Preparedness for Effective Response (PER)	per/epi-ready action plan developed	14
Preparedness for Effective Response (PER)	per/epi-ready orientation and assessment completed	7

The National Societies preparedness ITT data visualization (Table 30) reveals the following:

- Reporting of workstream 2 in ITT started in 2019, and 2019 was the data 's peak. Data decreased from 2019 and there was no data submitted in 2023.
- Epidemic planning, IPC and Preparedness for Effective Response were the most reported activities of Workstream 2.

Workstream 3" Key Stakeholders Engagement"

Table 31 below shows all CP3 Key Stakeholders engagement activities as reported on the ITT from 2019 to 2023.

Table 31. CP3 workstream 3" Key Stakeholders engagement" ITT data dashboard (all countries)

Activities	indicators	value
Community leader meetings / Community stakeholders engaged each month	total number of people reached	154437
Data readiness & data literacy training	total number of Red Cross staff, Red Cross volunteers, partners trained	752
Data sets compilation	total number of identified datasets researched and identified	855
Private sector participation	total number of private enterprises reached	16755
data readiness	# of sub-counties/sub-prefectures with epidemic risks mapped and visualised	93
management and coordination	# of monthly partner meetings attended	670
media preparedness	total number of people trained in BBC media sessions	233
media preparedness	total number who scored > 70% on BBC media training courses	32

The Key Stakeholders engagement ITT data visualization (Table 31) reveals the following:

- Reporting of workstream 3 in ITT started in 2019 and reached its peak in 2023. There was a consistent progressive reporting even if data dropped in 2022 coinciding with the end of phase 1 in some sites as reported by several stakeholders.
- Community leadership meetings/communities' stakeholders engaged each month, Datasets compilation and private sector participation were the most reported activities of Workstream 3.

7.3.2.3 WHAT DO THE MID-LINE KNOWLEDGE, ATTITUDES, AND PRACTICES (KAP) SURVEYS REVEAL ABOUT CP3?

The DR Congo's KAP survey[5] findings corroborate this evaluation findings supporting what the stakeholders reported that CP3 had a moderate to high level of awareness in communities about symptoms of diseases that can spread into epidemics and pandemics and many of the respondents attributed their knowledge source to the DR Congo Red Cross. Communities also were knowledgeable in prevention measures to take and the notification process to authorities. While in this evaluation, the stakeholders reported the adoption of positive practices and attitudes that protect against disease spread, the KAP survey noted many felt that the community was not very well prepared due to a lack of knowledge of epidemic diseases, lack of knowledge of how to prepare, and a failure to change behaviours to prevent illness. Stakeholders in the evaluation noted that the impact of CP3 was limited to CP3's reached communities and was not likely going to be sustained if not supported further.

The Indonesia KAP survey findings[6] are corroborating these evaluation findings supporting what the stakeholders reported that CP3 had contributed to increasing moderate to high-level communities' awareness about symptoms of diseases that can spread into epidemics and pandemics. Communities also were knowledgeable in prevention measures to take and the notification process to authorities. While in this evaluation, the stakeholders reported the adoption of positive practices and attitudes that protect against disease spread, the KAP survey data show that the community was not very well prepared due to a lack of knowledge of epidemic diseases, lack of knowledge of how to prepare, and a failure to change behaviours to prevent illness. Stakeholders in the evaluation noted that the impact of CP3 was limited to CP3's reached communities and was not likely going to be sustained if not supported further

Kenya's KAP survey[7] findings corroborate these evaluation findings supporting what the stakeholders supported that CP3 had a moderate to high level of awareness in communities about symptoms of diseases that can spread into epidemics and pandemics (noting for example that respondents reported hearing about the following diseases: yellow fever (51.7%), cholera or diarrhoea (56.3%) and Rift Valley Fever or anthrax (59.6%). Communities also were knowledgeable in prevention measures to take and the notification process to authorities, health professionals, and veterinary officers including high engagement with the KRCS volunteers (CHPs). The Kenya KAP survey also corroborated the stakeholders' report of the adoption of positive practices and attitudes that protect against disease spread. For instance, the KAP survey reported that most of the respondents (88.7%) said they wash their hands with soap after using the latrine. Other typical times include before eating (74.8%), before cooking and preparing food (42.4%). However, the KAP survey noted that open defecation remains a common practice posing a major risk for the spread of diseases with 39.4% of the respondents reporting that people sometimes or always defecate outside, not in a latrine. This practice is most common in West Pokot (90%) and Narok (67.7%). Stakeholders in the evaluation noted that the impact of CP3 was limited to CP3 reaching communities and was not likely going to be sustained if not supported further.

[5] DRC, CP3, Qualitative KAP Survey Results: https://www.ifrc.org/media/54928

[6] Indonesia CP3 KAP Survey Results: https://public.tableau.com/views/IndonesiaCP3KAPSurveyEN/Story1?:embed=yes&:display_count=yes&:showVizHome=no&:toolbar=y

[7] Kenya, CP3, Qualitative KAP Survey Results: https://www.ifrc.org/media/54927

7.4 Sustainability beyond donor funding

Stakeholders emphasized that the key mechanism of sustaining the gains achieved through CP3 in epidemic and pandemic preparedness is to domesticate the CP3 programme for local ownership by host country and the communities. This domestication by host countries would involve embedding the CP3 into the host country health system supported by legal instruments and financing of the same. This approach will facilitate integration of incentivized community health workforce (CHWs and volunteers) into the health system and improve coordination and operationalization of the program within the one health framework. In collaboration with local and international partners including National Societies. The host countries will therefore be able to scale-up the programme beyond CP3 piloted geographical areas.

> *"CP3 is a very successful project, and we see the value of funding it. It is important that we continue this activity in whatever fashion that we can. Nothing is sustainable without funding. You can have volunteers' network, but you need funding. I will definitely vote for this activity to continue; we don't want to be the sole funder, but we want to see it continue."* ***– USAID staff, Washington, USA***
>
> *"It is important that implementing partners engage with the local and national government and advocate to include CP3 activities in the government legislations to allocate budget for CBS. There is no sustainability without government ownership. USAID staff Indonesia.".* ***USAID staff Indonesia interview***

Kenya serves as a notable example of government involvement and ownership that will likely lead to the sustainability of CP3 initiatives. The government of Kenya has endorsed an elaborate Community Health Strategy that outlines how community healthcare services are delivered, facilitated through Community Health Promoters (previously known as Community Health Volunteers)), who are selected by the government under the Ministry of Health in close collaboration with sub-national government, local leaders and community members. The government recruits the CHWs and with support from the KRCS and local partner, they train the CHWs on basic health intervention packages and disease surveillance after which they graduate into CHPs who are incentivised by the local government from annual health budget. The CHWs are accountable to all One health ministries and help in coordination of partners and community health projects. With this model of domestication, local ownership, and additional partner funding, Kenya will seamlessly scale up the CP3 model beyond the pilot geography.

Indonesia is another example of a CP3 host country that has demonstrated commendable efforts to domesticate and locally own the CP3 model. Backed by a health regulation integrating community role in health and epidemic preparedness and the establishment of a village fund, the country successfully bid for the World Bank's Pandemic Fund in 2024[8] to scale up the CP3 across the Country and embed the model into Indonesia's health system to improve disease surveillance.

Lastly, as CP3 host countries make efforts to domesticate the programme using the different approaches, there is also the need for the host countries to identify existing programmes at country level that are targeting community protection with common areas of interest such as the USAIDs *EPiC* project and leverage on the resources for service delivery and strengthening community preparedness to achieve health security.

