



The World Bank's Early Support to Addressing COVID-19 Health and Social Response

An Early-Stage Evaluation



IEG
INDEPENDENT
EVALUATION GROUP

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Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
ASA	advisory services and analytics
AVATT	African Vaccine Acquisition Task Team
CAT DDO	catastrophe deferred drawdown option
CERC	Contingency Emergency Response Component
COVAX	COVID-19 Vaccines Global Access Facility
DPF	development policy financing
FCS	fragile and conflict-affected situation
GP	Global Practice
GPE	Global Partnership for Education
HNP	Health, Nutrition, Population
IDA	International Development Association
IEG	Independent Evaluation Group
IPF	investment project financing
MPA	Multiphase Programmatic Approach
PEF	Pandemic Emergency Financing Facility
PPR	prevention, preparedness, and response
SMS	short messaging service
SPJ	Social Protection and Jobs
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

All dollar amounts are US dollars unless otherwise indicated.

Acknowledgments

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Overview

This evaluation assesses the quality of the World Bank’s early response to the COVID-19 crisis and the initial steps toward recovery, focusing on the health and social response. It concentrates on the relief stage and support to restructure systems in the first 15 months of the pandemic (February 1, 2020, to April 30, 2021) in 106 countries. A parallel Independent Evaluation Group evaluation looks at the World Bank Group support to address the economic implications of the pandemic. To assess the quality of the response, the evaluation is guided by a theory of action that synthesizes evidence in three dimensions: relevance of support to the needs of countries; implementation, learning, and adjustment; and operational policy and partnerships to support smooth responses in countries. As the response is ongoing, the evaluation does not assess effectiveness but considers early results and pathways that are expected to lead to outcomes.

Main Findings

In a context of high uncertainty, the World Bank delivered a response of unprecedented scale and speed. The immediate support was particularly swift in the most vulnerable countries. In the first 15 months, the World Bank provided financing of an estimated \$30 billion for the health and social response in 106 countries with high or medium vulnerability to human capital and development losses. Support to small states, less-prepared countries, and fragile and conflict-affected situations was emphasized. About 20 percent of financing was disbursed in the first months of 2020, and 40 percent was disbursed by April 2021. Staff and clients worked long hours to deliver new and repurposed operations, all while learning to use remote connectivity tools and adapting to home-based work and personal stresses.

Relevance of Support to Country Needs

The evaluation looks at how well the World Bank responded to the immediate health threat of COVID-19, how well it focused on protecting vulnerable groups against human capital losses, and how well it integrated institutional

strengthening in the relief stage to help sustain preparedness and resilience postcrisis.

The World Bank support was relevant to the needs of countries and well aligned with most emergency areas in their COVID-19 responses. Emergency support expanded critical health services to prevent and control the spread of disease, including infection prevention and control, case management, surveillance, and provision of laboratories. The support prioritized social protection for poor and vulnerable people. For example, Djibouti, Honduras, India, Senegal, and Tajikistan expanded emergency health and social protection actions through World Bank operations. World Bank support in countries aligned well with national COVID-19 plans of governments, which coordinated emergency support of development partners to the response.

World Bank support addressed country needs most comprehensively where earlier work on human capital had built preparedness and where cross-sectoral coordination among Global Practices (GPs) and sectors in countries was stronger. Knowledge and relationships developed before COVID-19 helped reorient country portfolios in human development and other sectors to accommodate newly emerged needs. For example, in Uganda, the response built on existing relationships in health, education, water, agriculture, and nutrition. In the Philippines, new relationships needed to be developed in health, initially slowing the early response, while work before COVID-19 in social protection and community development enabled the rapid expansion of cash transfer programs and support in communities. Coordination across sectors was weak in most countries. However, where coordination was stronger (for example, in India and Senegal), it helped quickly mobilize a range of GPs and sectors in the country to address needs related to testing, surveillance, laboratories, social protection, child learning, and nutrition, and involved women's groups and the informal sector.

The early months of the World Bank response had a strong emergency focus, followed in about half of countries with efforts to protect human capital. The World Bank's knowledge work on gender, epidemic preparedness, supply chains, social protection, and behavior change communication helped prioritize actions in some countries (Djibouti, Honduras, India, and Uganda). Strong government leadership helped some countries rapidly adapt World

Bank support to both emergency and human capital needs. In the remaining half of countries, less attention was given in the first 15 months to continuing maternal and child health and education services, protecting women and girls from the shock of COVID-19, and engaging communities. The challenge of responding to urgent needs while protecting human capital was especially acute in countries with weaker systems for rapid health response and extensive human capital vulnerabilities (such as Chad and Niger).

Integrating institutional strengthening in the early COVID-19 response helped focus on sustaining public health preparedness and building resilience in health, education, and social protection systems. In more than 90 percent of countries, institutional strengthening was part of World Bank support. For example, in countries such as India, the Philippines, and Tajikistan, the World Bank helped strengthen and rapidly expand social protection systems, often to a national scale. In Djibouti and Uganda, extensive support in education helped develop and strengthen remote learning networks. Honduras emphasized early health support to strengthen laboratories. However, most countries still need strategies to sustain preparedness and ensure systems resilience after the crisis. Regional disease-focused projects, such as in Senegal, Zambia, and the countries of the Organisation of East Caribbean States, often helped countries to put better strategies in place for sustaining public health preparedness and to strengthen capacities in areas such as laboratories, testing, and case management.

Early Successes, Challenges, Learning, and Adjustment

The evaluation examines how well the World Bank supported implementation and adjustment to ensure a strong response. It looks at how well the World Bank supported countries to achieve early results, built on past lessons and evidence, and introduced innovation. It also examines how the World Bank used dialogue and coordination, knowledge sharing through regional projects, and data to inform decisions and adjust the response.

Although too early to observe outcomes, case studies provide promising evidence of early outputs that are key to satisfactory implementation and a good indicator that positive outcomes can be expected. Examples include the rapid expansion of critical health services, such as COVID-19 testing,

social protection benefits, and remote learning for children. These interventions likely helped reduce the health threat of COVID-19 and protect human capital. About 40 percent of countries had projects that included monitoring data, and a mix of interventions that provide critical health services for disease prevention and control and limited coverage of interventions to protect human capital and engage communities.

Broadly, the World Bank used its experience from past crises and existing knowledge about effective interventions. Most health projects built on past lessons and incorporated effective disease prevention and control interventions. For example, countries received widespread support for laboratories and infection prevention and control for COVID-19. At the same time, support to local government and service providers, community-based interventions, and support to address gender equality (such as psychosocial care and sexual and reproductive health interventions) were limited, despite consistent evidence of effectiveness and lessons from past crises and risk communication. The focus on broad national response was strong, and attention to local-level implementation challenges in reaching vulnerable groups was less prominent. The burden of the pandemic on frontline health workers was heavy, yet innovations in service delivery during the crisis were rare. In education, while there was often a focus on local learning, case studies suggest that countries faced challenges in supporting teachers and vulnerable children to continue learning during the crisis (India, Mozambique, and Uganda).

In its effort to respond quickly and effectively, the World Bank innovated—its response included some form of innovation in more than 80 percent of countries. This evaluation found more than 200 examples of innovations supported by the World Bank in its COVID-19 response, such as for health communication and vaccine monitoring (Tajikistan), surveillance (Colombia), expanding cash transfers (the Democratic Republic of Congo), remote coaching of teachers (Lebanon), and multisector coordination (Haiti). In Senegal, community-based disease surveillance and multistakeholder engagement supported community health workers and volunteers to detect COVID-19 and report cases to health facilities and local government. In Mali, a new national call center provided advice for implementing COVID-19 protocols. Global partnerships and knowledge sharing by regional projects were

useful to successfully promote innovation. For example, the World Bank's Education Technology team helped countries to expand remote learning; regional disease-focused projects helped expand country innovations in infection prevention and control, point of entry control, testing, and surveillance.

The World Bank engaged in frequent dialogue with governments and partners to coordinate and adjust implementation. Supporting government coordination to implement responses at the national and subnational levels worked best where there were country-led structures that predated COVID-19. Coordination structures facilitated dialogue on emerging needs, strengthened responses, and involved frontline services and communities for oversight, learning, communication, and problem-solving. One Health structures, which coordinate multisectoral disease response actions, in Senegal and Zambia helped coordinate actions in health with other sectors. Subnational nutrition structures were key for COVID-19 messaging and for disease surveillance in Honduras, Senegal, and Uganda. Parent-teacher networks were important for supporting learning. New structures for coordination took time to set up during COVID-19, for example, in Haiti and the Philippines.

Regional projects facilitated knowledge sharing and were particularly helpful for countries with limited capacity to respond independently to COVID-19. Regional projects supported technical cooperation (such as for planning and reporting on the response) between ministries and public health institutes, encouraged leadership, developed human capacity, and coordinated technical sharing and financing for COVID-19 responses in countries. Longer-running regional projects had more established networks, which had successfully built some preparedness before the pandemic to support COVID-19 responses, although even newer regional projects added value, mainly through convening and technical and learning support. The Economic Community of West African States was wellprepared to support countries during COVID-19, largely thanks to earlier support under the Regional Disease Surveillance Systems Enhancement Project. Despite being a newer organization, the Africa Centres for Disease Control and Prevention, supported by a World Bank regional project, quickly developed convening structures in Africa, such as for collaboration for disease surveillance, testing, and

vaccines. The Organisation of East Caribbean States Regional Health Project also quickly coordinated support for testing and case management.

