



Public Health
England



Nigeria Centre for Disease Control and Public Health England institutional partnership evaluation using the ESTHER EFFECT tool

International Health Regulations Strengthening Project

8 and 9 May 2019

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About Nigeria Centre for Disease Control

The Nigeria Centre for Disease Control (NCDC) is the country's national public health institute, with the mandate to lead the prevention, preparedness for, detection and response to communicable diseases.

The core functions of NCDC include:

- prevent, detect and control diseases of public health importance
- coordinate surveillance systems to collect, analyse and interpret data on diseases of public health importance
- support states in responding to small outbreaks, and lead the response to large disease outbreaks
- develop and maintain a network of reference and specialized laboratories
- conduct, collate, synthesize and disseminate public health research to inform policy
- lead Nigeria's engagement with the international community on diseases of public health relevance

The agency has over 200 staff, working across its locations at the Headquarters and the National Reference Laboratory in Abuja, as well as the Central Public Health Laboratory in Lagos State which is a campus of the National Reference Laboratory. Led by a Director General, the members of staff work in 6 Directorates.

These include:

- Public Health Laboratory Services
- Prevention and Programs Coordination
- Emergency Preparedness and Response
- Surveillance and Epidemiology
- Finance and Accounts
- Administration and Human Resources

The Nigeria Centre for Disease Control (NCDC) also has a very strong relationship with the new ECOWAS Regional Centre for Disease control (RCDC) which is also the regional Hub for the Africa Centre for Disease Control (ACDC). Nigeria serves as host of these regional centres, providing support to their activities as needed.

The NCDC is also the focal point for the implementation of the International Health Regulations (IHR).

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PHE IHR Strengthening Project - background

Public Health England (PHE) is contributing to international efforts to strengthen global health security through the IHR Strengthening Programme, to enhance IHR compliance by building up capacity of national and regional organisations. This is being done through several formal and informal relationships which include establishing institutional linkages, global health networks, long-term partnerships and professional relationships between the UK and partner country health institutions.

Through strong partnerships with national public health institutes, the approach is to work alongside partner countries, to build public health capacity and capability, whilst fostering ownership and long-term sustainability. Delivery of sustainable benefits will be achieved through the implementation of effective technical partnerships and ensuring the development of a trained local workforce, that will continue beyond the duration of the project.

The project is ODA funded through the Department of Health and Social Care and aims to contribute to action at national and regional levels, leading to measurable strengthening of public health systems in 6 partner countries: Ethiopia, Nigeria, Sierra Leone, Pakistan, Myanmar and Zambia. The project also works in partnership with Africa CDC and WHO AFRO.

The ESTHER EFfECt evaluation tool

The ESTHER EFfECt (Effective in Embedding Change) is a self-assessment evaluation tool designed to assess the effectiveness of interventions undertaken by international health partnerships. It assesses the sustainability of capacity development activities irrespective of the specific intervention undertaken. It is based on existing research and accepted good practice in the fields of capacity development, institutional development, international development and implementation theory. Sustainability of change is at the heart of the tool.

It can be used to assess the effectiveness, added value and long-term benefits of working in a high-quality partnership in a way that is comparable over time and between partnerships working on different interventions. It also provides insights into how to improve the effectiveness of partnerships in embedding change within beneficiary institutions.

The PHE IHR Strengthening Project, as part of its monitoring and evaluation framework, has identified the ESTHER EFfECt tool as an approach to assess, and then improve, the quality and effectiveness of the partnerships established, and to begin to understand and characterise the measurable achievements generated by these relationships.

Delivering the ESTHER EFFECT evaluation tool in Nigeria gives us understanding of the strength, value and impact of the partnership between Nigeria Centre Disease Control (NCDC) and PHE (through the IHR Strengthening Project) and allows us to identify areas for further development. Following training delivered to both PHE and NCDC staff in February 2019, the tool was applied with a view to evaluating:

- effectiveness of partnership interventions
- quality of the partnership
- lasting benefits of the partnership approach

PHE engagement with NCDC

PHE is providing technical assistance to the Nigeria Centre for Disease Control (NCDC), Nigeria's National Public Health Institution and IHR focal point. In response to identified need, as outlined in the June 2017 Joint External Evaluation and agreed following scoping and planning missions in February 2017, the IHR Strengthening Project is:

- supporting the development of national and regional capacity for emergency preparedness, resilience and response
- enhancing national surveillance systems and public health laboratory networks
- supporting the development of a skilled public health workforce, and
- supporting the development of NCDC as the national NPHI and as a regional lead public health institution in West Africa

Please see appendix for full list of IHR project engagement with NCDC to date.

Process

The evaluation exercise was conducted through two 3-hour facilitated workshop sessions over 2 days, involving senior representatives from NCDC and the PHE IHR Strengthening Project. Please see appendix for attendee list.

On the first day 3 members of the PHE team who had been trained in facilitating the ESTHER EFFECT evaluation exercise introduced the tool and questionnaire to PHE and NCDC participants. Each participant had a copy of the introductory presentation in their pack, together with a hard copy of the questionnaire. Two PHE team members joined the workshop by Skype. All participants then filled in the questionnaire individually. The trained facilitation team were on hand to answer questions.

On the second day, 2 Itad consultants involved in the 'Third Party Monitoring and Evaluation' of IHR Strengthening Project facilitated a discussion on the analysis of the questionnaire responses. Participants were guided to look at where there had been

particular variation in responses, either between PHE and NCDC or within each partner organisation and encouraged to discuss why they thought different responses had been made. Participants were also asked to suggest action points for improving areas that appeared to be scored lower or to move the partnership to the more mature levels represented by higher scores.

On the afternoon of the second day the PHE Monitoring and Evaluation team delivered a train-the-trainer session on the ESTHER EFFECT tool to NCDC colleagues. The aim of this training was to enable them to deliver and use the tool to evaluate other health partnerships (see final appendix on page 17 for more information).

ESTHER EFFECT score and discussion notes

This should be read in conjunction with the ESTHER EFFECT tool and questionnaire.