[8] Pandemic Fund Allocates Second Round of Grants to Boost Pandemic Preparedness in 50 Countries: https://www.worldbank.org/en/news/press-release/2024/10/19/pandemic-fund-allocates-second-round-of-grants-to-boost-pandemic-preparedness-in-50-countries

7.5 CP3 Lessons Learned

7.5.1 Success and Key Learning from Visited Countries.

Table 32. CP3 'success and Key learnings

	Successes	Key Learnings
1	An informed and cooperative community, including traditional healers and religious leaders who were previously resistant, now actively supports public health interventions to enhance the effectiveness of disease prevention and response efforts.	The lesson from DR Congo demonstrates that engaging community opinion leaders and entrenching ownership and buy-in through community forums at project inception is important for project success
2	A real-time alert system is in place to notify the next level of health authorities for early action and response.	The real-time alert system is important in meeting the 7-1-7 target for early disease detection, specifically, the notification that leads to rapid response.
3	✓ Public health interventions such as immunizations of unvaccinated children has been embraced by the community members. ✓ Following the awareness-raising activities, community members who were previously reluctant to use health centres have started seeking care from public health centres. ✓ The involvement of school children, students, and health clubs by CP3 in awareness campaigns in Kenya allows them to acquire and transfer knowledge to family members and close relatives in the community. ✓	Health promotion campaigns and strategies create sustainable community awareness that catalyzes public health interventions by health authorities and community members
4	✓ The communities are well informed about community case definitions, case detection, and reporting; they understand the risk factors associated with disease transmission and spread and have adopted good health practices and behaviors to improve their health outcome. ✓ Volunteers can organize activities, carry out rapid actions, and respond independently resulting in a significant reduction in Dengue Haemorrhagic Fever (DHF) cases in CP3 villages in Indonesia (https://www.ifrc.org/document/case-study-dengue-indonesia ✓ The trained National Societies' volunteers have successfully responded to outbreaks of chikungunya virus disease, cholera, FMD, Dengue Haemorrhagic Fever (DHF), and anthrax in Kenya and are appreciated by local stakeholders and communities. ✓ Community Health Volunteers (CHVs) are trained to be the focal points at the community level for CBS.	Training of community members, community and National society volunteers equips them with the necessary public health knowledge and skills in disease detection, notification, and early response actions and places epidemic prevention responsibility squarely on the community members and volunteers.
5	✓ Government responsibility, commitment, and leadership are crucial for sustaining the achievements of Programmes like CP3. It is inefficient for each government	Through the one-health approach, the host government could take up local ownership, and scale-up of the CP3 through health financing from national and

	Ministry to hire and incentivize its community-level representative. The Kenyan and Indonesia model is efficient and cost-effective, as the same CHPs engaged by the govt, are also engaged by KRCS. They serve as multisectoral and multi-hazard agents, equipped to understand the nexus of human health, animal health, and environmental health in the context of disease prevention and disaster management. An incentivized CHW who is accountable to all One Health partners and works with NS improves synergy between partners and sustains CP3 achievements beyond donor funding. In Kenya, CHWs are incentivized through monthly stipends paid by sub-national governments. ✓ Ensuring the inclusion of Community Health Workers (CHWs) in local government health budgets in Kenya helps retain a trained workforce for health emergencies at the community level.	sub-national government budgets. This would facilitate incorporating CHWs into health systems and sustain the incentivization of this health workforce while partnering with NS and other stakeholders on training and capacity building in a sustainable manner. Kenya and INO demonstrate this through the operationalization of government financing and health regulations.
6	Local stakeholders recognize NS as a key partner in epidemic preparedness and response, beyond just dead body handlers (DRC) and blood donor units (INO).	Through the CP3, the visibility of NS as a key partner in the epidemic preparedness and response at the country level by host governments improves the NS profile within the one health consortium and facilitates engagement with national stakeholders.
7	A national law has been released making it mandatory for communities to report any health threats to the next level of health authority in Indonesia.	The CP3 through multisectoral stakeholder engagement, collaboration, and advocacy can influence and shape national priorities on developing and endorsing effective laws and regulations touching on epidemic preparedness; the legal instruments augment a seamless implementation of preparedness, prevention, and response activities.
8	Evolving collaboration and stakeholder engagement among One Health partners at the local level	This ensures effective project implementation, concrete operational coordination, and cooperation on disease detection and response actions at the local level as exemplified in Kenya through one health approach for rabies and anthrax response.
9	The integration of the community's role in national regulation and CBS activities is a significant achievement for Indonesia.	This integration gave impetus to the establishment and operationalization of the village fund to support community-level preparedness and prevention interventions while contributing to scaling up the CBS at the national level in Indonesia. This CBS success is captured in the published WHO-JEE report for Indonesia 2024 and enabled the country to secure co-financing from the World Bank's Pandemic Fund round 2 towards scaling up CP3 beyond the pilot villages.
10	✓ National Societies in Kenya consistently share monthly updates among One Health stakeholders. ✓ National Societies employ evidence-based data to engage with sub-national and national governments in Kenya.	Data-driven decision-making informs curated interventions in epidemic preparedness, prevention, and response based on identified threats.

11	The IFRC continuously and proactively strengthens NS, based on varying levels of capacity and system strength.	The continuing support by the IFRC ensures that host country NS capacities and capabilities on epidemic preparedness, prevention, and response beyond CP3 target geography are enhanced; this capacity is cascaded to the community level and local stakeholders by the NS. This strength is demonstrated by the role played by the NS in response to other health emergencies including COVID-19, Ebola Virus Disease in DR Congo, and Cholera in Kenya.

7.5.2 Challenges and Key Learning from Countries Visited

Table 33. CP3 challenges and Key learnings

	Challenges	Key Learnings
1	The unavailability of emergency funds and personal protective equipment (PPE) for response actions to signals verified and notified to authorities reduces the programme's effectiveness.	✓ This calls for the need to establish contingency funds along the village fund model in Indonesia that could facilitate notifications and rapid response actions. ✓ Alternatively, the NS could work closely with IFRC to access resources through the IFRC Disaster Response Emergency Fund during health emergencies.
2	✓ The CP3 programme's geographical coverage in the host countries is limited and reduces the programme's effectiveness ✓ There are still many communities in hard-to-reach regions that have not been reached	Host countries could utilize the achievements of CP3 to mobilize additional resources to scale up the program as has been demonstrated by Indonesia which secured World Bank funding informed by the country's JEE recommendations.
3	✓ An inadequate number of volunteers responsible for large catchment areas coupled with equipment and transport issues hampers work ✓ Veterinarians are limited in number per assigned catchment area in some implementing sites ✓ Inadequate workforce for community epidemic preparedness gets overwhelmed during health emergencies and this reduces their effectiveness.	✓ NS should provide data on equipment and transportation needs to IFRC to inform decisions on the level and nature of logistical support sought ✓ Epidemic preparedness workforce development through training should be continuous and proportionate with the community needs, considering a country's geography, disease burden, and requisite skillset.
5	Resistance and threats from traditional healers and religious leaders at the initial phases of the project make security a priority for work to continue in some communities in the DR Congo.	The community engagement and involvement process at project inception is key in addressing the fears, concerns, and input from al the community members and leaders alike for ownership and seamless implementation.

6	Although the community's role has been integrated into national regulation, funding is at the local level, and there is still needed to approach the local government due to decentralization	
7	For the community volunteers in some countries, there is no minimum literacy level criteria and most of them are elderly and slow to adapt to technology.	The capacity building and training initiatives should integrate different tools including audio-visuals, Job Aids and Infographics for training. Additionally, the training of CHWs should target different ages to blend the old experiences with youthful energy for maximum impact.
8	✓ Delays in financing and administration lead to implementation delays, example: more than 3 months can be required to sign an agreement and before the transfer of funds from one level to another ✓ There have been delays in financial reporting which led to late disbursement of funds to NS for some time which impacted work on the ground in Kenya.	Prudent and prompt financial reporting by NS to the IFRC will be key in ensuring seamless financial flow and accountability between the IFRC and the implementing NS
9	The COVID-19 pandemic changed how work was done e.g. working from home, virtual training. This can inspire ideas to reach communities in times of crisis.	Virtual platforms for training would effectively replace contact training as was demonstrated during the COVID-19 pandemic.
10	Some NS senior managers believe the programme is not apriority within the national society scope of work leading to sub-optimal commitment to CP3 activities.	Some advocacy by IFRC to the NS would help address these underlying issues of commitment at the programme level

7.6 CP3 Contribution to Indicators of Joint External Evaluation and Additional Benchmarks for Health Emergency Capacities Beyond IHR Based on WHO benchmarks for strengthening health emergency capacities 2023 Guidance.