Few countries possessed real-time data systems and adequate data to inform decisions and adapt the response. Where they existed, diagnostics (Djibouti), geo-enabled monitoring (Tajikistan), iterative beneficiary monitoring, short messaging systems (Lesotho), online surveys (Tunisia), and dashboards (Colombia) supplied timely data to inform decisions, monitor behavioral change, and adjust actions. Where available, frequent data on the quality of health and education services in communities were critical for course corrections. Honduras and Uganda used remote supervision systems to monitor and improve local nutrition services during COVID-19. Tajikistan and Zambia used short messaging systems to track vaccine services and communicate with teachers. Djibouti, India, the Philippines, Senegal, and Tajikistan used real-time survey data to adjust social protection responses.

Operational Policies and Partnerships

The assessment of the operational policies and partnership looks at how well the World Bank's internal coordination, instruments for financing the COVID-19 response, and internal systems for reporting and monitoring supported the response. It looks also at the World Bank's financing and technical partnership, including support of the Pandemic Emergency Financing Facility and support to vaccine financing.

At the onset of the pandemic, Bank Group senior management demonstrated strategic and agile decision-making. Bank Group senior management articulated its approach early in March 2020 and delivered an Approach Paper to its Executive Directors in June 2020. This included front-loading International Development Association spending allocations and seeking an unprecedented International Development Association replenishment a year ahead of schedule, activating the International Bank for Reconstruction and Development's crisis buffer to release additional financing, and aligning with the World Health Organization technical guidance on health issues. Within the World Bank, the Emergency Operations Center facilitated good internal coordination across GPs and operational support units, which was critical for action alignment and technical problem-solving. Policy guidance and

knowledge sharing in GPs helped guide World Bank teams' design projects in the early months of the response. Country portfolio reviews led by World Bank country management facilitated coordination of support across GPs and project teams in countries. To quickly process projects, managers in the health sector mobilized surge capacity involving retirees, exchanging staff, and increasing the responsibilities of country office staff. Wider engagement of GPs outside Human Development could have drawn on more staff resources and financing to help countries and coordinate efforts to process project support in the early months of the response.

At the country level, having a pre-COVID-19 World Bank program with a good mix of instruments, including crisis instruments that could support timely financing in the first weeks of the crisis, facilitated a swift response. Crisis instruments, repurposed projects, regional projects, trust funds, and grants, where available in country program portfolios, helped rapid financing and just-in-time assistance in the early weeks and months of the crisis. Other instruments built on this support but often took longer to process: the Multiphase Programmatic Approach (MPA) was key to expanding new lending in more vulnerable countries for the health emergency response; development policy financing provided important funding for early systems strengthening in areas where it could achieve quick wins by building on previous policy dialogue on human capital; and Pandemic Emergency Financing Facility grants supported COVID-19 plans and coordination with United Nations partners, although the small amounts of funding took time to process. The early responses in Senegal and Uganda relied on crisis instruments, repurposed projects, and trust funds, which were complemented by development policy financing, Pandemic Emergency Financing Facility, and MPA support once available. Tajikistan used repurposed projects for its early COVID-19 response and then used the MPA financing in health when it became available.

The World Bank introduced operational flexibility, which facilitated rapid processing of new financing for the MPA. This included shortened clearance times and delegation of approvals. The first MPA projects disbursed in about two months compared with about five months in previous crises. This quick timing was important because there was less reliance on additional financing compared with previous crises. Other new investment project financing

projects took about five months to disburse, but in some countries, projects disbursed in less than one month. The procurement of medical goods early in the response also happened rapidly; from the first month of the response, personal protective equipment, test kits, and medical equipment were procured for emergency use in countries by using World Bank–facilitated processes and hands-on assistance or enabling governments to use emergency procedures in projects. Despite the extensive support of safeguard teams, the new Environmental and Social Framework was challenging for new projects in the first months of the crisis, given that ministries were overwhelmed, and it required new learning. Requirements of citizen engagement and gender could have benefited from more hands-on assistance to help teams.

It was challenging to collect timely data to report on the progress of support and track and coordinate procurement. Integrated reporting of data on various parts of the World Bank’s country-level COVID-19 response was important for discussions with governments, World Bank teams, partners, and headquarters. In India and other countries, the World Bank country office often lacked timely data to track implementation of projects to inform coordination. A key challenge was the difficulty in coordinating government procurement requests with other development partners in countries so the same items were not purchased. The tracking of goods—from ordering to shipping to arrival in health facilities—was also crucial though rare. Tracking was challenging, given the limited emergency preparedness of procurement systems in countries and lack of remote monitoring mechanisms.

Having well-established partnerships with development organizations in place before the COVID-19 pandemic facilitated rapid action. For example, the Global Partnership for Education, where available, helped quickly expand education support for children (such as in Uganda). In Mozambique, Senegal, and Uganda, partnership with the Global Financing Facility helped expand maternal and child health services and risk communication, though actions could have been quicker. In Tajikistan, the Global Partnership for Social Accountability supported efforts to involve civil society to monitor the COVID-19 response, and partnership with Gavi, the Vaccine Alliance supported early planning to access vaccines. Existing country-level development partnerships enabled coordinated financing and actions for the response (for example, in India and the Philippines). Collaboration with nongovernmental

organizations and the private sector in World Bank projects (such as in Belize, India, Peru, and Togo) helped expand community-based implementation, innovation, and use of technology and digital payments in social protection.

In the uncertain early months, the World Bank made good efforts in engaging with partners to help prepare countries to deliver vaccines and expedite access, but the World Bank lacked an instrument to rapidly facilitate advance market commitments. In the first months of the pandemic, the Health, Nutrition, and Population GP convened global partners to explore ways to help low-income countries access vaccines. This was followed by intense internal dialogue about how the World Bank could best support vaccine readiness and access, focusing on supporting country-level efforts for vaccines, given the lack of a global instrument to help finance advance market commitments. Partnerships worked well at the country level, and the MPA financing for vaccines was timely. But implementation of vaccine support was initially slow because countries had limited health systems capacities to support delivery, and they often could not access vaccines early in the response. The key was having access to financing for advance resource commitments, pooling resources with other partners in countries to support procurement, and aligning efforts in countries for vaccine safety and delivery. Earlier engagement with partners—namely, the COVID-19 Vaccines Global Access initiative and the African Vaccine Acquisition Trust—could have helped ensure advanced vaccine supplies for countries but also facilitated earlier preparedness and communication about vaccines.

Overall, the quality of the early World Bank response was good. Looking ahead, a number of areas need attention by the World Bank and its clients: better preparedness of countries to deliver emergency services that reach local levels; more resilient systems in countries to protect health, education, and gender equality; improved support for cross-sectoral coordination; data for managing quality implementation; regional learning and cooperation; and stronger internal preparedness to respond quickly in a crisis, including coordination with partners.

Recommendations

The findings from the evaluation inform four recommendations for ensuring stronger future preparedness.

Recommendation 1. Use the World Bank’s crisis recovery efforts to strengthen the resilience of essential health and education services to ensure that human capital is protected in a crisis.

Proposed Actions

- » In health, build on innovations developed during COVID-19 to help countries strengthen telehealth and other platforms for continuing essential health services in an emergency. Help countries improve the quality of frontline services, including the availability of data to inform decisions for quality improvements. Services could be improved to better manage supplies, deliver vaccines, support health workers to deliver effective care, and ensure infection prevention and control measures. The availability and use of feedback from beneficiaries and coverage of vulnerable groups are also important. The World Bank could also help develop new capacities to deliver services, such as in psychosocial care.
- » In education, draw on evidence and innovations of the COVID-19 response to strengthen platforms for continuous learning in a crisis. Strengthen community networks that have been established to support learning. To avoid learning losses, facilitate knowledge building to uptake effective approaches to help children in and out of school catch up. Help countries increase the reach to vulnerable groups that may have been missed by remote learning. Strengthen monitoring of beneficiary feedback on the quality of learning.

Recommendation 2. Apply a gender equality lens to health and social crisis response actions across sectors.

Proposed Actions

- » Develop actions across sectors (in health, education, urban, and social protection) for protecting women and girls from shocks, which can be drawn on in a crisis response. This is especially important in countries with high needs

for addressing gender equality. Examples of areas to support gender equality include psychosocial support, sexual and reproductive health, income and asset accumulation, and community engagement.

Recommendation 3. Help countries strengthen regional cooperation and crisis response capacities for public health preparedness.

Proposed Actions

- » Support regional organizations to facilitate cooperation, political leadership, and technical learning, especially in Africa. Such support could help strengthen preparedness in countries and regional mechanisms for crisis response, facilitate financing and technical partnerships, encourage innovation, and expand evidence to scale up effective approaches. Regional support could also facilitate evidence-based and data tools to help countries monitor crisis response actions.
- » Help countries strengthen national and subnational platforms to coordinate and deliver crisis interventions, such as One Health platforms, with greater emphasis on critical health services and demand-side activities, such as citizen engagement. At the national level, invest in platforms that coordinate action and prepare various sectors to take on specific roles in crisis. At the subnational level, invest in platforms that can reach local government and communities for disease surveillance, risk communication, delivery of health and social services, and monitoring support.

Recommendation 4. Build on the COVID-19 experience to strengthen the World Bank's internal crisis preparedness so that it has the tools and procedures ready to respond in future emergencies.

Proposed Actions

- » Review and expand operational flexibilities for processing new projects in crises and develop guidance on the effective use of instruments at different stages of crisis response. The World Bank could also explore innovative ways to strengthen the use of crisis instruments in countries, such as through support to communities, and expand guidance on hands-on assistance for

citizen engagement and gender, learning from the provision of such support in procurement.