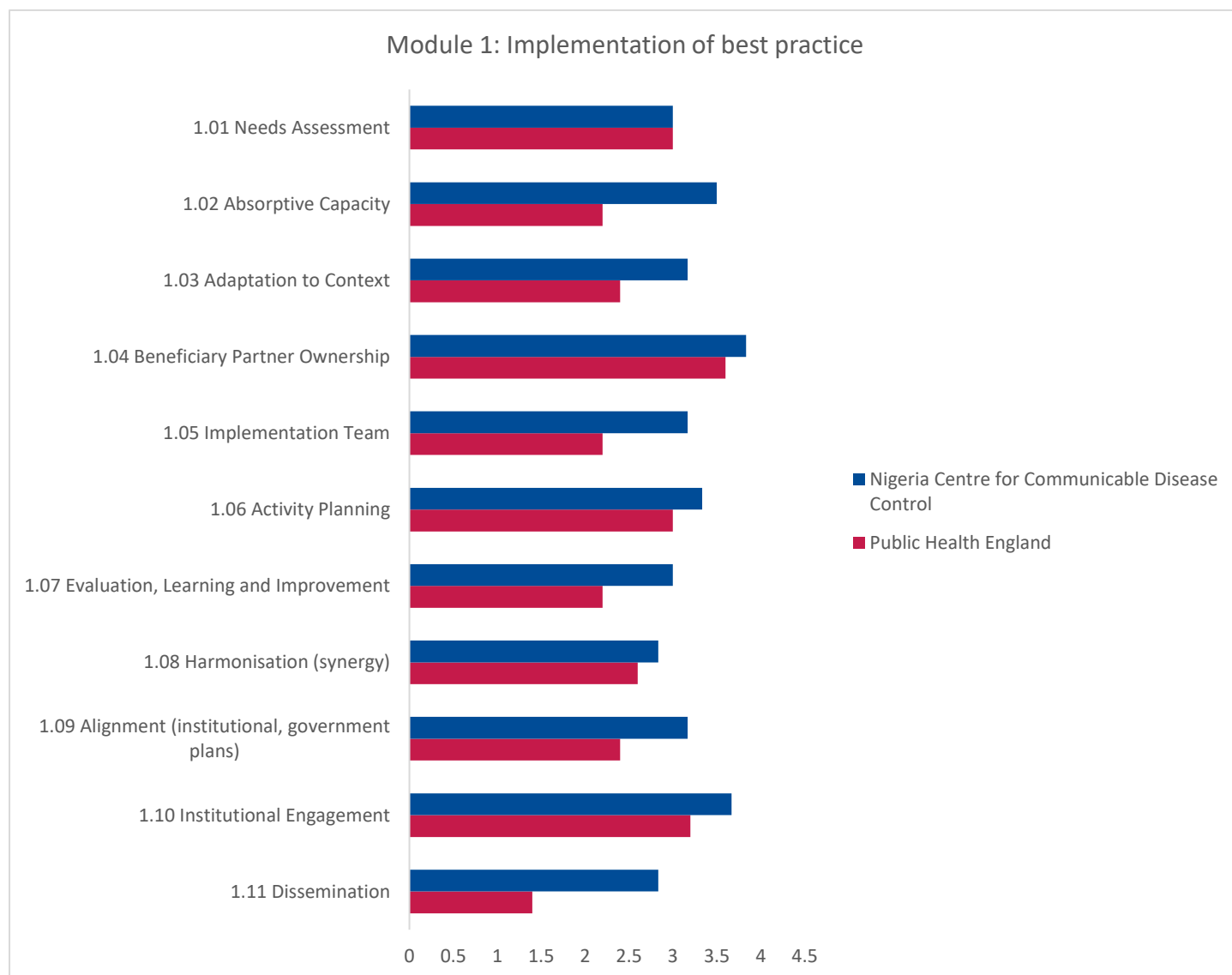
Module 1: Implementation best practice

Figure 1 presents the summarised scores by module component, disaggregated by partner (NCDC and PHE).

Key points to note from the facilitated discussion were:

- the Joint External Evaluation (JEE) gave a solid basis for determining country needs. There was also follow-on extensive discussion between PHE and NCDC on issues in and out of Nigeria, leading to agreement on the selection of activities for PHE to support
- there were fewer and less engaged people at the start of the partnership, which strengthened over time, both in NCDC and PHE
- staff capacity has varied over time depending on issues faced in Nigeria and the UK. There has been a good degree of flexibility to work around people's availability, which has been a key success factor
- engaged leadership has been critical but has varied somewhat by PHE IHR pillar. It was suggested that lessons learned from stronger areas could be applied to weaker areas, possibly through more regular discussion and/or an annual leadership meeting
- PHE as a partner is embedded within NCDC. The lessons learned from the partnership are disseminated organically; there may be some divergence in scores between PHE and NCDC around dissemination because PHE is not aware of this work. This is an area for NCDC and PHE to improve on in order to demonstrate value for money - a formal dissemination plan may help