Table 34 below highlights some of the CP3 contributions to JEE V3.0 and other epidemic and pandemic preparedness benchmarks:

Table 34. CP3 contributions to JEE and other epidemic and pandemic preparedness benchmarks

Technical Area of Focus: JEE & Additional benchmarks for health emergency capacities beyond the IHR	Indicator/Benchmark	The objective of the benchmark/ or Indicator	Contributions made by CP3 to the Advancements of Indicator /or Benchmark
RISK COMMUNICATION	**RISK COMMUNICATION** BENCHMARK 16A.2: Mechanisms to deliver quality, timely, impactful risk communication are operational	Objective: - To implement strong risk communication practices with community involvement for preparedness, readiness, and response to health emergencies to enable populations at risk to take protective, preventative, and supportive actions Desired impact: - Communication networks, platforms, methods, modes such as face-to-face meetings, print materials, local announcements through public address systems, online, TV or radio, telephone messages or as a ringing tone, etc.	• Established mechanisms for risk communication messages, products, and interventions, including the processes and engagement of trained teams linked with relevant technical focal points. • Engaged and trained NS' staff, volunteers, community health workers (CHWs), and community and religious leaders on risk communication and community engagement. • Developed and disseminated risk communication products in various formats through trusted channels and relevant local languages, including household visits, community meetings, and radio Programmes, ensuring two-way communication and addressing rumors and perceptions.
ADDITIONAL BENCHMARK FOR HEALTH EMERGENCY CAPACITIES BEYOND THE IHR	**COMMUNITY PROTECTION** BENCHMARK H2.1: Integrated vector control management systems are in place	Objective: - To establish and implement a multisectoral community integrated vector control management approach to reduce vector-borne disease outbreaks Desired impact: - A contextually informed, community driven vector control interventions leading to a significant reduction in vector-borne disease outbreaks.	• NS conducted assessments and vulnerability mapping for vector-borne diseases based on the epidemiological profile of the host country. • They implemented integrated, community-driven vector control strategies and plans tailored to meet the needs and challenges of the community while providing a channel for local knowledge and data integration. • NS conducted training Programmes and workshops to build the capacity of communities and NS 's volunteers in implementing integrated, community-driven vector control interventions through a One Health approach.

ZOONOTIC DISEASES	BENCHMARK 5.1: 5.1: A multisectoral surveillance system is in place for priority zoonotic diseases/pathogens BENCHMARK 5.2: A functional mechanism to respond to priority zoonotic diseases is in place	OBJECTIVE: To strengthen multisectoral surveillance systems for priority zoonotic diseases/pathogens OBJECTIVE: To strengthen mechanism for responding to priority zoonotic diseases	• Identify key stakeholders and focal points from animal health (domestic animals and wildlife), human health, environmental health and other key sectors, and formalize a coordination mechanism (e.g. a multisectoral national surveillance team). • Share surveillance data on zoonotic diseases with the animal health sector on a routine basis. • Established a mechanism for rapidly alerting relevant sectors in case of priority zoonotic outbreak events to reduce the time to initiate a coordinated outbreak response as demonsrated in Kenya on the detection and response to outbreaks of anthrax, rabies, brucellosis, mpox outbreaks through its multisectoral CBS
ADDITIONAL BENCHMARK FOR HEALTH EMERGENCY CAPACITIES BEYOND THE IHR	**COMMUNITY ACCESS TO WATER, SANITATION AND HYGIENE (WASH)** BENCHMARK H2.2: Community driven water, sanitation and hygiene (WASH) interventions are in place and effective	Objective: - To develop community capacities in planning, implementation and monitoring of safe WASH interventions to ensure sustainable access to facilities Desired Impact: - A community driven WASH interventions fostering sustainability and resilience and resulting in improved health outcomes and enhanced overall well-being through WASH-related diseases being significantly reduced.	• Conducted hygiene promotion and awareness campaigns on safe practices, including hand hygiene, the use of pit latrines, and boiling drinking water. • Provided training on community-driven WASH to key stakeholders, such as community leaders, volunteers, and school-going pupils. • Facilitated community engagement activities to gather input and ensure active involvement in WASH decision-making processes and implementation.

RISK COMMUNICATION, COMMUNITY ENGAGEMENT & INFODEMIC MANAGEMENT ADDITIONAL BENCHMARKS	**COMMUNITY ENGAGEMENT** BENCHMARK 16B.2: Inclusive community centred governance and management of health emergencies is in place	Objective: - To ensure communities and civil societies participate in decision making, priority setting and resource allocation and to apply community engagement approaches in risk assessment, health emergency planning, prevention, preparedness, readiness, case detection, early warning, response and services to build community ownership, trust, accountability and resilience Desired Impact: - A community dialogue and participation, interpersonal communication, coordination skills and processes, collaborative teams, a social and behavioural change, health literacy.	• Trained community stakeholders, CHVs, NS' volunteers, and community leaders on detection, early warning, and response coordination for epidemic prevention and control. • Conducted community dialogues and events with participation from community stakeholders through schools and faith-based organizations, which increased awareness and community preparedness. • Involved local institutions, including schools, faith-based organizations, private entities (such as veterinary services), and local partners in epidemic prevention planning and response activities. • Promoted and supported evidence-based interventions, including vector control, among stakeholders implementing community engagement Programmes in epidemic prevention and control.
RISK COMMUNICATION, COMMUNITY ENGAGEMENT & INFODEMIC MANAGEMENT ADDITIONAL BENCHMARKS	**COMMUNITY ENGAGEMENT** BENCHMARK 16B.3: Capacity-building mechanisms for multisectoral community health workforce and community engagement in the management of health emergencies and resilience building are well established	Objective: -To develop capacity-building mechanisms to improve community engagement for the management of health emergencies and to empower communities with necessary resources and tools to take timely actions to prevent, detect and respond to health emergencies in their communities. Desired Impact: - A community dialogue and participation, interpersonal communication, coordination skills and processes, collaborative teams, a social and behavioural change, health literacy.	• NS organized community health promotion activities and supported immunization campaigns for children and animals against vaccine-preventable diseases (VPDs) • NS developed and disseminated training packages on minimum standards, capacity development frameworks for the community health workforce (including community health volunteers and National Society volunteers), and competencies for community engagement in epidemic prevention and control at the community level. • The One Health Partnership strengthened preparedness by bringing together the focal points from the Ministries of Health and Animal Health and enhancing collaboration for epidemic preparedness at sub-national levels under one health platform in Kenya. • Training on notifiable diseases improved the understanding of CHVs, NS' volunteers, and community members, enabling them to engage in environmental interventions. These interventions included clearing bushes around homes and draining stagnant water in mosquito breeding sites to control larvae and prevent disease outbreaks.

SURVEILLANCE	**SURVEILLANCE** BENCHMARK 10.1: Early warning surveillance systems are well established and functional	Objective: To establish a well functional early warning surveillance system Desired Impact: - A Coordinated surveillance systems that collectively address the full range of objectives for monitoring, detecting and responding to prioritized hazards and risks. Strengthened public health intelligence for improved decision making through routine collaboration across key dimensions	• Identified priority events, diseases, and conditions for surveillance based on an all-hazards approach, informed by the country's epidemiological context. • Established Community-Based Surveillance (CBS) focusing on underserved areas, groups, and vulnerable populations in collaboration with local stakeholders and Community Health Worker (CHW) and Community Health Volunteer (CHV) networks operating on a one-health platform. This initiative led to a reduction in disease outbreak cases in the communities. • Collaborated with public health surveillance teams, including orientation on the capacities of other sectors such as animal and environmental health at the subnational level. • Shared information and data in real time with public health decision-makers (one-health line ministries) and local stakeholders regarding events that may impact community and health security.
SURVEILLANCE	**SURVEILLANCE** BENCHMARK 10.2: Well-functioning event verification and investigation systems are in place	Objective: To establish a robust well-functioning early warning, alert and response (EWAR) capacity Desired Impact: - A Coordinated surveillance systems that collectively address the full range of objectives for monitoring, detecting and responding to prioritized hazards and risks55. Strengthened public health intelligence for improved decision making through routine collaboration across key dimensions	• Community Health Workers (CHWs) and/or Volunteers send notification alerts. Data is transmitted from the sub-national level to the Ministries of Health and Animal Health for decision-making. • There has been increased collaboration between One Health partners for the routine exchange of data and information, as well as undertaking joint signal verification, alert generation of events, investigation, and response to relevant alerts related to notifiable diseases.