- » Expand and strengthen the World Bank’s partnerships and instruments to enable coordinated financing, advance market commitments, and technical support that will help countries strengthen crisis preparedness. The partnerships could be at the global, regional, and country levels. They could include technical partnerships to expand knowledge for quality implementation of preparedness activities, partnerships with nongovernment and the private sector to support community-based implementation, feedback on services and use of technology, and global partnership for aligning financing, plans, and guidance to support countries.
- » Strengthen tools to allow for the integrated management and frequent reporting of monitoring data on projects in World Bank portfolios.

Management Response

Management of the World Bank thanks the Independent Evaluation Group (IEG) for the opportunity to respond to the IEG report *The World Bank's Early Support to Addressing COVID-19: Health and Social Response—An Early-Stage Evaluation*. Management appreciates IEG for supporting the World Bank's COVID-19 response by offering just-in-time lessons and evaluative evidence to inform management's choices. Management recognizes the usefulness of this evaluation for informing the World Bank's efforts to support countries to prevent, prepare for, and respond to present and future crises.

Global Leadership, Partnerships, and Learning

Management welcomes the report's recognition of the World Bank's global leadership in the delivery of an unprecedented crisis response. The report underscores the importance of prior World Bank country engagement and the mix of instruments that enabled a swift response comprising new lending and repurposed projects.¹ The World Bank's COVID-19 response has been, from multiple angles, an extraordinary one. The World Bank responded at speed and at scale in an unprecedented fashion.

The World Bank

- » Completed pathbreaking analytical work to help understand how an unknown pandemic was evolving and impacting social and economic circumstances, globally and at the country level;
- » Provided affected countries with a sharp increase in financing tailored to their circumstances, including by accelerating an International Development Association Replenishment by a full year;
- » Innovated on instruments, especially the health Multiphase Programmatic Approach (MPA), which was the initial Fast Track COVID-19 Facility of \$6 billion;²
- » Achieved record commitments and disbursements;

- » Made more financing for vaccines available than any multilateral development bank or international organization—this is especially true once the vaccine donations provided by countries that are members of the Organisation for Economic Co-operation and Development are excluded from the calculation; and
- » Built on lessons from past crises, including the need to employ a variety of instruments like the Contingency Emergency Response Component; repurposed projects, including regional projects, trust funds, and grants; and guidelines on a variety of topics for projects in emergency situations.

Management acknowledges IEG’s recognition that the flexibility of the World Bank’s processes for project financing improved in COVID-19 from past crises and allowed an agile and swift response that shortened time to disbursement by half compared with previous crises. Procurement plans for vaccine projects also disbursed nearly 10 times faster than other investment project financing health projects. Moreover, the World Bank continued to be a full-service development bank, addressing all key aspects of the pandemic and its impacts while maintaining a focus on its corporate commitments, including a large increase in climate financing and on preserving the basis for a resumption of progress toward long-term development outcomes.

Management believes that the World Bank’s early coordination with global and regional partners on interventions in relation to vaccines were instrumental for the effectiveness of the response. From the beginning, the World Bank’s COVID-19 response recognized the centrality of vaccination for containing the pandemic—once an effective vaccine was available—but prior to vaccines becoming available in 2021, the interim emphasis of the response was on prevention, testing, treatment, and surveillance. Management notes the strength of its partnership with external partners, including with COVID-19 Vaccines Global Access (COVAX)⁵ on the following areas: (i) assessing countries’ readiness to deliver vaccines (World Bank 2021a) through the Vaccine Introduction Readiness Assessment Tool and Vaccine Readiness Assessment Framework (VRAF); (ii) streamlining the vaccine acquisition process by setting up a cost-sharing mechanism (World Bank 2021b) with COVAX that supported countries willing to procure doses in addition to free doses through COVAX; and (iii) monitoring countries’ capacity to deliver

vaccines by monitoring, sharing, and coordinating information, data, and activity regarding vaccine availability and countries' readiness through the Multilateral Leaders' Task Force, which included the World Bank, World Health Organization (WHO), the International Monetary Fund, and the World Trade Organization. Management also appreciates the report's acknowledgment in relation to the challenges of having a global instrument to support advanced market commitments for vaccines, but notes that the Gavi Alliance and World Bank do have a long track record of financial innovation at the global level, most notably through the International Finance Facility for Immunization, for which the World Bank serves as Treasury Manager. This frontloading tool, which creates vaccine bonds through raising finance on capital markets backed by long-term donor pledges, meant that a global mechanism was in place to raise additional funds through COVAX, and several donor countries made their contributions to the COVAX Advanced Market Commitment through this mechanism. The World Bank, through its cost-sharing mechanism developed with COVAX, allowed COVAX to make advance purchases from vaccine manufacturers based on aggregated demand across countries, using financing from the World Bank. Additionally, the World Bank's efforts to strengthen regional capacity was one of the most notable highlights of the vaccine response, particularly the support offered to the African Union to make use of the African Vaccine Acquisition Task Team (AVATT) initiative. By the time the announcement was made, many of the 36 countries with approved vaccine operations had already formalized plans to procure vaccines through AVATT. Both COVAX and AVATT financing arrangements were part of the World Bank's effort to ensure countries had flexibility in financing in alignment with country preferences. The World Bank, as a country-based model, demonstrated the ability to complement the other mechanisms, and specifically, to take advantage of the centralized procurement capacity of COVAX and AVATT. To date, 630 million vaccine doses have been purchased with World Bank financing (\$6.5 billion) through a variety of procurement channels.

Management believes that the efforts made pre-COVID-19 in helping strengthen regional capacity, especially in Africa, yielded results during the COVID-19 pandemic. Regional projects facilitated knowledge sharing and were particularly helpful for countries with limited capacity to respond

independently to COVID-19. They also supported technical cooperation (such as for planning and reporting on the response) among ministries and public health institutes, encouraged leadership, developed human capacity, and coordinated technical sharing and financing for COVID-19 responses in countries. World Bank operations have also helped strengthen institutional capacity of Africa Center for Disease Control, and regional projects such as the World Bank project Regional Disease Surveillance Systems Enhancement have improved prevention, preparedness, and response (PPR) capacity using a One Health approach. The World Bank is building on these partnerships through its global PPR program, including the PPR Financial Intermediary Funds.

Adaptive Management and Internal Coordination

Management emphasizes its adaptive response in a context characterized by deep uncertainty and fluidity. As the crisis evolved and as new information became available, the World Bank's response remained flexible and adapted continuously as country and regional needs evolved throughout the 15-month period of this review. The World Bank remained relevant by analyzing the evolution of the virus, enhancing its understanding of it, and calibrating its response to the changing external environment. As a global institution working across all regions in a context of high uncertainty and shifting landscape of vaccine development and regulatory approvals, management had to recalibrate safeguards carefully and continuously in relation to financing for vaccines. The early use of a waiver for the first vaccine project in Lebanon (as mentioned by the report), was critical for upholding both speed and safety. When more data became available, the World Bank aligned with WHO regulatory approvals, and the focus shifted to helping countries to navigate the severe supply constraints at the global level and working with countries to match supply and demand in a context where donation timelines were highly uncertain. Adaptive management is an essential element of the World Bank's outcome orientation. There was sufficient flexibility built into the World Bank's operational policies and approaches, building on lessons learned from earlier crises, and the speed and agility with which these were triggered (allowing substantial additional commitments to be made within months of the WHO declaration that COVID-19 constituted a pandemic).

Management highlights the contribution of the Social Protection and Jobs (SPJ) Global Practice as one of the most dynamic aspects of the World Bank's COVID-19 response. During the period covered by the report, SPJ had the highest lending volume (in fiscal year [FY]21 \$8,837 million, almost four times that of the Health, Nutrition, Population [HNP] Global Practice). In addition, significant effort was devoted to adapting existing operations and safety net programs, topping-up benefits to existing beneficiaries, or expanding the beneficiary pool without new lending. These efforts led to securing financial support to households to face health-related restrictions. As businesses closed and movement was restricted to essential services only, social protection (through new or repurposed SPJ-led projects) provided essential intermediate income that allowed people to stay home instead of continuing to work and mingle, risking disease transmission. It should be noted that over 40 evaluations have demonstrated the effectiveness of SPJ programs in saving lives and protecting or enhancing well-being across a range of dimensions. A new “lessons learned” paper, recently released by SPJ, includes an overview of those evaluations (Gentilini 2022). Similarly, the upcoming Poverty and Shared Prosperity Report shows evidence from microsimulations for low- and middle-income countries showing that poverty would have been significantly higher without safety net responses, and that countries with better social protection systems were able to mitigate the impact of the pandemic more effectively.

Management took unprecedented steps for an effective internal coordination to help manage its engagement globally and will reflect on ways to further improve for future crises. Management established coordination arrangements that permitted the delivery of the MPA in just three weeks—the fastest and largest response in the history of the World Bank. The success of the effort was a combination of top-down and bottom-up creativity of many teams across the institution that found innovative ways to quickly resolve challenges. Among the many actions taken, management highlights the adoption of streamlined processes and efforts for cross-fertilization; regular coordination meetings starting in February 2020 within the Human Development practice; and design of the global blueprint for the MPA Program, with close coordination of headquarters and field offices. Management also compiled operational updates from

countries about restructuring ongoing projects and reallocating funds to support initial national responses. Moreover, management established the Emergency Operations Center as the engine of internal coordination. The Emergency Operations Center was established quickly with experienced staff; it shared information, held weekly cross-functional coordination meetings, resolved queries with a daily turnaround, and maintained regular communication between headquarters and country offices for the health sector.^{4,5} It was instrumental in coordinating operational responses and facilitating problem solving. Management also notes that the World Bank gained considerable experience engaging stakeholders and built on this experience over time, including using electronic platforms, stronger engagement with civil society networks to ensure governments' accountability to citizens, and strengthening opportunities for citizen engagement through the World Bank's Global Partnership for Social Accountability.