Figure 1: Module 1 summarised scores by component



Module 2: Embedding change

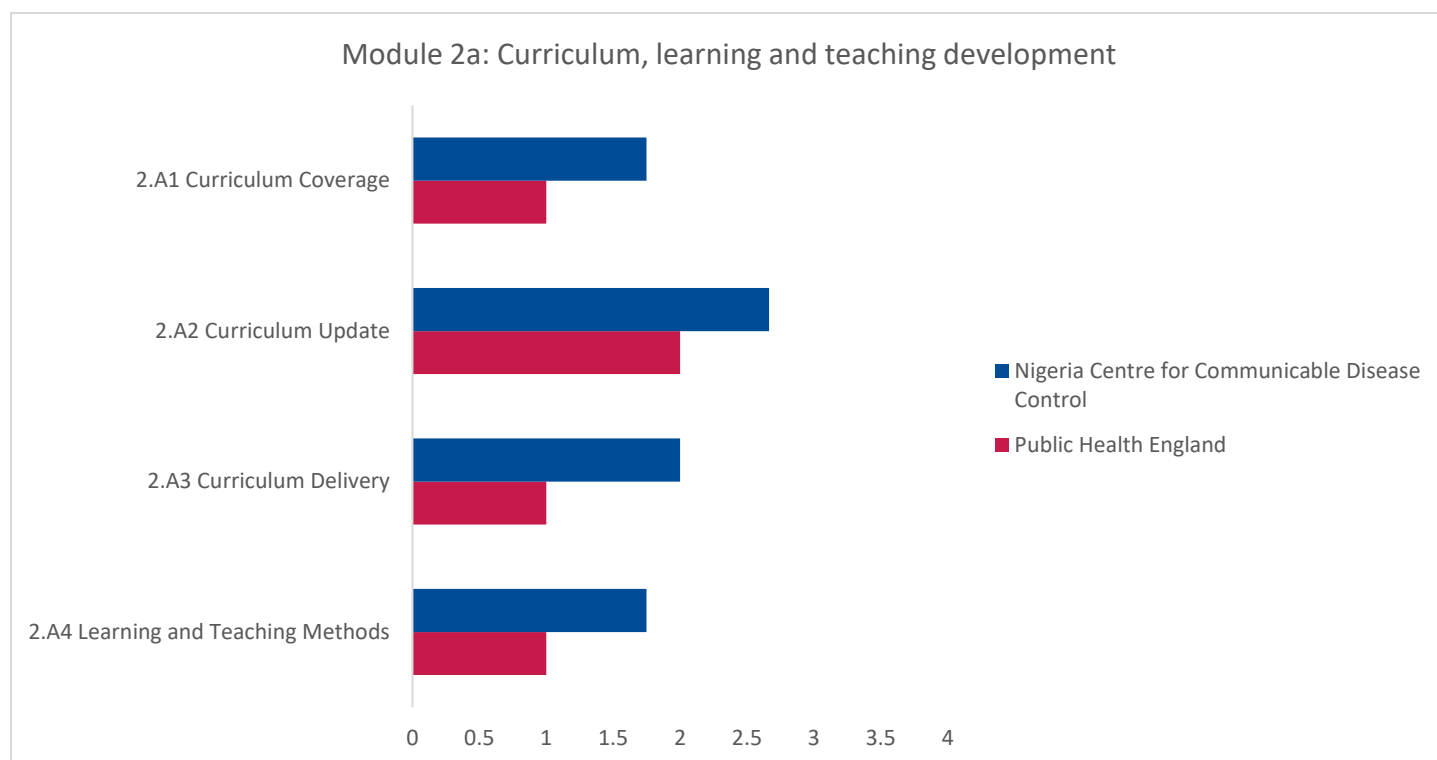
Module 2a: Curriculum, learning and teaching development

Figure 2 presents the summarised scores by module component. Key points to note from the facilitated discussion were:

- it was unclear to many participants if this module was relevant, hence the low number of responses. It was discussed that this area and the creation of a vision for knowledge management should be strengthened going forwards
- engagement by wider NCDC staff in this area has to date been unclear, however, it is important that all colleagues recognise the importance of having a training curriculum in place. There was a recommendation to look at curriculum development and standardisation with regards to the various training resources being used

- a knowledge management hub has been created within NCDC to address this issue. There is a need to make sure that all NCDC staff are aware of this resource and that departments articulate and coordinate training needs

Figure 2: Module 2a summarised scores by component



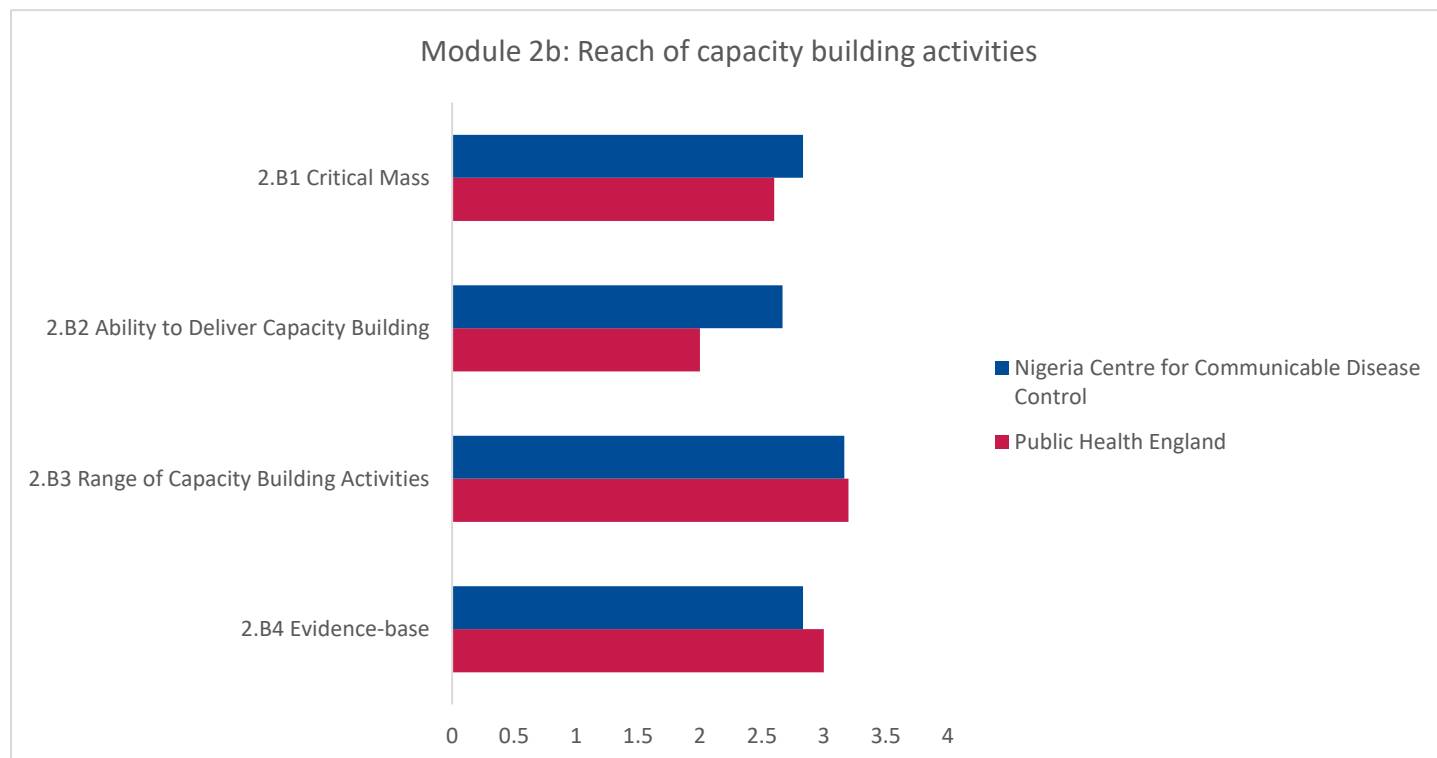
Module 2b: Reach of capacity building activities