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

The overall objective of the Mid-term Evaluation was to assess and analyse the delivery of the first phase of the Community Epidemic and Pandemic Preparedness Programme (CP3) covering the period from October 2017 to September 2023 and derive key recommendations from the findings. The findings from this evaluation will inform how the CP3 could better support the identified priorities and goals of the global health security benchmarks, ensuring that efforts to prevent, prepare for, detect, and respond to public health risks are effective, efficient, and sustainable at the community, National Society and local stakeholder levels.

The COVID-19 pandemic revealed deep flaws in the world's protection against health emergencies, exposed and aggravated profound inequities within and between countries and communities, and eroded trust in governments and institutions. Against this background and through a new approach, the health emergency preparedness, response, and resilience (HEPR) framework provide a renewed and integrated approach to strengthen the global architecture for health emergency management at the community level. HEPR calls for progress that should be made with collaborative surveillance and community protection at the core of the intersecting subsystems.

Effective epidemic and pandemic prevention, preparedness, and response achieve the protection of those at risk or directly affected. Under CP3, community protection was implemented around community-centered actions that protect those who are at risk or affected by the health and social impacts of health emergencies. The CP3 outcomes were achieved through three core approaches that intersect and work together in the following perspectives.

The community protection outcomes were achieved through the implementation of the technical approaches, strategies, and service mechanisms that are part of epidemic preparedness. The CP3 approach strengthened community resilience, drawing on local strengths and assets, centering on civil society and local partner involvement and participation, while promoting the co-delivery of Programmes, policies, and interventions.

The second CP3 approach targeted the key population, environmental and public health interventions for managing the health impacts of emergency events, including those for preventing zoonotic spillover, vector control and management, public health and social measures, Water, Sanitation and Hygiene (WASH), and vaccination. These interventions reduced the risk and scale of infectious disease transmission by reducing exposure to pathogens or suppressing the spread of disease at the community level. The CP3 emphasized the need to contextualize interventions based on specific features of the pathogen-causing disease, epidemiological patterns evidence of effectiveness, standard practice, and risk-benefit analyses to guide planning and implementation of these interventions.

The third CP3 approach to community protection targeted the comprehensive, whole-of-government, multisectoral, and whole-of-society approach that is needed at local, national, and global levels. Key areas of focus were the one-health approach to detection, notification, and response mechanisms to health threats at the sub-national and community level approach. Although epidemics and pandemics pose a risk for social and economic disruption, with disproportionate impacts on vulnerable and marginalized communities as demonstrated by COVID-19, the CP3 by design was not envisaged to incorporate the social protection aspects such as compensation for lost or culled animals to sustain livelihoods post epizootics

Despite the above, these set of approaches have guided a more comprehensive set of actions that ensured better community protection for those at risk and affected by health emergency events in the respective countries of CP3 implementation. It is equally evident that the CP3 has contributed to the advancement of the priorities and goals of the global health security instruments including but not limited to the IHR benchmarks; the additional benchmarks for health emergency capacities beyond the IHR; and the WHO

general Programme of work number 14 (WHO GPW 14) strategic objectives 5 and 6 addressing prevention, preparedness, mitigation, rapid detection and effective response to health emergencies targeting 7 billion persons. Last but not least, the CP3 also contributed to USAID priority areas of health security investments such as Strengthening Global Health Security Capacities in Partner Countries targeting effective prevention, detection, and rapid response to outbreaks, epidemics, and pandemics

An overarching summary of the CP3 evaluation data on its contribution to and alignment with the global health security goals and priorities is below.

i. **CP3 health promotion strategies created awareness:** enabling communities to take control of their health by embracing a wide range of social and public health interventions across the implementing countries. Communities are now more knowledgeable about the health risks and their roles in interventions for prevention and detection.

ii. **CP3 led to the Epidemic and Pandemic System Strengthening (CEPSS) at the community level-** by increasing skill mix and good practices; strengthening early alerts and response systems; reducing outbreak frequencies through surveillance and prompt notification and early action; strengthening Epidemic and Pandemic Preparedness M&E systems; development of Epidemic and Pandemic Preparedness guidelines and overall improvement in Community Health

iii. **Workforce development for epidemic and pandemic preparedness & response –** by training Community Health Volunteers (CHVs), NS' volunteers, and community leaders and raising awareness among households on social, public health, and environmental interventions to improve prevention, detection, notification, and early response to health threats across the implementing countries.

iv. **One Health Collaboration:** CP3 fostered collaborations and partnerships that facilitated the establishment of the one-health platforms at National and sub-national levels to coordinate with local partners on capacity-building efforts for epidemic preparedness and response. Through multi-sectoral collaboration, the partners appreciated the interconnectivity between the environment, animals, and humans in disease transmission, prevention, and control. CP3 also offered the first platform for One Health partners to engage in epidemic and pandemic preparedness and response in practice, moving beyond theoretical discussions and meeting settings.

v. **Strengthening National Societies capacity for epidemic and pandemic preparedness, response, and control** - With the limited resources, National Societies in the CP3 countries have built internal capacity and capability to contain epidemics in these countries including priority diseases like cholera, Ebola, Chikungunya, anthrax, rabies, and kala-azar that affected people and animals in the past.

vi. **Strengthened National Societies community presence** - Strengthening National Societies staff capacity, skills and knowledge. The National Societies has developed a network of field officers who are trained in high-risk regions and among vulnerable communities making their response time short in case of outbreak threats. In addition, the NS has become a strategic reliable partner to local stakeholders including the Ministry of Health at the community level on epidemic preparedness and response in the implementing countries.

vii. **Collaboration and Multisectoral Coordination** –CP3 facilitated the engagement with local partners, including the local religious leaders, midwives, traditional healers, private veterinarians, and other health authorities to improve health outcomes at the community level.

8.4 Recommendations

Although the CP3 has made substantive achievements in capacity-building communities, NS, and local partners on epidemic and pandemic prevention, preparedness, detection, and response in the selected countries of implementation, there are still teething challenges that could be addressed to improve the Programme outcomes and maximize the benefits and value for the investment as described on Table 35 below.

Table 35. List of recommendations and orientation for implementation

Recommendation	Priority Action	Priority level	Responsible entity
Workforce development for community epidemic preparedness, prevention, and response	Leverage technology such as virtual platforms (Home | Epidemic Control Toolkit), to enhance adequate, sustainable, effective, and efficient training for CHWs, CHVs, NS volunteers, community leaders, and local partners to enable scaling up the training for all actors across the one-health platform involved in prevention, detection and notification and response activities.	High	NS, IFRC – lead Others - local stakeholders and partners
Governance & coordination for One-Health approach	Sustained advocacy for political commitments and ownership by the local stakeholders. Strengthen the governance and accountability for joint results through promoting forums, mechanisms, partnerships, representation, and decision-making tools to advance coordination of One-Health across all relevant sectors and stakeholders.	Medium	NS – lead Others - local stakeholders
Strengthening Community Protection	Reduce the risks and mitigate the impacts of health emergencies from all hazards focusing on notifiable diseases. Plan to scale up population and environmental health interventions through a One Health approach, including support to the expansion of animal vaccinations, enhancing of social measures, vector control, and food safety initiatives to target specific epidemic-prone diseases based on country and community epidemiological context. Additionally, foster community engagement and leadership and prioritize equitable access to animal vaccines and other interventions, especially for people in vulnerable, marginalized, and hard-to-reach.	Medium	NS, IFRC – lead Others – community leaders, local stakeholders
7-1-7 Target	Advocacy for incorporation of this approach into the CBS to monitor performance, evaluate interventions, and document progress with full transparency on detection, notification, and early response functions in countries that have embraced the target. Advocacy for host countries that are yet to embrace the 7-1-7 target to adopt the same.	Medium	NS – Lead Others – local stakeholders, One Health line ministries