Gender and Targeted Beneficiaries

Management points out that the World Bank projects continued to focus on women, as teams were given the flexibility to waive the gender tag requirements in the early stages of the COVID-19 response. While reviewing the FY20 MPAs as they were approved, based on the gender priorities detailed in the Gender HNP Guidance Note, management observed that a good share of the MPA projects did consider gender issues to the extent possible, even if not all of them were able to specify project interventions due to the limited scope and time frame. Although the early response projects did not adopt entry points of gender that would have been used under “normal” circumstances (such as psychosocial support or sexual and reproductive health), HNP's COVID-19 projects acknowledged and responded to gender-based gaps directly related to the pandemic response, such as ensuring women received critical health information, training of female service providers, supporting countries in providing compensation packages to frontline workers (mostly women) who were at high risk, and psychosocial support for frontline workers. By April 2021, HNP, in collaboration with the Gender Group, also produced a second set of guidelines on reducing gender gaps in vaccine delivery for COVID-19, which includes recommendations for contin-

uation of essential health services including sexual and reproductive health services, community engagement, and provision of psychosocial support. These recommendations are reflected in subsequent COVID-19 projects. The subsequent additional financing operations covered cross-sectoral issues more systematically, based on the learnings and lessons of the initial MPA operations along with a growing body of global evidence and data showing the impact of the pandemic on health, education, and social protection.⁶ By phase II of the pandemic response, the gender tag was resumed. From the early stages of the response, management provided multiple trainings to staff on identifying and addressing gender gaps in their pandemic response. Key guidelines from this training have also been incorporated into the HNP Flagship Course (aimed at client countries) as part of the gender and health training module. Currently, as part of the gender strategy update, HNP is developing its action plan, which covers pandemic preparedness and ensuring continuity of health services including sexual and reproductive health and psychosocial services along with community engagement.

Management clarifies that the World Bank's COVID-19 response targeted vulnerable populations from the onset. Although in health, vulnerability is a broad concept (it includes women, children, adolescent girls, poor people, farmers, and so on), the wider World Bank COVID-19 response targeted vulnerable populations as more narrowly defined based on their risk of COVID-19 mortality and morbidity. This prioritization process was aided by the WHO Strategic Advisory Group of Experts Road map for prioritizing use of COVID-19 vaccines, which was referenced in project documents and which countries then adapted to their specific country needs. Key vulnerable groups were defined as people most at risk of COVID-19 infection, (severe) illness, and death, including health workers, and adults over 60, and people with comorbidities. Children were not prioritized, given their lower risk and lack of approval for COVID-19 vaccines early in the pandemic. Still, the SPJ projects succeeded in reaching 92 percent of the vulnerable population they intended to reach at design, including 95 percent of the intended women and children. These projects also reached the "last mile" of vulnerable and marginalized beneficiaries from the outset, using existing platforms for behavior change communication (that usually accompanies cash transfers) to deliver COVID-19 messages. Given the broad impact of the crisis, universal programs have a

greater likelihood of reaching most, if not all, vulnerable populations. That said, the decision regarding whether a program should be universal or targeted requires consideration of the trade-offs in coverage, cost, and efficiency.

Management underscores that essential service delivery to meet human capital needs was supported by the ongoing Human Development portfolio (not tagged as COVID-19 response) and through COVID-19 response operations. At the global level, the World Bank was one of the first large-scale development organizations to point to the risk and impact of disruptions in essential health services resulting from COVID-19. The report correctly notes that beyond its immediate impact on health outcomes (mortality and morbidity), the pandemic also had a dramatic impact through disruptions in essential health services, especially for maternal and child health and gender-related services.⁷ The World Bank's ongoing portfolio of projects complemented the emergency response: the long-term investment portfolio in health systems amounted to \$30 billion in more than 200 countries. The World Bank has been supporting countries to strengthen the resilience of essential health services, expand reach of telemedicine, strengthen data to inform decision-making, and strengthen citizen engagement.⁸ To mitigate drops in coverage rates of childhood immunization, the World Bank continues to work closely with Gavi Alliance partners to find ways to protect financing of routine vaccines in the highest risk countries, drawing on World Bank financing to complement domestic financing through existing health projects when necessary. Furthermore, health systems strengthening, including preparedness planning for delivery of essential health services, was represented in about one-third of all MPA commitments. Some of the COVID-19 response investments under the MPA project had positive spillovers for the delivery of essential public health services for dealing with comorbidities that increased the risk of severe COVID-19 disease, hospitalization, and death.⁹ Examples include the Essential Health Services Recipient Executed Trust Fund grant program and the Global Financing Facility, launched toward the end of calendar year (CY)2020 to help incorporate support for essential health services into COVID-19 operations.

Recommendations

Management welcomes the report's recommendations as the World Bank continues to scale-up its engagement in crises preparedness and response in a world affected by compounding crises, not just COVID-19. As stated in the Management Action Record FY22, management has observed that the effects of IEG's evaluations often start long before the issuance of the formal report, as evaluation processes highlight key issues, spark new ways of thinking, and trigger real-time learning and adaptation. This is particularly true for this evaluation given IEG's effective collaboration with management in building the knowledge base to confront the crises. Most of the recommendations are therefore being internalized in existing engagements and the report will only help advance their implementation.

Management agrees with the first recommendation to use the World Bank's crisis recovery efforts to strengthen the resilience of essential health and education services to ensure that human capital is protected in a crisis. The World Bank is already working toward strengthening resilience of essential health and education services, including through operational design that better addresses the intersection of primary health care and pandemic preparedness and response, and through the sharing of experiences on mechanisms to strengthen telehealth and other relevant platforms for use in emergencies, and for education through evidence and innovations and an expanding portfolio in addressing learning losses and accelerating long-term learning.

Management agrees with the second recommendation to apply a gender equality lens to health and social crisis response actions across sectors. The World Bank's gender strategy and guidelines will continue to provide support and capacity building to country teams to implement these recommendations, making the report's findings operational. However, there is scope to do more, and HNP will leverage new opportunities to ensure a gender lens in its analytical and operational work, for example, through capacity building and knowledge exchanges to encourage more gender focused analytics; through support for the collection of gender-disaggregated data; by documenting lessons learned; and by developing a thematic paper to feed into the update of the gender strategy in 2023. The World Bank will also apply a gender lens to its strategic priorities (Global Solutions).

Management agrees with the third recommendation to help countries strengthen regional cooperation and crisis response capacities for public health preparedness. The World Bank's work to strengthen regional cooperation is articulated in both the position paper on pandemic prevention, preparedness, and response (which will be launched soon), and PPR Financial Intermediary Fund communications.¹⁰ The 20th Replenishment of International Development Association regional window would continue to support countries in this regard. The World Bank recognizes the need to find new ways to better engage civil society and increase stakeholder engagement, and it is also looking for opportunities to further strengthen platforms for coordination and to be more inclusive of civil society organizations.

Management also agrees with the fourth recommendation to build on the COVID-19 experience to strengthen the World Bank's internal crisis preparedness so that it has the tools and procedures ready to respond in future emergencies. Applying the lessons from COVID-19 and other crises, the World Bank will build on the experience of developing guidance notes for World Bank teams to operate more efficiently and effectively as it supports countries to strengthen capacities for pandemic PPR (including through PPR Financial Intermediary Funds), for example, by providing hands-on support for Environmental and Social Framework, promoting cross-country learning, and strengthening the monitoring and use of data on World Bank portfolios. Additionally, the World Bank has a long history of involvement working on global innovative financing mechanisms (for example, Treasury Manager for International Finance Facility for Immunization, and pneumococcal Advance Market Commitment), and is actively involved in dialogue with other partners. World Bank will explore further to shape and redesign global and regional financing instruments to be more "fit-for-purpose" during crises.

Reference

World Bank. 2021. "COVAX and World Bank to Accelerate Vaccine Access for Developing Countries" Press release no. 2022/006/HNP, July 26, 2021. <https://www.worldbank.org/en/news/press-release/2021/07/26/covax-and-world-bank-to-accelerate-vaccine-access-for-developing-countries>.

¹ For example, the report demonstrates what had been expected: that countries with stronger government leadership; investments in human capital and health system strengthening; prior pandemic and epidemic experience; and prior World Bank–related investment such as the Regional Disease Surveillance Systems Enhancement program and analytical work or both were able to mount a more effective response. Advisory services and analytics were critical for informing the design of COVID-19 operations and for a broader policy dialogue on immediate and longer-term responses (for example, the flagship paper on health financing challenges in developing countries *From Double Shock to Double Recovery—Implications and Options for Health Financing in the Time of COVID-19: Technical Update 2. Old Scars, New Wounds*).

² The Multiphase Programmatic Approach offered an umbrella approach with a menu of components and interventions that participating countries could adapt to their needs in line with the World Bank’s country-based model and strengthen to address subsequent stages of the response. This allowed projects to maintain some uniformity in content, with the added advantage of increased speed of design, processing, and approval, and a menu of indicators for countries to tailor to their individual circumstances.

³ The World Bank is a founding member of the Gavi Alliance, the vaccine alliance, and played an important role as an implementing partner of the Gavi Alliance even before COVID-19. The World Bank was part of COVID-19 Vaccines Global Access (COVAX) from its inception, and participated in decision-making on COVAX through the Gavi Board.