Figure 3 presents the summarised scores by module component. Key points to note from the facilitated discussion were:

- PHE considers that NCDC capacity could be further strengthened to deliver capacity building activities. This is however team specific, and in weaker areas more follow up would help
- most training is designed to facilitate a training of trainer's approach, although PHE is unclear whether this is working. PHE would benefit from having a better understanding of what effect training is having
- for component 2.B4, PHE scores reflect that its guidance has been adapted to the local context, while NCDC scores are more mixed in this area. This does however vary by NCDC department and depends on the strength of the initial evidence base (e.g. there is no need to adapt guidance to context for many laboratory functions, while AMR work guidelines were adapted to the local context); getting this right is critical and PHE is learning, especially around understanding learning styles and the local evidence base

- NCDC is also growing in capacity in this area, for instance with the creation of the knowledge hub

Figure 3: Module 2b summarised scores by component



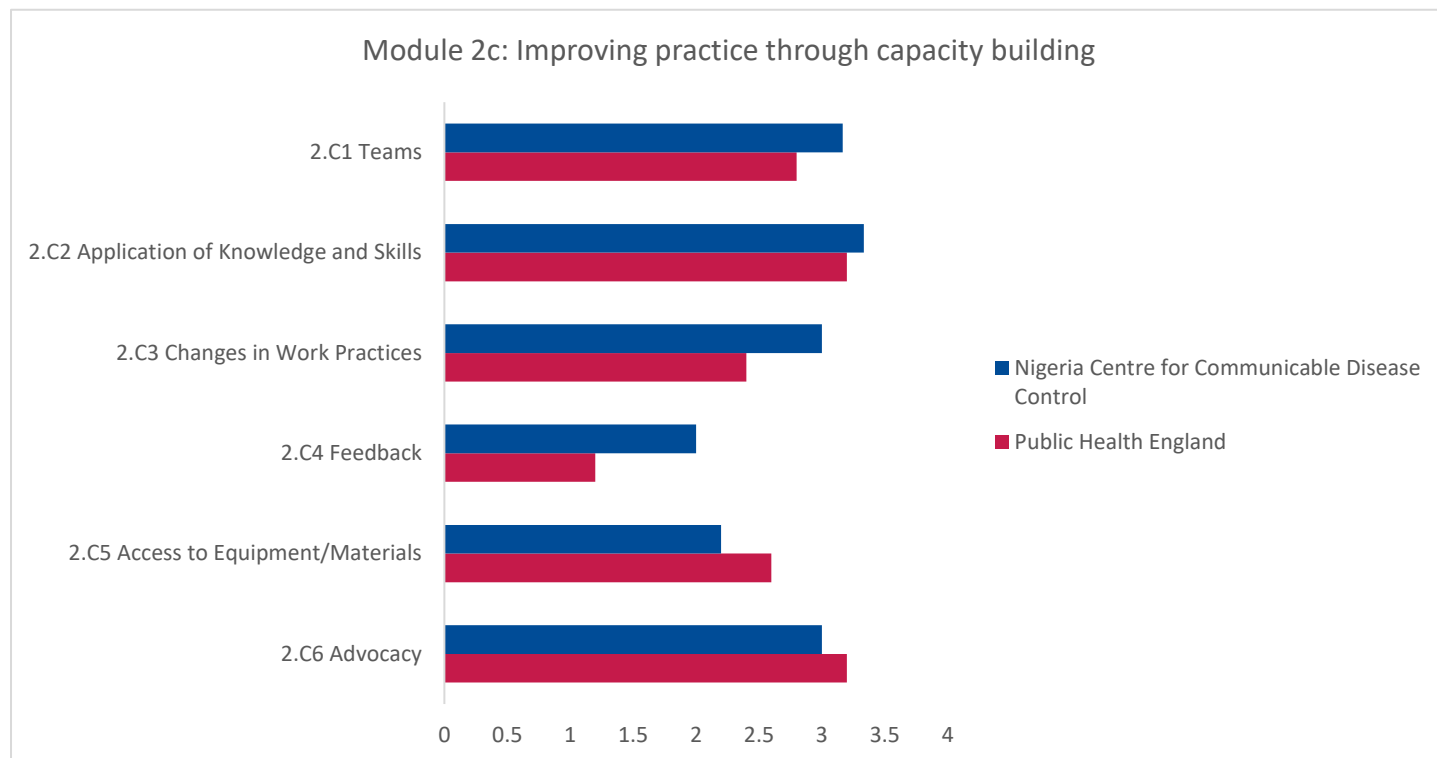
Module 2c: Improving practice through capacity building

Figure 4 presents the summarised scores by module component. Key points to note from the facilitated discussion were:

- changes in work practices. There was a wide spread of responses in this area, with a general perception that higher scores were provided by more senior participants with a higher level and more strategic overview of organisation-wide performance. Turnover in staff has restricted change in some departments but focusing on this area will be critical for sustainability. NCDC is positive that learning is being disseminated across departments leading to widespread change
- feedback. There was overall agreement that this area could be improved, with feedback currently ad hoc and reactionary and a need to systematise processes. PHE does follow up on activities but this area could also be improved. Better communications across teams and between PHE and NCDC in this area would be helpful, possibly including a formal review process
- equipment and materials. Trainings are provided based on available equipment and commodities, which can sometimes prove challenging. NCDC gave an insufficient score, as basic commodities are still needed to meet PHE/NCDC objectives. PHE is not however set up to deliver commodities (although discussions are ongoing)

internally). This issue is in relation to laboratory strengthening and is not such an issue for the other technical areas