Financing & sustained resourcing for community readiness, response, and resilience including Supporting modernization and digital transformation of CP3 at the country and IFRC level	Identify innovative financing solutions, advocate for resources from national governments, and mobilize other resources from domestic and international partner sources based on country context to augment and support community preparedness, readiness, and response. Strengthen data systems to enhance Programme effectiveness and essential functions such as data collection, storage, transfer, analysis, and communication of data to the national and subnational levels, real-time surveillance, early warning capacities, M&E performance, and decision-making.	High	IFRC-Lead Others – NS, local partners and stakeholders
Aim to review the CP3 M&E system based on the theory of change and develop a clear M&E framework.	• Identify and define objective, quantifiable, measurable, and unambiguous indicators for CBS, community preparedness, national society preparedness, and stakeholder engagement associated with each activity or intervention. These indicators should enable the measurement and demonstration of CP3 effectiveness and impact. Additionally, determine the baseline, target, data source, and frequency of reporting, and assign responsibility to a champion for reporting these indicators. • Map all activities and provide clear guidance regarding which activities correspond to each indicator. This will enable countries to translate their activities into quantifiable elements that can be used to inform the indicators. • Consult with the countries to design data collection tools that allow for the collection of all necessary data elements to aggregate these indicators. Standardize these tools across all countries by maintaining version control and restricting unnecessary modifications. • Document all M&E tools, structures, functions, capabilities, and procedures in a Standard Operating Procedure (SOP) that highlights all CP3 data management steps. Conduct workshops on the SOP at all levels of data management and ensure it is available to all staff and volunteers involved in the data management process	Low	IFRC – Lead Others - NS

Annex 1. Evaluation Matrix

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
Introduction: In response to large-scale epidemics and pandemics outbreaks claiming millions of lives, disrupt societies, and devastate economies, posing a serious threat to countries, communities, and individuals as well as to global health security. IFRC launched the Community Epidemic and Pandemic Preparedness Programme (CP3) in October 2017. This Mid-term Evaluation is assessing the effectiveness, relevance, appropriateness and sustainability of the Programme up to September 2023.					
1. Relevance/ Appropriateness	1.1. To what extent is the Programme consistent with the needs and priorities of targeted communities, NS, and local partners as well as relevant commitments and global health security goals of countries, USAID, IFRC and NS?	1.1.1. To what extent is the Programme consistent with the **needs and priorities of targeted communities**?	Likert scale, supported by qualitative response	Community-level KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score.
		1.1.1.1. Please explain why you selected that option.	Open-ended qualitative response	Community-level KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
		1.1.2. To what extent is the Programme consistent with the **needs and priorities of NS**?	Likert scale, supported by qualitative response	National level KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.1.2.1. Please explain why you selected that option.	Open-ended qualitative response	National level KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
		1.1.3. To what extent is the Programme consistent with the **needs and priorities of local partners**? ***Prompt where applicable*** *Local government representatives; One Health partners at the national and sub-national levels; Education authorities; Disaster management authorities; Private sector entities, Media and community leaders.*	Likert scale, supported with qualitative response	Local partners KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.1.3.1. Please explain why you selected that option.	Open-ended qualitative response	Local partners KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		1.1.4. To what extent is the Programme consistent with the **needs and priorities of relevant commitments and global health security goals of countries, USAID, IFRC** etc?	Likert scale, supported with qualitative response	Global partners KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.1.4.1. Please explain why you selected that option.	Open-ended qualitative response	Global partners KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
	1.2. To what degree have local country partners, recipients, and target communities been actively involved in the design, implementation, and monitoring/evaluation of the CP3 Programme?	1.2.1. To what degree have **local country partners** been actively involved in CP3 Programme? ***Prompt where applicable*** *Local government representatives; One Health partners at the national and sub-national levels; Education authorities; Disaster management authorities; Private sector entities; Media; Community leaders*	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score **Qualitative analysis** Thematic and/or content analysis.
		1.2.1.1. To what degree have local country partners been actively **involved in the design** of CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.2.1.1.1. Please explain why you selected that option	Open-ended qualitative response	ALL KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
		1.2.1.2. To what degree have local country partners been actively **involved in implementation** of CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.2.1.2.1. Please explain why you selected that option	Open-ended qualitative response	ALL KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		1.2.1.3. To what degree have local country partners been actively **involved in Monitoring/evaluation of the** CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.2.1.3.1. Please explain why you selected that option	Open-ended qualitative response	ALL KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
		1.2.2. To what degree have **recipients, and target communities** been actively involved in CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score **Qualitative analysis** Ranking of most significant input.
		1.2.3. To what degree have recipients, and target communities been actively **involved in the design** of CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.2.3.1. Please explain why you selected that option	Open-ended qualitative response	ALL KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
		1.2.4. To what degree have recipients, and target communities been actively **involved in Implementation** of CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.2.4.1. Please explain why you selected that option	Open-ended qualitative response	ALL KIIs, activities report	**Qualitative analysis** Ranking of most significant input.

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		1.2.5. To what degree have recipients, and target communities been actively **involved in Monitoring/evaluation** of the CP3 Programme?	Likert scale, supported with qualitative response	ALL KIIs, activities report	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score
		1.2.5.1. Please explain why you selected that option	Open-ended qualitative response	ALL KIIs, activities report	**Qualitative analysis** Thematic and/or content analysis
	1.3. Has there been proactive engagement between the NS and partners for initiatives related to Global Health Security beyond the scope of the CP3 Programme? If so, what are the nature and extent of these actions?	1.3.1. Has there been proactive engagement between the NS and partners for initiatives related to Global Health Security beyond the scope of the CP3 Programme? ***Prompt where applicable*** *Local government representatives; One Health partners at the national and sub-national levels; Education authorities; Disaster management authorities; Private sector entities; Media; Community leaders.*	Yes or No, if YES: Qualitative response, could be supported by quantitative, number of actions	Global, regional and local partners and NS level KIIs, activities report data.	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions
		If YES, 1.3.1.1. what is the nature of this engagement?	Open-ended qualitative response naming the engagement activities	Global, regional and local partners and NS level KIIs, activities report data.	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions
		If YES, 1.3.1.2. What is the extent of these actions?	Open-ended qualitative response give a frequency (Weekly, monthly, yearly?)	Global, regional and local partners and NS level KIIs, activities report data.	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions
		If NO 1.3.1.3. Is there any plan to engage other partners in the future?	Open-ended qualitative response	Global, regional and local partners and NS level KIIs,	**Qualitative analysis** Thematic and/or content analysis

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		Please elaborate on the steps taken to achieve this.		activities report data.	
2. Effectiveness	2.1. What specific advancements have been made in reaching the Programme's expected outcomes and impacts, and what are the observed results, both planned and unplanned, at various levels of output, outcome, and impact? *Two KAP surveys in each country will as well inform this question to some extent.	2.1.1. What specific advancements have been made in reaching **Community Preparedness**:	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report data from the Indicator Tracker Template (ITT).	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions
		2.1.1.1. What specific advancements have been made in enhancing health security through community preparedness and early action to public health threats?	Same as 2.1.1	Same as 2.1.1	Same as 2.1.1
		2.1.1.2. How are communities, Red Cross (RC) volunteers, and community health volunteers being prepared for early detection and action on public health threats?	Same as 2.1.1	Same as 2.1.1	Same as 2.1.1
		2.1.1.3. How are communities being prepared for early detection and action through community-based education campaigns and information sharing?	Same as 2.1.1	Same as 2.1.1	Same as 2.1.1
		2.1.1.4. What progress has been made in increasing awareness of epidemic and pandemic risks in schools?	Same as 2.1.1	Same as 2.1.1	Same as 2.1.1