⁴ The Emergency Operations Center team prepared the following: A model Operational Manual in April 2020 that was translated into Spanish, French, Portuguese, and Russian to facilitate the start of implementation of Multiphase Programmatic Approach operations; “how to” guidance notes, including for processing retroactive funding requests; technical notes on several aspects of the health response and challenges that arose during the early months of the pandemic; regular weekly and bi-weekly global learning seminars that facilitated the cross-fertilization of knowledge among country officials, high level experts, and World Bank Group staff; and a template for Project Papers of AF-V operations (October 2020), later taken over by Operations Policy and Country Services.

⁵ Social Protection and Jobs Global Practice had a similar central resource hub with regional focal points, weekly (later monthly) meetings to provide advice to teams, extensive guidance material on a SharePoint site and a tracking system to monitor the Social Protection and Jobs response, which was used extensively for Senior Management briefings.

⁶ For example, women and girls bearing the burden of caring for the sick or of providing child and elderly care during the pandemic; losing jobs and being ineligible for a social safety net due to the informal nature of employment; and the importance of engaging women’s community groups to carry out knowledge dissemination and service provision.

⁷ External factors also played a role in the disruption of essential health services. For example, even when services were available, people were afraid to use them for fear of catching COVID-19; this was particularly true for services like childhood immunization. Although the report correctly identifies the gap in World Bank’s support for demand-side engagement of communities, this should be further qualified by noting that client governments have limited capacity to design and execute demand-side community engagement interventions in both emergency and nonemergency situations. In addition, governments’ and the World Bank teams’ limited attention to community engagement and continuity of essential health and education services should be understood in the context of an overwhelming pandemic with little understanding of virus behavior—and in the absence of proven preventive and treatment measures. The focus of the response was on early detection and containment through a test and trace strategy, along with wide-scale lockdowns to prepare health systems to handle the pandemic.

⁸ On March 16, 2022, the World Bank published its report *Walking the Talk: Reimagining Primary Health Care After COVID-19*, and has completed the latest flagship report *Change Cannot Wait: Building Resilient Health Systems in the Shadow of COVID-19—Investing in Health System Resilience for the Anthropocene*, which underscores the importance of pandemic preparedness and strengthening systems.

⁹ See Multiphase Programmatic Approach projects for Afghanistan, Papua New Guinea, India, Argentina, Ecuador, Indonesia, Haiti, Iran, Senegal, Somalia, and Ukraine.

¹⁰ See <https://www.worldbank.org/en/news/press-release/2022/09/09/new-fund-for-pandemic-prevention-preparedness-and-response-formally-established>.

Report to the Board from the Committee on Development Effectiveness

The *Committee on Development Effectiveness* met to consider the World Bank's *Early Support to Addressing COVID-19: Health and Social Response: An Early-Stage Evaluation* and the draft management response.

The committee welcomed IEG's findings and recommendations and management's constructive response and echoed their support for the World Bank's multifaceted and rapid response to the COVID-19 pandemic both in scale and also in quality. Members underscored their appreciation for the unprecedented World Bank's efforts and innovative work in the first 15 months of the pandemic (February 1, 2020, to April 30, 2021—the period covered by this evaluation) aimed at strengthening health systems, supporting country needs, prioritizing social protection for poor and vulnerable people, and facilitating knowledge sharing with client countries. They highlighted the operational processes and the number of financing instruments and modalities that enabled the rapid response. While recognizing the unprecedented global context, members however noted that the World Bank could have played a more decisive role at the global level, particularly on vaccines, and encouraged management to consider lessons learned from this experience and what could be done differently for a more robust crisis preparedness of the World Bank and client countries.

Members commended management for the innovations adopted in the World Bank's early response to the pandemic. They asked management to provide initial views on lessons learned including which approaches and tools should be retained and applied more systematically, and how the World Bank can promote continuous innovation in its work. They urged the World Bank to continue collaboration with development organizations and regional partners to coordinate interventions and achieve sustainable crisis response. Members also recognized the timeliness of the evaluation, given ongoing efforts to setup the Financial Intermediary Fund for Pandemic Prevention,

Preparedness and Response, and also its usefulness in informing discussions with country delegations on pandemic preparedness and crisis response at the 2022 Annual Meetings.

1 | Introduction

The evaluation answers the following question: What has been the quality of the World Bank's early COVID-19 response in countries in terms of saving lives and protecting poor and vulnerable people? The focus is on the first 15 months of the pandemic and the large-scale and rapid actions that took place during these months in a very uncertain global context.

Outcomes are not assessed; rather, the focus is on how the quality of the early response, design, processes, and outputs supported pathways to outcomes.

The evaluation's purpose is also to draw lessons from the World Bank's support in the early COVID-19 response to inform recovery efforts and future support for crisis preparedness.

Response

The World Bank Group quickly launched a large-scale response to help countries address both the health threat and the social and economic impact of the COVID-19 crisis. The support comprised three stages (relief, restructuring, and recovery) and four pillars (saving lives, protecting poor and vulnerable populations, ensuring sustainable business growth and jobs, and strengthening institutions for recovery). Country support was to be tailored to address needs and priorities across these areas. Institutional strengthening was to be undertaken from early in the relief stage to ensure sustained support to countries and maintain a clear route toward their longer-term development priorities. Attention to gender equality, digitalization, monitoring, evaluation, learning, and encouraging innovations was intended to cut across all the pillars (World Bank Group 2020b). The Bank Group support to a country was often part of a national COVID-19 response plan, developed in collaboration with the government, partners, and other country stakeholders.

In a highly uncertain context, the response was notably swift and unprecedented, with support provided to more than 100 countries: in February 2020, the Bank Group committed \$160 billion in financing for the COVID-19 response in fiscal years 2020 and 2021. The response was aligned with global actions of the World Health Organization (WHO) and other partners (figure 1.1). The total financing included about \$76 billion of World Bank commitments, of which about half supported the health and social response—the focus of this evaluation—in three of the four pillars (saving lives, protecting poor and vulnerable populations, and strengthening institutions for recovery). Other financing was for the economic response in sectors such as agriculture and governance and for the International Finance Corporation response, which are outside the scope of this evaluation. This all took place in a context with much uncertainty about the virus, vaccines, and how to best respond quickly and at scale, with information on the situation evolving daily. Key elements of the response included support through a Multiphase Programmatic Approach (MPA), new projects prepared through a fast-track facility, repurposing of existing projects, grant support from the Pandemic Emergency Financing Facility (PEF), and activation of existing crisis

instruments embedded in the portfolio. Although the pandemic continues to destroy lives with waves of infection occurring at different times and intensities across countries, even with deployment of effective vaccines, attention is moving toward coping with COVID-19 endemism, protecting vulnerable populations, and restructuring systems for recovery. This will shift the priorities in social and health sectors toward a return to stability and building back better to ensure future preparedness and protection of human capital.

Evaluation Purpose and Scope

Purpose

The evaluation provides an early assessment of the quality of the World Bank's COVID-19 health and social response to save lives and protect people living in poverty. Its purpose is to draw lessons to inform ongoing and future support for crisis preparedness and response. As the response is ongoing, the evaluation pays attention to processes, outputs, and pathways to outcomes, focusing on the relief stage and early support to restructure systems that can inform learning for recovery and future pandemic and crisis preparedness.

Figure 1.1. Global Milestones and Timeline of World Bank Group Response

Milestones in COVID-19		World Bank Group Response	
First COVID-19 case reported outside China WHO declares COVID-19 public health emergency	January 2020	Statement of support issued for COVID-19 outbreak in China	
First COVID-19 death reported outside China WHO finalizes its strategic preparedness and response plan	February 2020	Announces plan to mobilize resources, draft policy notes Commits up to \$160 billion in financing through June 2021; includes \$104 billion from IDA and IBRD	
WHO Global Preparedness Monitoring Board established World Bank calls for \$8 billion financing WHO declares COVID-19 a pandemic	March 2020	Convenes meetings of multilateral development banks and works with WHO Committees to coordinate response; creation of fast-track facility World Bank immediate financing \$12 billion, with IFC \$8 billion First countries (Mongolia, Samoa) receive financing	
Launch of United Nations supply chain task and ACT Accelerator Meeting of WHO emergency committee advises work on, among other areas, One Health and support to essential health services WHO drafts landscape of vaccine candidates	April 2020	HNP MPA with financing up to \$6 billion to a number of countries Suspended countries' debt service; convened a joint meeting with IMF to mobilize action; COVID-19 termed an unprecedented crisis PEF funds \$195 million; financing reaches more than 60 countries	
WHO Supply Portal launched World Health Assembly resolution to fight COVID-19	May 2020	First reports on COVID-19 governance, education, SPJ responses; emergency support reaches 100 countries	
More than 10 million cases	Global Vaccine Summit; first \$0.5 billion for COVAX AMC	June 2020	Commitment to work with COVAX facility
	COVAX secures engagement of more than 165 countries	July 2020	IFC launches \$4 billion financing to support health care