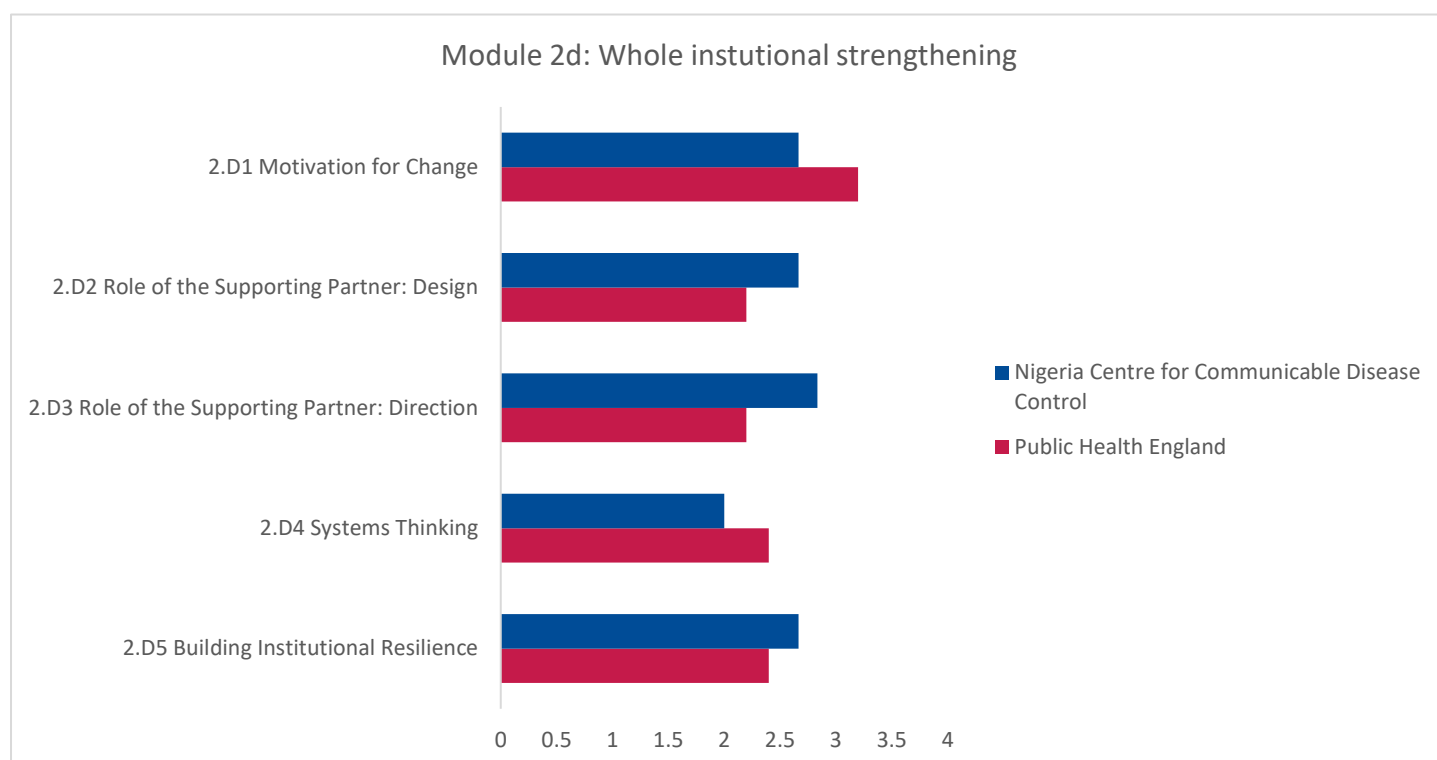
Figure 4: Module 2c summarised scores by component



Module 2d: Whole institutional strengthening

Figure 5 presents the summarised scores by module component. Key points to note from the facilitated discussion were:

- in terms of the motivation for change (2.D1), NCDC responses were widely spread – this was surprising to the PHE team and to some NCDC colleagues. Stakeholders agreed however that there is general alignment in thinking for this area
- low NCDC scores related to systems thinking (2.D4) partly reflecting that there is further work to do to ensure that NCDC has fully embedded/mainstreamed the ‘One Health’ approach. This is however expected to improve over time

Figure 5: Module 2d summarised scores by component

Module 3: Added benefits to PHE/NCDC

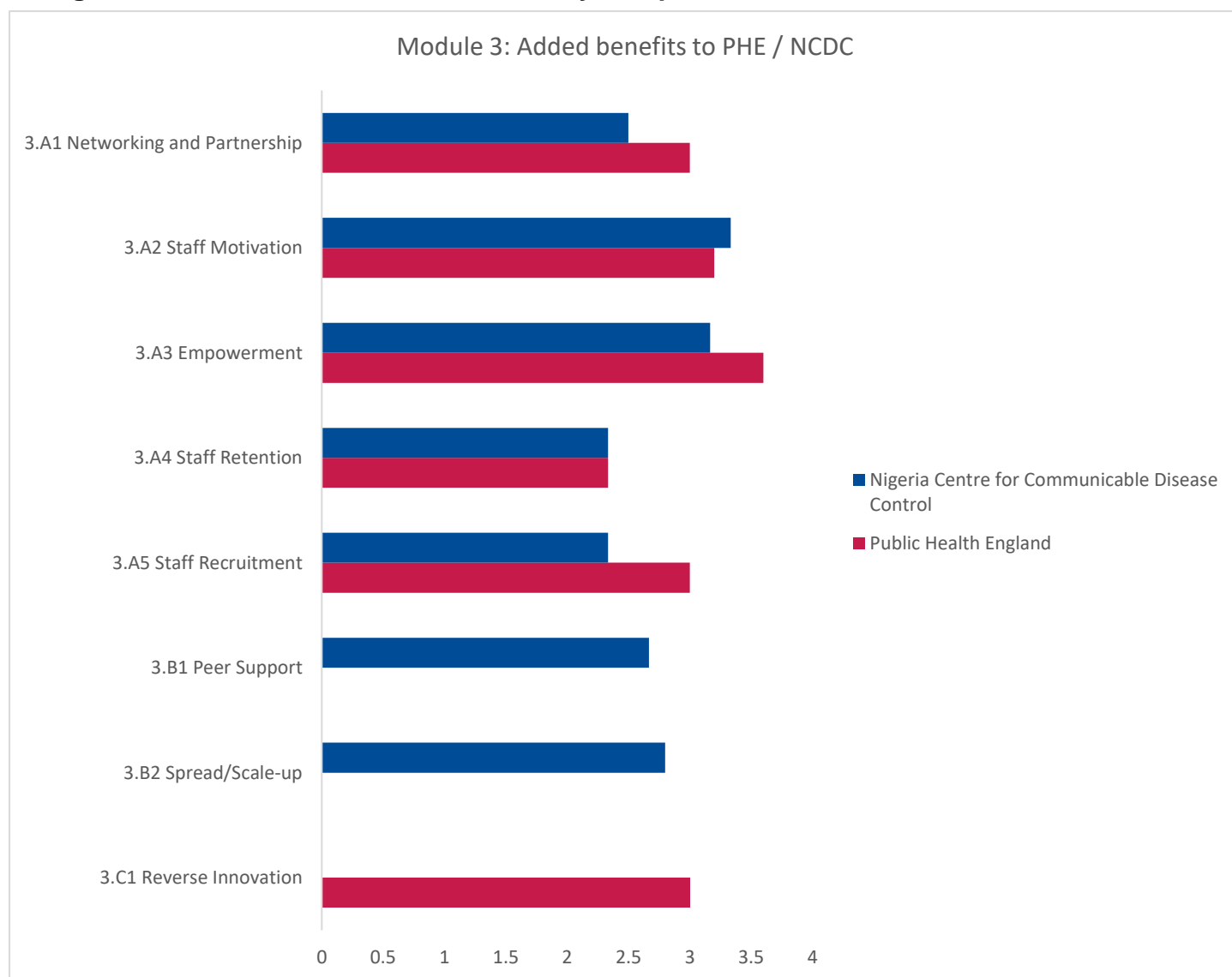
Figure 6 presents the summarised scores by module component for PHE and NCDC stakeholders. Key points to note from the facilitated discussion were:

- a few of the lower scores from NCDC stakeholders were felt to reflect the early stage of the partnership, the technical nature of which is in general viewed very positively. While this is an area where further progress is required, efforts to engage with WHO and partners across sectors, as well as at a regional level, were acknowledged. NCDC could nonetheless consider doing more to coordinate partners, in addition to the technical working groups already in place
- staff motivation (3.A2) and empowerment (3.A3) scores were relatively high for both PHE and NCDC stakeholders. The group discussed that NCDC staff do feel empowered and more confident as a result of the technical assistance and opportunities that PHE support has provided, with staff now taking more responsibility for functions and championing new ideas for improvement
- scores related to staff retention (3.A4) were mixed for NCDC, where the staff didn't see the partnership as influencing retention, but less so for PHE where staff engagement in the programme has increased motivation. This is thought to be due to being different to usual PHE work, but very much aligned to PHE's core mandate. Other benefits of PHE's engagement were discussed, such as helping PHE systematise processes and technical content that other staff can learn from and

build on. Programme engagement has not however been used as a mechanism to recruit staff (3.A5)

- in terms of peer support (3.B1) and spread/scale-up (3.B2), NCDC responses were mixed but generally positive. It was discussed that this is a core focus of PHE's engagement and it is hoped that this area of work can be improved over time by enhancing the 2-way relationship – i.e. where
 - PHE makes sure that training content is appropriate
 - NCDC takes forward using skills in Nigeria and across West Africa

Figure 6: Module 3 summarised scores by component for PHE and NCDC stakeholders



Module 4: Improved skills

Figure 7 presents the summarised scores by module component for professional skills. Key points to note from the facilitated discussion were:

- higher rated areas generally reflect the focus of programme so far
- there is some degree of variance between responses from PHE and NCDC stakeholders across component
- the zero response by PHE on multidisciplinary team working was felt to reflect its prior experience of this type of working, as compared to a high number of NCDC responses in this area, reflecting a lack of experience of this type of working
- in general, stakeholders agreed that skills and confidence has increased through programme engagement
- the clear result that the partnership is benefiting PHE staff could be shared within PHE and across the UK public health community, which would help to publicise the programme

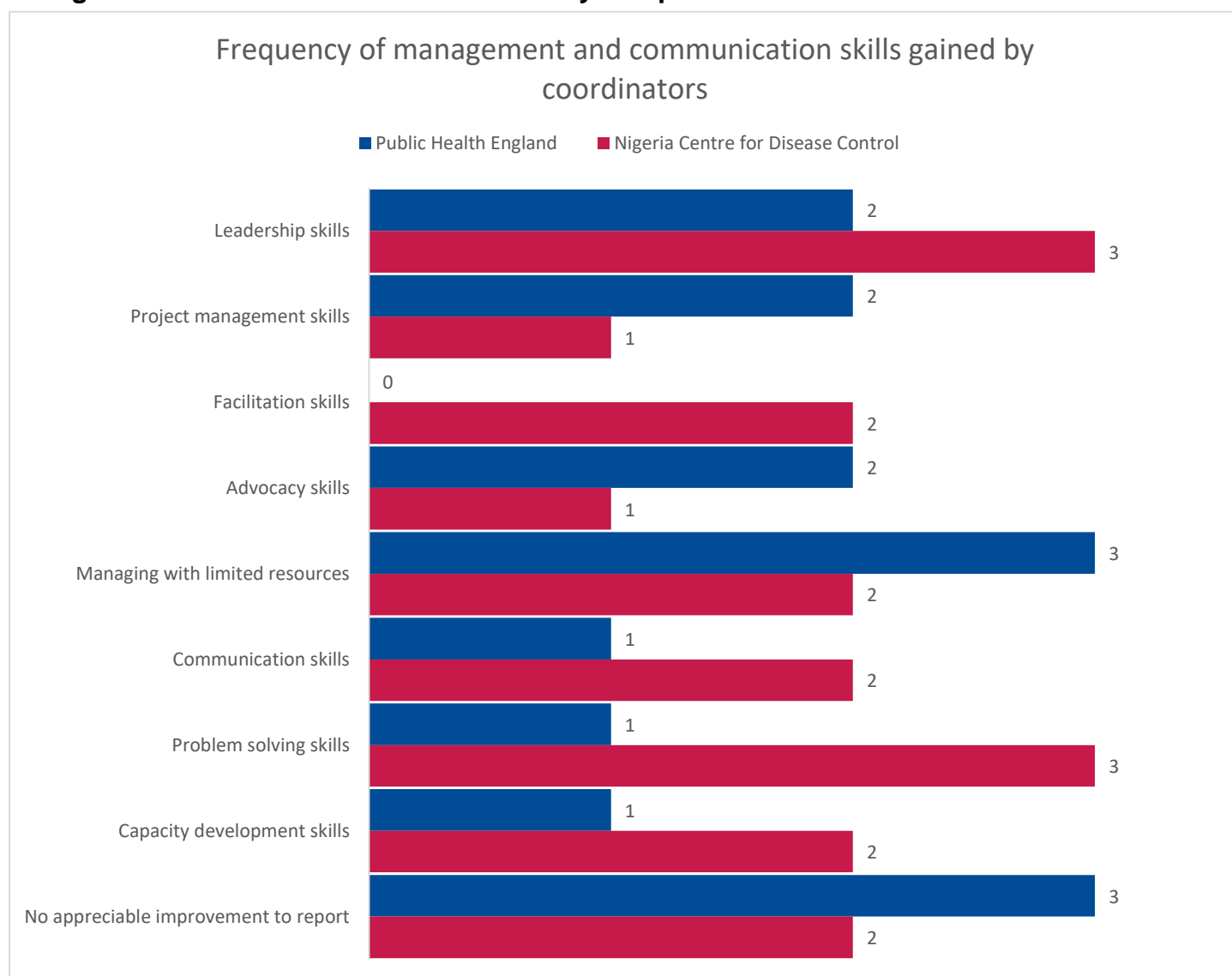
Figure 7: Module 4 summarised scores by component