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		2.1.2. What specific advancements have been made in reaching **National Society Preparedness?**	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report data from the Indicator Tracker Template (ITT).	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions
		2.1.2.1. What specific advancements have been made in strengthening NS' capacity for epidemic response?	Same as 2.1.2	Same as 2.1.2	Same as 2.1.2
		2.1.2.2. How is the National Society being prepared to respond to epidemics and contribute to local and national health security?	Same as 2.1.2	Same as 2.1.2	Same as 2.1.2
		2.1.2.3. How have National Society health facility services been made epidemic-ready?	Same as 2.1.2	Same as 2.1.2	Same as 2.1.2
		2.1.3. What specific advancements have been made in reaching **Key Stakeholder Engagement**?	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report data from the Indicator Tracker Template (ITT).	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions
		2.1.3.1. What specific advancements have been made in increasing key stakeholders' knowledge or capacity to support epidemic preparedness and response?	Same as 2.1.3	Same as 2.1.3	Same as 2.1.3

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		2.1.3.2. How have media outlets been trained to effectively disseminate epidemic-related information?	Same as 2.1.3	Same as 2.1.3	Same as 2.1.3
		2.1.3.3. How have private sector actors, religious/traditional leaders, and traditional healers increased their knowledge of epidemic prevention and control measures?	Same as 2.1.3	Same as 2.1.3	Same as 2.1.3
		2.1.3.4. How are Red Cross (RC) staff, volunteers, and partners being equipped to use data for decision-making in disaster and emergency risk management?	Same as 2.1.3	Same as 2.1.3	Same as 2.1.3
		2.1.3.5. What progress has been made in enhancing coordination between One Health actors to strengthen epidemic preparedness at the local level?	Same as 2.1.3	Same as 2.1.3	Same as 2.1.3
		2.1.4. What specific advancements have been made in reaching **Epidemic Response (ONLY UGANDA and GUINEA)**? • What specific advancements have been made in increasing capacity for early outbreak response in Programme districts and other regions? • What effective outbreak response actions has the National Society taken to prevent and control the spread of outbreaks?	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report data from the Indicator Tracker Template (ITT).	**Qualitative analysis** Thematic and/or content analysis **Quantitative analysis** Means, medians, Frequencies and proportions

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
	2.2. What successes and challenges have been faced by NS and the IFRC Secretariat in ensuring effective and efficient epidemic preparedness?	2.2.1. What successes have NS achieved in ensuring effective and efficient epidemic preparedness?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
		2.2.2. What successes has the IFRC Secretariat achieved in ensuring effective and efficient epidemic preparedness?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
		2.2.3. What challenges have been faced by NS in ensuring effective and efficient epidemic preparedness?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
		2.2.4. What challenges have been faced by the IFRC Secretariat in ensuring effective and efficient epidemic preparedness?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
	2.3. How effective has the knowledge and skill transfer been to local partners and stakeholders, and what improvements are suggested for the next phase?	2.3.1. How effective has the transfer of knowledge and skills been to local partners?	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report data from the	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score **Qualitative analysis** Thematic and/or content analysis

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
				Indicator Tracker Template (ITT).	
		2.3.2. What improvements would you suggest for transferring knowledge and skills to local partners in the next phase?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
		2.3.3. How effective has the transfer of knowledge and skills been to local stakeholders?	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report data from the Indicator Tracker Template (ITT).	**Quantitative analysis** – Frequency of Likert Score responses – Ave Likert Score **Qualitative analysis** Thematic and/or content analysis
		2.3.4. What improvements would you suggest for transferring knowledge and skills to local stakeholders in the next phase?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
	2.4. Are there documented instances where NS have effectively responded to epidemics, demonstrating the success of preparedness efforts?	2.4.1. Are there documented examples of NS effectively responding to epidemics, showing the success of their preparedness efforts?	Qualitative response. Quantitative data from activities.	ALL levels KIIs, select areas that are relevant to the respondent. Activities report	**Qualitative analysis** Thematic and/or content analysis
	2.5. Has the CP3 Programme facilitated the development of a more robust partnership	2.5.1. Has the CP3 Programme facilitated the development of a more robust partnership between the NS, the	Likert scale? Followed by examples (Qualitative response)	ALL levels KIIs, select areas that are relevant to the	**Qualitative analysis** Thematic and/or content analysis

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
	between the NS, the Ministry of Health, the Ministry of Agriculture and/or the Ministry of Environment? Please provide examples of how this relationship has evolved.	Ministry of Health, the Ministry of Agriculture and/or the Ministry of Environment? **Please provide examples of how this relationship has evolved**.		respondent. Activities report data from the Indicator Tracker Template (ITT)	**Quantitative analysis** Means, medians, Frequencies and proportions
		2.5.2. What partnerships or collaborations have been most effective in integrating the Programme with wider health systems?	Qualitative response. Name the partnership and what they have achieved	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from activities report	**Qualitative analysis** Thematic and/or content analysis
3. Sustainability	3.1. How can the Programme's design and strategies be further adapted to anticipate and adapt to future changes in local contexts, resources, and needs?	3.1.1. How can the Programme's design be adapted to respond to future changes in local contexts?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. Qualitative data from activities report recommendations.	**Qualitative analysis** Thematic and/or content analysis.
		3.1.2. How can the Programme's strategies be adjusted to address changes in resources and needs?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. . Qualitative data from activities report recommendations.	**Qualitative analysis** Thematic and/or content analysis.

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
	3.2. Regarding the potential for Programme expansion, what initial pitfalls or good practices should be considered when initiating the Programme in new countries or locations?	3.2.1. Regarding the potential for Programme expansion, what initial pitfalls should be considered when initiating the Programme in new countries or locations?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. Qualitative data from activities report challenges.	**Qualitative analysis** Thematic and/or content analysis
		3.2.2. Regarding the potential for Programme expansion, what initial good practices should be considered when initiating the Programme in new countries or locations?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. . Qualitative data from activities report good practices.	**Qualitative analysis** Thematic and/or content analysis
	3.3. What could NS do to sustain community epidemic preparedness Programmeming and embed epidemic preparedness in overall disaster preparedness, early action and response mechanisms?	3.3.1. What can NS do to sustain community epidemic preparedness Programmeming in overall disaster preparedness, early action and response mechanisms?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. Qualitative data from activities report recommendations.	**Qualitative analysis** Thematic and/or content analysis
		3.3.2. What can NS do to embed epidemic preparedness in overall	Qualitative response.	ALL levels KIIs, select areas that are relevant to the	**Qualitative analysis** Thematic and/or content analysis

Area of focus	Original Eval question.	KII Questions	Answers type	Source of Information and guidance	Data analysis Method
		disaster preparedness, early action and response mechanisms?		respondent. Qualitative data from respondent perspective. . Qualitative data from activities report recommendations.	
	3.4. Have the NS been able to implement and apply approaches and tools used in the Programme in their emergency response efforts that are not financed by the CP3 Programme (e.g. during the COVID-19 pandemic, EVD or cholera outbreaks)?	3.4.1. Have the NS been able to implement and apply approaches used in the Programme in their emergency response efforts that are not financed by the CP3 Programme (e.g. during the COVID-19 pandemic, EVD or cholera outbreaks)?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. Qualitative data from activities report recommendations.	**Qualitative analysis** Thematic and/or content analysis
		3.4.2. Have the NS been able to use tools from the Programme in their emergency response efforts that are not financed by the CP3 Programme (e.g., during the COVID-19 pandemic, EVD, or cholera outbreaks)?	Qualitative response.	ALL levels KIIs, select areas that are relevant to the respondent. Qualitative data from respondent perspective. Qualitative data from activities report recommendations.	**Qualitative analysis** Thematic and/or content analysis