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	Milestones in COVID-19		World Bank Group Response
	Review committee on functioning of the International Health Regulations announced	August 2020	
More than 30 million cases	UNGA discussions on preparedness and response	September 2020	\$48 billion financing already committed for COVID-19 response
	UNICEF and WHO lead vaccine readiness assessment		
More than 40 million cases	Survey indicates disruption or halting of mental health services in 93 percent of 130 countries	October 2020	Approves \$12 billion additional financing for MPA on vaccines, tests, and treatment Annual Meetings discuss responses and addressing "IDA cliff"
	Interim guidance on national deployment and vaccination plans	November 2020	Vaccine readiness assessment of World Bank combined with WHO and UNICEF process Releases fact sheet on citizen engagement and stakeholder consultation during COVID-19
	UNGASS Special Session on COVID-19 response	December 2020	Report indicates school-related closures risk learning poverty
	Pfizer-BioNTech first vaccine to receive emergency use validation from WHO COVAX signs advance purchase agreement with Pfizer	January 2021	Lebanon: support to first vaccine purchase through reallocation in existing resilience project
	COVAX's first interim distribution forecast and first delivery of COVAX outside India to Ghana	February 2021	

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Milestones in COVID-19		World Bank Group Response
	Johnson & Johnson vaccine receives emergency use validation from WHO; report on virus origins published	March 2021 Launch of UNICEF, Johns Hopkins, and World Bank tracker measuring education impact
More than 150 million cases	Moderna vaccine receives emergency use validation from WHO; COVAX purchase agreement for 500 million doses	April 2021 Launch of early IDA Replenishment for recovery from COVID-19 Approved fund for vaccine rollout reaches \$2 billion
	COVAX delivers 38 million doses to 100 economies	
More than 3 million deaths	High-level independent panel releases recommendations to curb pandemic Launch of new One Health High-Level Expert Panel	May 2021 Migration and Development Brief states that remittance flows were resilient in 2020, with smaller decline than projected
	WHO adds Sinovac vaccine to its emergency use list G7 commits to sharing 870 million vaccine doses The United States plans to buy 500 million Pfizer vaccine doses to donate to more than 90 lower-income countries and African Union	June 2021 Initiates multilateral leaders task force Commitment to work with AVAT High-Level Advisory Group on Sustainable and Inclusive Recovery and Growth with IMF HNP report— <i>Walking the Talk: Reimagining Primary Health Care after COVID-19</i>
		July 2021 Rollout of new financing mechanism on advance market commitments with COVAX
	IMF approves \$650 billion in special drawing rights	August 2021 AVAT vaccine shipments begin with World Bank contribution
		September 2021 Bank Group role in future crises and GRID papers

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Milestones in COVID-19		World Bank Group Response
Only five African nations are on track to fully inoculate 40 percent of the population by the end of the year; the continent faces a shortfall of 275 million vaccine doses	October 2021	World Bank and IMF Annual Meetings 2021 Development Committee Communiqué for Bank Group, IMF, WHO, and World Trade Organization task force
WHO and the United States find that more than 22 million children missed a measles vaccine dose in 2020, the largest increase in 20 years	November 2021	Commits \$5.8 billion to vaccine support, enabling delivery of 20.2 million doses, with 245 million in pipeline; \$2.8 billion vaccine contracts signed
Omicron variant identified in South Africa; Africa experiencing 83 percent spike in new cases	December 2021	IDA Replenishment package of \$93 billion announced with new human capital and crisis preparedness cross-cutting issues

Sources: Barış et al. 2021; Dixon et al. 2021; Independent Panel for Pandemic Preparedness and Response 2021; KNOMAD 2021; Ravelo and Jerving 2022; Saavedra et al. 2020; WHO 2020a, 2020b, 2021b, 2022; World Bank 2020a, 2020b, 2020c, 2020d, 2020e, 2020f; World Bank Group 2021a, 2021b.

Note: ACT = Access to COVID-19 Tools; AMC = advance market commitment; AVAT = African Vaccine Acquisition Trust; COVAX = Country Access to COVID-19 Vaccines; G7 = Group of Seven; GRID = Green, Resilient, and Inclusive Development; HNP = Health, Nutrition, and Population; IBRD = International Bank for Reconstruction and Development; IDA = International Development Association; IFC = International Finance Corporation; IMF = International Monetary Fund; MPA = Multiphase Programmatic Approach; PEF = Pandemic Emergency Financing Facility; SPJ = Social Protection and Jobs; UNGA = United Nations General Assembly; UNGASS = United Nations General Assembly Special Session; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

Scope

The evaluation answers the following question: What has been the quality of the World Bank’s early COVID-19 response in countries in terms of saving lives and protecting poor and vulnerable people? The evaluation uses three lines of inquiry to answer this question (box 1.1).

Box 1.1. Three Questions That Guide the Evaluation

1. What has been the relevance of the World Bank’s early COVID-19 response to addressing the needs of countries in saving lives and protecting poor and vulnerable people (that is, the diagnosis, design, and tailoring of interventions to country situations)?
2. What has facilitated or hindered implementation of the World Bank’s COVID-19 responses in countries, and how is the World Bank supporting learning and adjustments?
3. How well are operational processes, instruments, and partnerships supporting the World Bank’s COVID-19 responses in countries?

Source: Independent Evaluation Group.

The evaluation focus is the health and social response during the first 15 months of the COVID-19 pandemic, from February 1, 2020, to April 30, 2021, and a portfolio of 106 countries. The evaluation looks to learn from the World Bank’s health and social support to countries most vulnerable to reversal of development and human capital gains because of COVID-19 (see appendix B for the portfolio identification). Five World Bank Global Practices (GPs) led the early support to countries: Health, Nutrition, and Population; Social Protection and Jobs; Education; Urban, Disaster Risk Management, Resilience, and Land; and Macroeconomics, Trade, and Investment. A concurrent Independent Evaluation Group (IEG) evaluation assesses the economic response to COVID-19.

The health and social support evaluation portfolio consists of an estimated \$30 billion of commitments to save lives and protect poor and vulnerable people in vulnerable countries, of which about \$11 billion (one-third) was committed by May 2020 (appendix B).¹ This includes \$27 billion in operational financing (\$15 billion International Development Association [IDA] and \$14 billion International Bank for Reconstruction and Development), \$1.5 billion in trust funds, and \$60 million in advisory services and analytics (ASA) commitments. Forty percent of this was disbursed in the first 15 months of the response, and about 20 percent was disbursed in the first three months, by May 2020. It is also estimated that there was \$1.54 billion in Contingency Emergency Response Component (CERC) commitments from other GPs allocated to the health and social response not covered by the portfolio. The Human Development GP led these commitments. During the early response, Health, Nutrition, and Population had five times more projects approved and managed about 600 percent more in annual allocations, spread across small projects (about 43 percent smaller on average than other health projects) with short durations of two to three years. Social Protection and Jobs almost doubled the number of projects approved, whereas Education had about 56 percent more projects. For other GPs, lending activity increases were more limited during the early response to COVID-19, whereas lending in areas such as Agriculture and Food increased in the second year of the response.

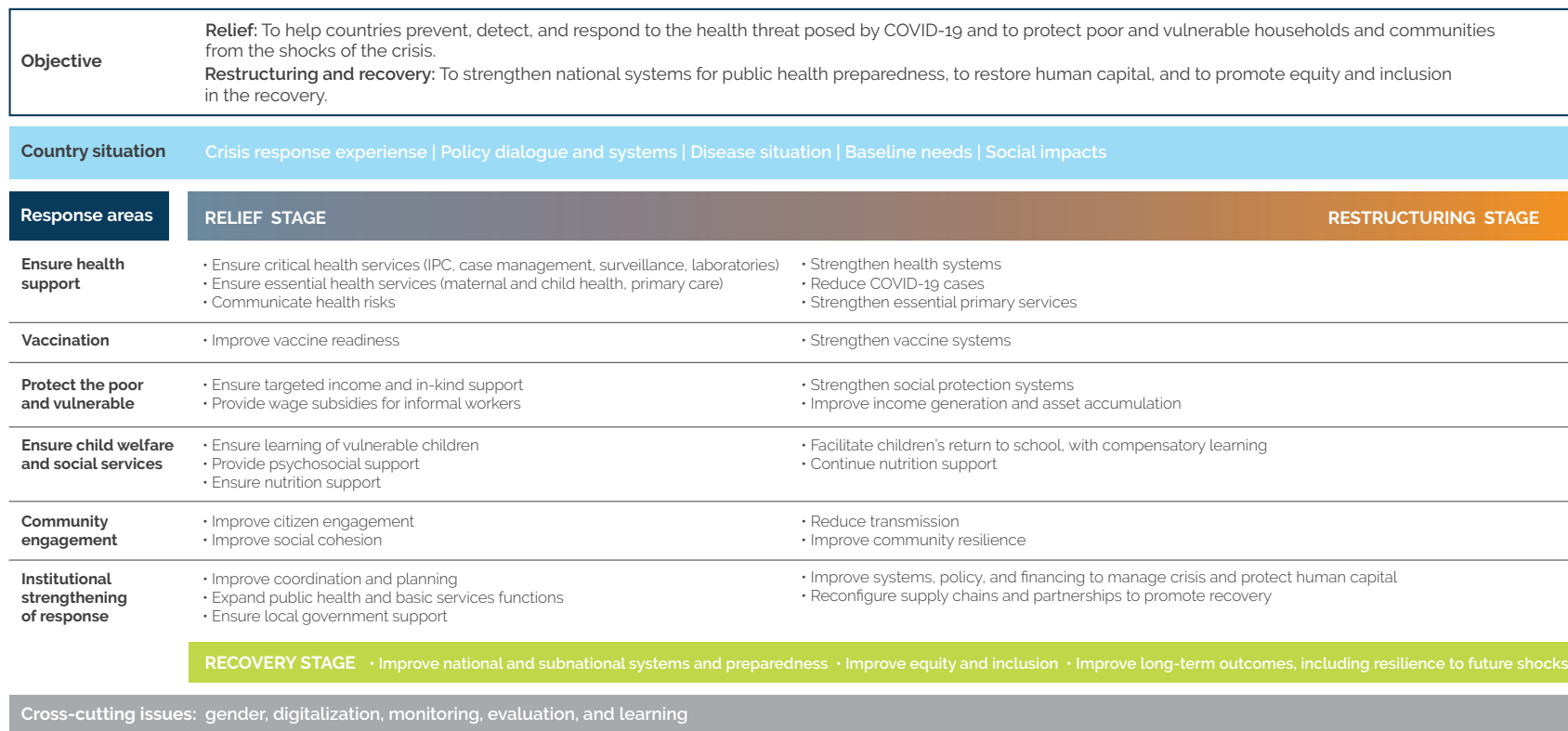
The evaluation portfolio focuses on countries with moderate to high vulnerability to development losses because of the impact of COVID-19.² It emphasizes support to less-prepared countries, small states, countries with fragile and conflict-affected situations (FCS), and countries at risk of human capital losses (appendix B). Most financing commitments were allocated to less-prepared countries with pressing needs. Commitments in these countries included support of new projects and repurposing of existing projects and ASA to support the crisis response. Small states received about \$26 million per million population in the COVID-19 response compared with about \$6 million for other countries. FCS countries received \$9 million per million population. New project support focused on countries with lower levels of human capital in Africa and South Asia that included countries with high vulnerability to development losses as a result of COVID-19.