Figure 8 presents the summarised scores by module component for management and communication skills. Key points to note from the facilitated discussion were:

- leadership skills are felt to have been demonstrably improved in NCDC technical areas, with teams having strengthened capacity and working with greater confidence having engaged in the programme
- organisational skills and networking skills are also felt to have improved from state level engagement, particularly for the EPR component of the programme. There is still scope to strengthen this within the wider programme

Figure 8: Module 4 summarised scores by component



In summary

Key partnership strengths include:

- high level of NCDC ownership over proposed technical activity
- wide ranging institutional engagement
- NCDC approval of PHE proposed capacity building activity
- high level of motivation for change in NCDC

Areas for strengthening included:

- improving dissemination mechanisms following key learning activity
- considering and applying a 'Systems Thinking' approach
- knowledge management and strengthening curriculum use
- evaluating the effectiveness of capacity building activity

PHE and NCDC have committed to repeat the ESTHER EFFECT tool in the near future at an appropriate point in the programme to review progress in sustainable partnership working.

Recommendations/actions agreed by both institutions

Recommendation	Action
Leadership: Engaged leadership has been critical to implementation but has varied somewhat by PHE IHR pillar.	Lessons learned from stronger areas could be applied to weaker areas. Agree appropriate mechanism for this, possibly through more regular discussion and/or an annual leadership meeting.
Dissemination and feedback: The lessons learned from the partnership between PHE and NCDC are disseminated organically, although PHE is not always aware of this dissemination and whether the approaches (e.g. the training of trainer's approach to capacity building) adopted are working.	A formal feedback and dissemination plan may help both parties to ensure that: training content is appropriate; and both entities are aware of the reach of activities. The PHE Global Public Health Team may consider incorporating this plan into a broader dissemination/ communications strategy, as mentioned under the Communications recommendations below.
Knowledge management: There is a need for a strengthened vision for knowledge management, including a more standardised training curriculum that all NCDC staff are aware of, have access to and mobilise around.	A consistent and agreed approach to knowledge management would benefit both institutions. Look at curriculum development and standardisation with regards to the various training resources being used and identify ways of increasing awareness of and access to training curriculum for NCDC staff.
Capacity: Further efforts should be invested into building NCDC capacity to deliver follow-on capacity building activities, particularly in the technical areas where capacity is weakest.	Scope and plan how best the 2 partners can ensure follow on capacity building is delivered, particularly in technical areas where capacity is weakest. Feedback on capacity building is ad hoc rather than systematic. Consider putting a formal review process in place and keep under regular review.
Equipment and materials: PHE should clarify its position and ability to provide laboratory equipment and materials as soon as possible.	PHE to communicate clearly with NCDC on its position and ability to provide laboratory equipment and materials. Training should take account of availability of equipment and commodities.
Coordination: NCDC should consider opportunities to further coordinate partners in the IHR space, being inclusive of entities operating in other sectors within the 'One Health' sphere.	Both partners to consider how opportunities can be identified and taken to support NCDC to further coordinate partners in the IHR space, being inclusive of entities operating in other sectors within the 'One Health' sphere. NCDC to continue to take forward sharing skills, knowledge and expertise in Nigeria and across West Africa.
Communications and publicity: The clear result that the partnership is benefiting PHE staff could be shared within PHE and across the UK public health community, which would help to publicise the programme.	As part of the communication plan, PHE to identify opportunities to promote the benefits of staff engagement in the programme more widely within PHE and the UK public health community.

Appendix

List of attendees

Evaluators

Name	Organisation	Role
Dr Chikwe Ihekweazu	NCDC	Director General, Nigeria Centre for Disease Control
Dr John Oladejo	NCDC	Head of Department, Health Emergency Preparedness and Response Department
Mrs Elsie Ilori	NCDC	Deputy Director Surveillance & Epidemiology
Dr Joshua Obasanya	NCDC	Director, Prevention and Programmes Coordination Department
Ms Oyeronke Oyebanji	NCDC	Technical Assistant to the Director General, NCDC
Mrs Nwando Mba	NCDC	Director National Reference Laboratory
Dr Ebere Okereke	PHE	IHR Strengthening Project Lead
Dr James Elston (via Skype)	PHE	Consultant Epidemiologist, Field Epidemiology
Dr Colin Brown (via Skype)	PHE	Consultant Medical Microbiologist
Mr Paul Sutton	PHE	Director Emergency Response Department
Dr Olusola Aruna	PHE	Senior Public Health Advisor, IHR Strengthening Programme Nigeria