Annex 2. Stakeholders mapping per type & location

IFRC COMMUNITY EPIDEMIC AND PANDEMIC PREPAREDNESS PROGRAMME (CP3)			
Phase 1 Mid-Term Evaluation			
Stakeholder Mapping for 3 Countries - DRC, Kenya and Indonesia			
S/N	**Stakeholder Type**	**Names of Institutions/group**	**Relevant Country**
1	Donor/Funder	USAID	All countries
2	Project Management Partner (Recipient)	IFRC (Headquarters)	All countries
		IFRC Health and Care Department	All countries
		IFRC country cluster or country offices	All countries
3	Implementing Partners	NS of the Red Cross and Red Crescent	All Countries
4	National Partners	The Ministry of Public Health	DRC
		National Border Hygiene Programmeme (PNHF)	DRC
		The Directorate of Disease Control	DRC
		The Cholera and Diarrhoeal Disease Eradication Programmeme	DRC
		Ministry of Agriculture and Livestock	DRC, Kenya
		Ministry of the Environment	DRC
		Coordinating Ministry of Human Development	Indonesia
		Ministry of Health	Indonesia, Kenya
		Ministry of Agriculture	Indonesia
		Ministry of Home Affairs	Indonesia
		Ministry of Village Development	Indonesia
		Ministry of Social Affairs	Indonesia
		National Agency for Disaster Management (BNPB)	Indonesia
		Cabinet Secretariat of Indonesia's Government	Indonesia
		Zoonotic Disease Unit (ZDU)	Kenya
		Ministry of Environment, Water and Natural Resources	Kenya
		Ministry of Education	Kenya
		Disaster Management Department	Kenya
		Meteorological Departments	Kenya
		Public Health Emergency Operation Centres	Kenya
		CORE Group Partners Project (CGPP)	Kenya
		The Medicines, Technologies, and Pharmaceutical Services (MTaPS)	Kenya
		Vétérinaires Sans Frontières (VSF) Germany	Kenya
		Ministry of Health technical working groups	All countries
5	International Partners	World Health Organisation (WHO)	DRC, Indonesia
		Food and Agriculture Organisation (FAO)	DRC, Indonesia
		Kinshasa School of Public Health	DRC
		MTAP's	DRC
		Global Health Security Agenda (GHSA) partners	All countries
		USAID's Infectious Disease Detection and Surveillance (IDDS) Project	All countries
		CDC Indonesia	Indonesia
		DFAT through AIHSP (Australia Indonesia Health Security Partnership)	Indonesia
		USAID's Country Health Information Systems and Data Use (CHISU)	Indonesia
6	Civil Society	Breakthrough Action	DRC
		Indonesia One Health University Network (INDOHUN)	Indonesia
		Dig Deep	Kenya
		Africa One Health University Network (AFROHUN)	DRC, Kenya
7	Private Sector	Boehringer-Ingelheim	Kenya
		Media Houses	All countries

8	Beneficiaries	Volunteers	All countries
		Community leaders (political and religious)	All countries
		Community members	All countries

Annex 3. KII Tool

Key Informant Interviews Tool

Interviewer Name_____

Date of Interview _____

Time Interview started: (HH:mm): _____

Location/Site Details:

Location / Site / Organisation Name _____

Name of sites _____

Province name_____

District name _____

Sub-district name _____

Type of Site: (**tick one)**

- Funder/ USAID
- IFRC Headquarter office (Geneva)
- IFRC Regional Office (Nairobi)
- IFRC cluster office (please specify country) _____
- IFRC Country Programme Manager
- National Society
- Local partners:
  - government representatives (please ministry) _____
  - One Health partners at the national and sub-national levels
  - Education authorities
  - Disaster management authorities
  - Private sector entities (please specify) _____
  - Media (please specify) _____
- Community leaders
- Other (please specify) _____

Names and Positions of Persons Interviewed:

Person 1_____ Position _____

How Long Person 1 has been in the position _____

Person 2_____ Position _____

How Long Person 2 has been in the position _____

Person 3_____ Position _____

How Long Person 3 has been in the position _____

Consent form

Thank you for taking the time to participate in this evaluation. This evaluation is being conducted by independent consultants for the International Federation of Red Cross and Red Crescent Societies (IFRC).

In response to Large-scale epidemics and pandemics outbreaks claiming millions of lives, disrupt societies, and devastate economies, posing a serious threat to countries, communities, and individuals as well as to global health security. Funded by United States Agency for International Development (USAID), IFRC launched the Community Epidemic and Pandemic Preparedness Program (CP3) in October 2017. This Mid-term Evaluation is assessing the effectiveness, relevance, appropriateness and sustainability of the program up to September 2023.

The purpose of the interview is to understand how the IFRC and CP3 supporting Partners can better support the WHO Joint External Evaluation's (JEE) identified priorities, ensuring that efforts to prevent, detect, and respond to public health risks are effective, efficient, and sustainable. What you tell us about the IFRC and Partners will help to identify how this initiative can be strengthened.

The interview should take approximately 60 minutes to complete.

Your participation in this interview is voluntary. You are free to decline to answer any question you do not wish to answer for any reason; however, we want to assure you that your responses are completely anonymous. You may refuse to take part in the research or exit the interview at any time without penalty. Your responses will be combined with those of others and analysed as a group, to further protect your anonymity.

If you have questions at any time about the study or the procedures, you may Kris Essosola Eale (+15192815277) or via email at kris.eale@ifrc.org

CONSENT: I understand the above information and I voluntarily agree to participate.

PERSON 1	***PERSON 2***	***PERSON 3***
☐ *Agree*	☐ *Agree*	☐ *Agree*
☐ *Disagree*	☐ *Disagree*	☐ *Disagree*
Signature	*Signature*	*Signature*
PERSON 4	***PERSON 5***	
☐ *Agree*	☐ *Agree*	
☐ *Disagree*	☐ *Disagree*	
Signature	*Signature*	

Area of focus	KII Questions	Response Options	Answer
0. Introduction	0.1. How do you know about the Community Epidemic and Pandemic Preparedness Programmeme (CP3)	Open-ended	–
	0.2. What was your involvement in the CP3Programmeme?	Open-ended	–
	0.3. Which activities of the CP3 Programmeme did you attend, participate in or lead?	Open-ended	–
3. Relevance/ Appropriateness	1.1.4. To what extent is the Programme consistent with the **needs and priorities of targeted communities**?	• Not at all consistent • Slightly consistent • Moderately consistent • Very consistent • Completely consistent	–
	1.1.4.1. Please explain why you selected that option.	Open-ended	
	1.1.5. To what extent is the Programme consistent with the **needs and priorities of NS/the Red Cross National Society in your country**?	• Not at all consistent • Slightly consistent • Moderately consistent • Very consistent • Completely consistent	–
	1.1.5.1. Please explain why you selected that option.	Open-ended	

Area of focus	KII Questions	Response Options	Answer
	1.1.6. To what extent is the Programme consistent with the **needs and priorities of local partners**? ***Prompt where applicable*** *Local government representatives; One Health partners at the national and sub-national levels; Education authorities; Disaster management authorities; Private sector entities, Media and community leaders.*	• Not at all consistent • Slightly consistent • Moderately consistent • Very consistent • Completely consistent	
	1.1.4.2. Please explain why you selected that option.	Open-ended	
	1.1.5. To what extent is the Programme consistent with the **needs and priorities of relevant commitments and global health security goals of countries, USAID, IFRC** etc?	• Not at all consistent • Slightly consistent • Moderately consistent • Very consistent • Completely consistent	
	1.1.5.1. Please explain why you selected that option.	Open-ended	
	1.2.6. To what degree have **local country partners** been actively involved in CP3 Programme? ***Prompt where applicable*** *Local government representatives; One Health partners at the national and sub-national levels; Education authorities; Disaster management authorities; Private sector entities; Media; Community leaders*	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	
	1.2.6.1. To what degree have local country partners been actively	• Not at all involved • Slightly involved • Moderately involved	