Evaluation Design

Conceptual Framework

The conceptual framework defines the thematic areas and stages of support within the scope of the early COVID-19 response assessed by the evaluation (figure 1.2 and box 1.2). The framework is based on the Bank Group's COVID-19 response framework (World Bank Group 2020b). The conceptual framework supports a theory-based approach that models the interlinked elements of the health and social response, with the current evaluation focusing on the early World Bank response in the relief and initial restructuring stages.

Figure 1.2. Conceptual Framework for COVID-19 Health and Social Response



Source: Independent Evaluation Group. Adapted from World Bank Group 2020b to focus on the health and social aspects of the COVID-19 response.

Note: IPC = infection prevention and control.

Box 1.2. The Logic of the Conceptual Framework

The conceptual framework outlines the elements of the World Bank's health and social support for COVID-19, which are the focus of the evaluation. These elements are anchored in three pillars of the World Bank Group response (saving lives, protecting poor and vulnerable populations, and strengthening institutions for recovery). The framework expresses interlinked elements to respond to the health and social shocks of COVID-19 regarding:

- » The progression of the response through the three stages (relief, restructuring, and recovery)
- » The menu of areas that could be operationalized through World Bank support and tailored to needs in the country context
- » The types of results expected at each stage to respond to the health threat and protect human capital, from early outputs and processes to longer-term outcomes for recovery
- » The integration of institutional strengthening from the early response to improve capacities to manage crises and build more resilient systems to protect against future shocks, including supporting coordination and planning, expanding public health functions (such as disease surveillance), and strengthening local services
- » The cross-cutting areas important to effective implementation in a country (gender equality, improvements to digitalize systems, and monitoring, evaluation, and learning)

The evaluation assesses the World Bank's health and social support to the early relief stage and initial restructuring stage of COVID-19. The relief stage concentrates on responding to the immediate health and social shocks of COVID-19. In health, relief stage is intended to ensure the supply of critical health services (infection prevention and control, case management, surveillance, and laboratories), early readiness for vaccines, and health risk communication. Continued access to essential health services for primary care of vulnerable groups was also important. The health response is intended to be coupled with tailored support to address social shocks as a result of COVID-19 and to protect accumulated human capital.

(continued)

Box 1.2. The Logic of the Conceptual Framework (Cont.)

In the relief stage, the social emergency response aims to ensure social protection for poor and vulnerable groups, continued child welfare (access to learning and nutrition), psychosocial services for mental health, community and citizen engagement, and social cohesion support for the demand-side aspects of the response. Vulnerable groups include the elderly, people with underlying conditions or comorbidities, poor and marginalized populations, and women and children.

The restructuring stage can overlap with and follow the relief stage. Restructuring stage support seeks to strengthen systems and policies for public health preparedness and restoring human capital. The restructuring stage in the health response seeks to strengthen health systems, vaccine delivery, and essential health services. The social response seeks to improve social protection systems, education systems, and community resilience.

The recovery stage had yet to be reached in the early COVID-19 response, but relief efforts and some initial restructuring are intended to be put in place as building blocks to transition to this stage. The recovery stage is intended to apply the learning from the COVID-19 response to ensure pandemic-ready health systems; improve equity and inclusion through better access to health, education, and social services; and enhance policies that protect human capital.

Source: Independent Evaluation Group.

Methodology

The evaluation adopts a multilevel analysis and a mixed methods approach that combines quantitative and qualitative evidence. It follows a consultative approach to inform the analyses and a modular approach to share preliminary findings. Throughout the evaluation, there was engagement with World Bank GP management and project teams, operational support units, country management, and technical experts to discuss analyses, share preliminary findings, and receive feedback. These consultations are important because the evaluation focuses on an active and evolving portfolio.

Theory of Action

The evaluation's theory of action outlines the dimensions for the assessment of the quality of the World Bank's early COVID-19 response (figure 1.3).

The theory of action aligns with the evaluation questions and complements the conceptual framework. It posits three interrelated areas that define the quality of the response, each with specific dimensions for which the evaluation gathered and triangulated evidence:

- » **Support to needs** looks at the relevance of the World Bank's large-scale early response to help address the immediate health threat of COVID-19 and to protect vulnerable groups against human capital losses.
 - » *Dimensions:* Responsiveness of World Bank support to health and social needs of countries, addressing gender, building on existing human capital capacities, alignment with COVID-19 plans in countries, reorientation of projects in the portfolio, prioritization of support in the portfolio to focus on key areas within needs and vulnerable groups, use of knowledge work to inform needs, and integrating institutional strengthening and support to build resilient systems for recovery
- » **Implementation and learning** looks at factors that facilitated and hindered the World Bank early response in countries, which can provide proxy evidence of early results, and how there has been learning and adjustment to strengthen the response.
 - » *Dimensions:* Implementation status of the response, factors facilitating implementation, early results, anchoring of support in lessons and evidence from past crises, and emphasis on innovation, learning, dialogue and coordination with the government and other stakeholders in countries, use of data and other inputs to make course corrections to ensure a strong mix of support to countries, and regional knowledge sharing
- » **Operational policies and partnerships** looks at how well World Bank internal process, instruments, and partnerships supported a smooth and speedy early response.

- » *Dimensions*: World Bank internal coordination, the mix of instruments supporting the response, streamlined operational processes, internal reporting and monitoring, and development partnerships including PEF and vaccines support.

Figure 1.3. Theory of Action to Assess the Quality of the Early COVID-19 Response



Source: Independent Evaluation Group.

Levels of Analysis

The assessment of quality and lessons arise from triangulating evidence gathered by different evaluation components at the country, portfolio, and corporate levels. The evaluation uses a mix of methodological applications to ensure construct, internal, and external validity and reliability of findings through a transparent methodological design, with clear justification of choices made (see appendix A for the evaluation methodology). Box 1.3 describes the evaluation components.

Box 1.3. Evaluation Components at Each Level

At the country level:

- » Eight country case studies provided in-depth evidence on the COVID-19 response in specific contexts (Djibouti, Honduras, India, Mozambique, the Philippines, Senegal, Tajikistan, and Uganda). The team reviewed World Bank projects and analytic work, and interviewed staff, government officials, and representatives of civil society (appendix C).
- » A review of country situations was conducted to develop a heat map to understand the needs of countries early in the COVID-19 pandemic, analyze the extent of addressing these needs in countries in the portfolio, and identify factors that facilitated satisfactory implementation of World Bank support. The analysis used portfolio data on World Bank projects and advisory services and analytics supporting COVID-19 and publicly available health and social data on country indicators relevant to areas of the conceptual framework of the evaluation (appendix D).
- » A rapid review of the literature synthesized evidence on effective crisis interventions from systematic reviews and country studies of past epidemic and crises to benchmark World Bank support. The review synthesized existing evidence from the literature on 50 crisis interventions. The findings were used to understand the alignment of interventions supported by the World Bank's early COVID-19 response with the available evidence base (appendix E).
- » A review of past crisis response projects benchmarked successes and challenges from these projects against the early COVID-19 response. The evaluation synthesizes lessons from 170 closed projects where the World Bank responded to crises in the past 20 years (appendix F).
- » A review of regional projects assessed the early results of disease-focused projects for COVID-19. Interviews and document review were used to understand the value added of four disease-focused regional projects to help advance early results of COVID-19 responses in countries (appendix G).
- » A stocktaking analysis identified innovations to understand how the World Bank undertook new actions to support the COVID-19 context. The innovations were identified through a crowdsourcing survey of country teams, review of the

(continued)

Box 1.3. Evaluation Components at Each Level (Cont.)

project portfolio supporting COVID-19, a review of innovation stories published by Global Practices, and as part of the analysis of the eight case studies conducted for the evaluation.

At the portfolio level:

- » An analysis of operational financing projects and advisory services and analytics supporting the early COVID-19 response was conducted, including analyses of monitoring of the response and procurement. The evaluation undertakes a systematic document and data review focused on internal databases and coded information on a portfolio of COVID-19 projects (appendix B).
- » An analysis of projects under the Multiphase Programmatic Approach led by Health, Nutrition, and Population was conducted. The analysis uses data from the evaluation portfolio, case studies, regional project analysis, and innovation stocktaking to review Multiphase Programmatic Approach projects in the first year of the response—projects approved by April 30, 2021 (appendix H).