Facilitators

Name	Organisation	Role
Ms Katie Haddock	PHE	Monitoring and Evaluation Assurance Manager
Ms Anna Osei-Kofi	PHE	IHR Strengthening Programme, Senior Project Officer
Dr Gurnam Johal	PHE	Monitoring and Evaluation Assurance Manager
Ms Cynthia Carlson	ITAD	Project Team Leader

Observers

Name	Organisation	Role
Dr Jonathan Ashcroft	PHE	Microbiologist UK Public Health Rapid Support Team
Mr Matt Cooper	ITAD	Project country lead

Key engagement with Nigeria CDC to date

- **November 2017** - PHE's partnership with NCDC was formalised through the signing of a Memorandum of Understanding between both institutions.
- **January 2018** - PHE IHR Project facilitated workshops to develop AMR surveillance plans for Nigeria.
- **January 2018** - PHE IHR Project contributed to and participated in the NCDC lead workshop to begin Nigeria's roadmap to a National Action Plan for Health Security.
- **February 2018** - PHE IHR Project Senior Public Health Advisor for Nigeria, Dr Olusola Aruna was appointed.
- **March 2018** - PHE IHR Project sponsored an NCDC Epidemiologist to receive GOARN (Global Outbreak Alert and Response Network) training, hence increasing deployable GOARN accredited staff on the continent.
- **March 2018** - PHE IHR partnered with R3P programme of GIZ to develop a draft strategy for inter-institutional communication and coordination for the West African Health Organisation (WAHO), to address epidemics in the ECOWAS Region.
- **May 2018** - PHE IHR Project collaborated with NCDC and WAHO on a West Africa Yellow Fever Simulation Exercise.
- **May 2018** - PHE IHR Project designed and facilitated a workshop on the Future of Electronic Surveillance in Nigeria.
- **May 2018** - Initiation of Internal Quality Assurance Scheme at the National Reference Laboratory, and progress made on a variety of laboratory system governance initiatives.
- **June 2018** - PHE IHR Project delivered Emergency Operations Centre and Incident Manager training.
- **June 2018** - SITAware, a Command and Control software facilitating efficient incident situational analysis and coordination was adapted for use in Nigeria and installed; NCDC staff were trained on its use.
- **June 2018** - PHE hosted 2 NCDC senior laboratory staff for a Lassa fever training workshop at PHE Porton Down and a series of laboratory systems coordination training sessions at PHE Colindale.
- **July 2018** - PHE IHR Project provided technical support to the WHO-led After-Action Review of the Nigerian Monkey Pox outbreak.
- **July 2018** - PHE IHR Project provided technical support to the validation and costing of the National Action Plan for Health Security (NAPHS) for Nigeria.
- **July 2018** - PHE IHR worked as a member of the Core Group in partnership with R3P GIZ to finalise the Strategy for Interinstitutional Communication and Coordination for epidemic control in the ECOWAS Region for WAHO.
- **August 2018** - PHE IHR Project delivered a laboratory-based technical workshop on laboratory diagnosis of enteric pathogens.
- **August 2018** - PHE IHR provided technical input to the finalisation of Nigeria national Rapid Response Team (RRT) Training Guidelines.

- **September 2018** - PHE IHR Project delivered at a pre-conference workshop on multi-disciplinary response to emergencies, as part of the 3rd NCDC/NFELTP Conference.
- **September 2018** - PHE IHR Project designed and provided technical input to a national consultative meeting on choice of appropriate EQA for AMR surveillance in Nigeria.
- **October 2018** - PHE CEO (Duncan Selbie) visit to Nigeria to attend official launch of the IHR project in Nigeria and meet with NCDC Director General (Dr. Chikwe Ihekweazu).
- **October 2018** - Joint delivery of first multi-state multisectoral emergency response simulation exercise, 'Keep Pushing'.
- **December 2018** - Supported the participation of (and delivered training to) laboratory scientists from NCDC at the African Society for Laboratory Medicine (ASLM) conference.
- **January 2019** - Delivered Lassa Fever biosecurity and biosafety training to 12 laboratory specialists from NCDC, to build laboratory capacity for Lassa fever outbreak management.
- **February 2019** - Delivered training on molecular diagnosis of vaccine preventable diseases to 2 NCDC national reference laboratory staff.
- **March 2019** - PHE-NCDC joint delivery of second multi-state multisectoral emergency response simulation exercise, 'Keep Pushing'.
- **April 2019** - The IHR Project supported the attendance of senior NCDC laboratory staff to microbiology laboratory management training with National Infection Service (NIS) in Colindale, participation the European Congress of Clinical Microbiology and Infectious Diseases (ECCMID) in Amsterdam and the PHE Public Health Research and Science Conference, Manchester.
- **May 2019** - Delivery of institutional partnership evaluation exercise using the ESTHER EFFECT tool.
- **June 2019** - Supported NCDC participation in Global Health Security conference in Sydney Australia.
- **July 2019** - NCDC visit to PHE for delivery of advanced Geographic Information System workshop delivered by PHE's emergency response department.
- **August 2019** - Planned delivery biosecurity and biosafety training in collaboration with NCDC.

ESTHER EFFECT tool train the trainer session, 9 May 2019

Summary

The Monitoring and Evaluation Assurance Managers and the Senior Project Officer provided training to NCDC colleagues enabling them to use the ESTHER EFFECT tool to assess the quality of partnership working and sustainability of change with any of their existing partnerships.

The team provided background on the tool and discussed benefits of this approach for evaluating the effectiveness of partnership working between health institutions. The purpose of the tool was explained, as well as the process for completing the questionnaire. The group were trained on how to analyse the findings and present the results, and importantly how to facilitate the workshop to discuss the outcomes and agree recommendations. Attendees had the opportunity to ask questions and trial using the tool.

PHE monitoring and evaluation colleagues offered to follow up by sending through resources including a copy of the tool and a mock-up of results for trainees to refer to. PHE will share any developments in the tool and provide ongoing support if NCDC staff required this when they come to use the tool.

An evaluation was carried out at the end of the train the trainer session. Feedback provided positive comments as well as helpful suggestions for the future such as sending out the questionnaire in advance and allowing more time to practice using the tool.