Area of focus	KII Questions	Response Options	Answer
	involved in the design of CP3 Programme?	• Very involved • Fully involved	
	1.2.6.1.1. Please explain why you selected that option	Open-ended	
	1.2.6.2. To what degree have local country partners been actively **involved in implementation** of CP3 Programme?	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	
	1.2.6.2.1. Please explain why you selected that option	Open-ended	
	1.2.6.3. To what degree have local country partners been actively **involved in Monitoring/evaluation of the** CP3 Programme?	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	
	1.2.6.3.1. Please explain why you selected that option	Open-ended	
	1.2.7. To what degree have **recipients,** and **target communities** been actively involved in CP3 Programme?	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	
	1.2.7.1. To what degree have recipients, and target communities been actively **involved in the design** of CP3 Programme?	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	

Area of focus	KII Questions	Response Options	Answer
	1.2.7.1.1. Please explain why you selected that option	Open-ended	
	1.2.7.2. To what degree have recipients, and target communities been actively **involved in Implementation** of CP3 Programme?	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	
	1.2.7.2.1. Please explain why you selected that option	Open-ended	
	1.2.7.3. To what degree have recipients, and target communities been actively **involved in Monitoring/evaluation** of the CP3 Programme?	• Not at all involved • Slightly involved • Moderately involved • Very involved • Fully involved	
	1.2.7.3.1. Please explain why you selected that option	Open-ended	
	1.2.8. Has there been proactive engagement between the NS and partners for initiatives related to Global Health Security beyond the scope of the CP3 Programme? ***Prompt where applicable*** *Local government representatives; One Health partners at the national and sub-national levels; Education authorities ; Disaster management authorities; Private sector entities; Media; Community leaders.*	• Yes • No	

Area of focus	KII Questions	Response Options	Answer
	If YES, 1.3.1.4. What is the nature of this engagement?	Open-ended: Names the type of engagement activities	
	If YES, 1.3.1.5. What is the extent of these actions?	Daily Weekly Monthly Quarterly Yearly Other please specify	
	If NO 1.3.1.6. Is there any plan to engage other partners in the future? Please elaborate on the steps taken to achieve this.	Open-ended	
4. Effectiveness	2.1.5. What specific advancements have been made in reaching **Community Preparedness**:	• Not advancement at all • Some advancements • Moderately advancements • Good advancements • A lot of advancements	
	2.1.5.1. Please explain why you selected that option	Open-ended	
	2.1.5.2. What specific advancements have been made in enhancing health security through community preparedness and early action to public health threats?	Open-ended	
	2.1.5.3. What specific advancements have been made in how communities, Red Cross (RC) volunteers, and community health volunteers being	Open-ended	

Area of focus	KII Questions	Response Options	Answer
	prepared for early detection and action on public health threats?		
	2.1.5.4. What specific advancements have been made in how communities are being prepared for early detection and action through community-based education campaigns and information sharing?	Open-ended	
	2.1.5.5. What specific advancements have been made in increasing awareness of epidemic and pandemic risks in schools?	Open-ended	
	2.1.6. What specific advancements have been made in reaching **National Society Preparedness?**	• Not advancement at all • Some advancements • Moderately advancements • Good advancements • A lot of advancements	
	2.1.6.1. Please explain why you selected that option	Open-ended	
	2.1.6.2. What specific advancements have been made in strengthening NS' capacity for epidemic response?	Open-ended	
	2.1.6.3. What specific advancements have been made in how the National Society being prepared to respond to epidemics and contribute to	Open-ended	

Area of focus	KII Questions	Response Options	Answer
	local and national health security?		
	2.1.6.4. What specific advancements have been made in how National Society health facility services been made epidemic-ready?		
	2.1.7. What specific advancements have been made in reaching **Key Stakeholder Engagement**?	• Not advancement at all • Some advancements • Moderately advancements • Good advancements A lot of advancements	
	2.1.7.1. Please explain why you selected that option	Open-ended	
	2.1.7.2. What specific advancements have been made in increasing key stakeholders' knowledge or capacity to support epidemic preparedness and response?	Open-ended	
	2.1.7.3. What specific advancements have been made in how media outlets been trained to effectively disseminate epidemic-related information?	Open-ended	
	2.1.7.4. What specific advancements have been made in how private sector actors, religious/traditional leaders, and traditional healers increased their knowledge of	Open-ended	

Area of focus	KII Questions	Response Options	Answer
	epidemic prevention and control measures?		
	2.1.7.5. What specific advancements have been made in how Red Cross (RC) staff, volunteers, and partners being equipped to use data for decision-making in disaster and emergency risk management?	Open-ended	
	2.1.7.6. What specific advancements have been made in enhancing coordination between One Health actors to strengthen epidemic preparedness at the local level?	Open-ended	
	2.1.8. What specific advancements have been made in reaching **Epidemic Response (ONLY UGANDA and GUINEA)**? • What specific advancements have been made in increasing capacity for early outbreak response in Programme districts and other regions? • What effective outbreak response actions has the National Society taken to prevent and control the spread of outbreaks?	**NOT TO INCLUDE ON FINAL TOOL**	**NOT TO INCLUDE ON FINAL TOOL**
	2.2.5. What successes have NS achieved in ensuring effective and efficient epidemic preparedness?	Open-ended	

Area of focus	KII Questions	Response Options	Answer
	2.2.6. What successes has the IFRC Secretariat achieved in ensuring effective and efficient epidemic preparedness?	Open-ended	
	2.2.7. What challenges have been faced by NS in ensuring effective and efficient epidemic preparedness?	Open-ended	
	2.2.8. What challenges have been faced by the IFRC Secretariat in ensuring effective and efficient epidemic preparedness?	Open-ended	
	2.3.5. How effective has the transfer of knowledge and skills been to local partners?	• Not effective at all • Slightly effective • Moderately effective • Very effective • Extremely effective	
	2.3.5.1. Please explain why you selected that option	Open-ended	
	2.3.6. What improvements would you suggest for transferring knowledge and skills to local partners in the next phase?	Open-ended	
	2.3.7. How effective has the transfer of knowledge and skills been to local stakeholders?	• Not effective at all • Slightly effective • Moderately effective • Very effective • Extremely effective	
	2.3.7.1. Please explain why you selected that option	Open-ended	

Area of focus	KII Questions	Response Options	Answer
	2.3.8. What improvements would you suggest for transferring knowledge and skills to local stakeholders in the next phase?	Open-ended	
	2.4.2. Are there documented examples of NS effectively responding to epidemics, showing the success of their preparedness efforts?	Open-ended	
	2.5.3. Has the CP3 Programme facilitated the development of a more robust partnership between the NS, the Ministry of Health, the Ministry of Agriculture and/or the Ministry of Environment? **Please provide examples of how this relationship has evolved**.	• Not at all • To a small extent • To a moderate extent • To a large extent • To an exceptional extent	
	2.5.3.1. Please explain why you selected that option	Open-ended	
	2.5.4. What partnerships or collaborations have been most effective in integrating the Programme with wider health systems?	Open-ended	
3. Sustainability	3.1.3. How can the Programme's design be adapted to respond to future changes in local contexts?	Open-ended	
	3.1.4. How can the Programme's strategies be adjusted to address changes in resources and needs?	Open-ended	
	3.2.3. Regarding the potential for Programme expansion, what initial pitfalls should be considered when	Open-ended	

Area of focus	KII Questions		Response Options	Answer
		initiating the Programme in new countries or locations?		
	3.2.4.	Regarding the potential for Programme expansion, what initial good practices should be considered when initiating the Programme in new countries or locations?	Open-ended	
	3.3.3.	What can NS do to sustain community epidemic preparedness Programmeming in overall disaster preparedness, early action and response mechanisms?	Open-ended	
	3.3.4.	What can NS do to embed epidemic preparedness in overall disaster preparedness, early action and response mechanisms?	Open-ended	
	3.4.3.	Have the NS been able to implement and apply approaches used in the Programme in their emergency response efforts that are not financed by the CP3 Programme (e.g. during the COVID-19 pandemic, EVD or cholera outbreaks)?	Open-ended	
	3.4.4.	Have the NS been able to use tools from the Programme in their emergency response efforts that are not financed by the CP3 Programme (e.g., during the COVID-19 pandemic, EVD, or cholera outbreaks)?	Open-ended	