At the corporate level:

- » A review of internal processes and partnerships sought to distill lessons and findings on how the World Bank's COVID-19 internal coordination and collaboration, financing instruments, operational processes, partnerships, knowledge support, digital tools, and monitoring and reporting guided and supported the early COVID-19 response. The review was based on information from document review and individual or group semistructured interviews.

Source: Independent Evaluation Group. The stocktaking of innovations is available in World Bank 2022a.

Limitations

An important limitation of the evaluation is the dynamic nature of the COVID-19 situation and World Bank response, and the overlap of the evaluation with the ongoing response implementation. The World Bank was adapting the response during implementation to improve its actions, given

the evolving and uncertain global and country-level contexts of COVID-19. Moreover, interviews were challenging because of the high number of COVID-19 cases in some countries, the burden of the pandemic on health sector personnel, and illness and personal losses of interviewees as a result of COVID-19. Although the evaluation analyses estimate early support and financing in the countries covered by the portfolio, a rapid update of the portfolio was done at the end of the evaluation to gauge shifts in support as the portfolio continued to evolve throughout the evaluation timeline. A future later-stage evaluation is proposed to look at the effectiveness of the response. Appendix A also outlines limitations of specific methods of the evaluation.

Structure

The report structure is based on the theory of action of the evaluation. Each chapter highlights evidence on early support to countries to effectively respond to the health and social shocks of COVID-19 and to start a process to strengthen systems and policy for better crisis preparedness and protection of human capital. Chapter 2 looks at the extensive scale of the World Bank support and its relevance to needs of countries. Chapter 3 covers the implementation successes and challenges of the World Bank's early support to countries, which can point to early results, and how the World Bank has adapted and learned during implementation. Chapter 4 covers how well operational policies and partnerships facilitated a smooth and speedy response. Chapter 5 synthesizes key areas of learning from the evaluation, which can inform future preparedness, and presents recommendations for the way forward.

¹ An in-depth analysis of COVID-19 commitments and financing allocations is outside the scope of the current evaluation. The evaluation provides an estimate from available data on the portfolio for the time period, countries, and Global Practices covered by the analysis.

² The Inform COVID-19 Risk Index was used to categorize countries based on their vulnerability to development achievements being offset by the pandemic. The evaluation adjusted the index to consider the country's human capital index, given concerns surrounding losses of human capital in countries. The countries were then separated into quartiles based on their vulnerabilities to development and human capital losses (very high vulnerability, high vulnerability, moderate vulnerability, and low vulnerability). Appendix B includes a list of the countries in the portfolio by vulnerability quartile. The Inform COVID-19 Risk Index includes dimensions of social inclusion (such as gender inequality and poverty), economic vulnerability, governance and institutional capacity, health systems capacity, environment, and population risks (such as access to sanitation and population mobility and density; Poljanšek, Vernaccini, and Marin Ferrer 2020; World Bank 2020f).

2 | Quality of Response: Relevance

World Bank financing quickly expanded emergency support to critical health services and social protection to respond to countries' needs in a context of uncertainty.

Support to essential health services, child welfare, community engagement, and particularly protection of women and girls from the shock of COVID-19 were less prominent in early response actions.

The response was quicker and more comprehensive where the World Bank built on existing policy dialogue, analytic work, and support to human capital development, yielding a strong return on earlier investments in human capital.

World Bank support aligned with COVID-19 strategies of health ministries. In the few cases where countries planned support involving multiple sectors, integrated emergency health planning helped ensure relevant support for human capital needs.

Repurposing existing World Bank operations in country portfolios and adding new support helped mobilize surge capacities across sectors to quickly address needs during the crisis response.

Countries with existing health preparedness and health system capacities were well placed to use World Bank support to take rapid actions. Across countries, there were progressive efforts to prioritize actions for vulnerable groups and to protect human capital.

The integration of institutional strengthening brought a longer-term focus on rebuilding health, education, and social protection systems into the early response, but countries have yet to develop strategies to sustain efforts and prioritize preparedness actions.

This chapter assesses the quality of the World Bank’s support in terms of its relevance to addressing country needs in saving lives and protecting poor and vulnerable people during the early COVID-19 response. The assessment is based on dimensions of quality from the theory of action in figure 2.1.

Figure 2.1. Dimensions Assessed for Quality of Support to Need



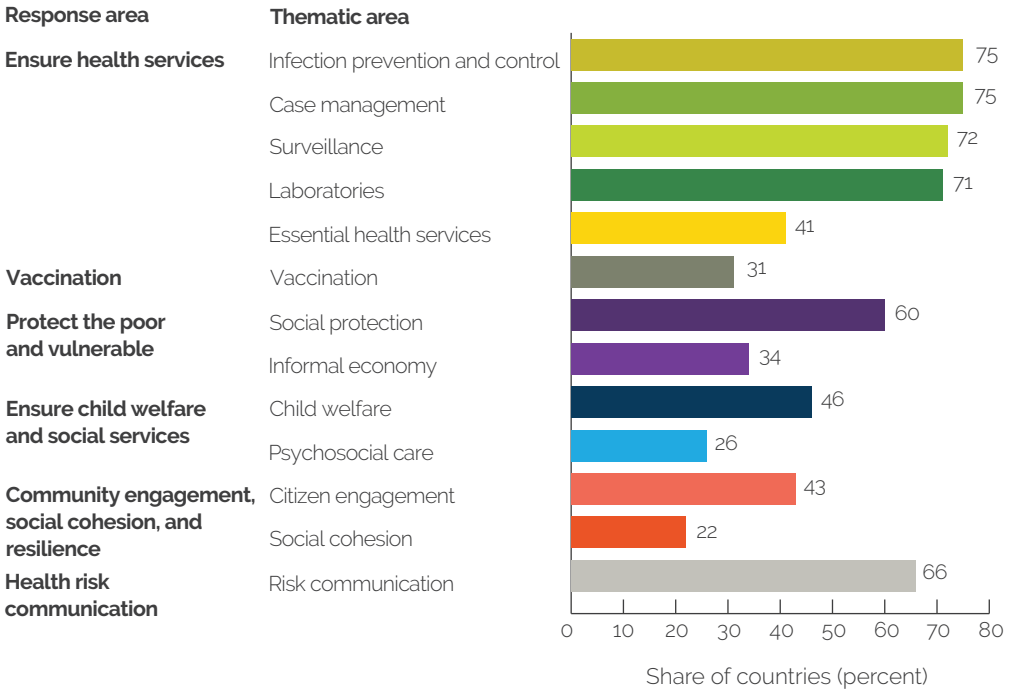
Source: Independent Evaluation Group portfolio.

Addressing Health and Social Needs

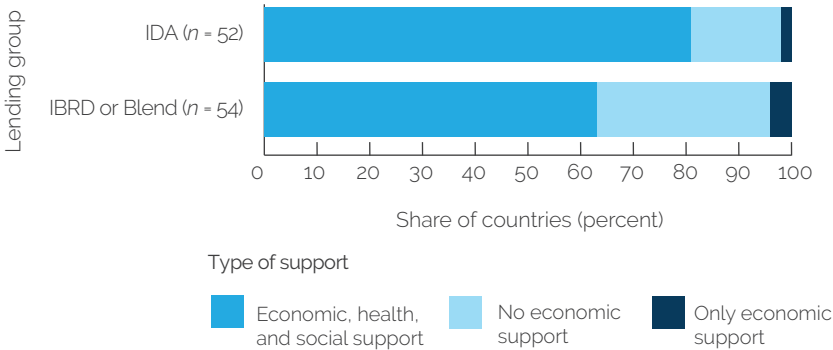
In a context of uncertainty, the World Bank’s support in the early COVID-19 response helped quickly expand critical health services and social protection across countries. More than 80 percent of countries in the evaluation portfolio received support for critical health services, and 67 percent received support to protect poor and vulnerable persons (social protection and informal economy support). Support largely focused on the delivery of critical health services, including infection prevention and control, case management, surveillance, and laboratories, and on the expansion of social protection for vulnerable groups, including income support and food support (figure 2.2, panel a). The extensive expansion of social protection during COVID-19 is an improvement from the global financial crisis where the challenges in expanding country social protection systems limited the response (World Bank 2012). Recent studies have shown that the expansion of social protection helped mitigate food insecurity and reduce increases in poverty (Gentilini 2022). The pandemic has had a highly unequal economic impact (World Bank 2022c)—the economic support complemented health and social interventions in about 72 percent of countries (figure 2.2, panel b). As noted in chapter 1, the analysis of the economic response is part of another IEG evaluation focused on COVID-19 and is outside the scope of this evaluation and is covered in a parallel IEG evaluation.

Figure 2.2. Areas of Health and Social Response Support in Countries

a. Areas of health and social response support in countries



b. Balance of health and social support with economic support in countries



Source: Independent Evaluation Group portfolio.

Note: Data in both panels are based on 106 eligible countries. Panel a covers the 253 projects in the portfolio. In panel b, support is based on 567 crisis response projects that were active at any point between February 1, 2020, and April 30, 2021. In panel b, economic support is estimated to have been provided for (i) countries where the World Bank provided support to the COVID-19 economic pillar of the World Bank's response or (ii) countries where the World Bank provided support to the COVID-19 institutional strengthening pillar of the response led by Global Practices outside the Human Development Practice Group. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

In the early response, the emphasis was on critical health services, disease prevention and control, and social protection and was aligned with most of the immediate needs to respond to the health and social shocks of COVID-19. The needs analysis shows that about 60 percent of countries' needs identified at the onset of COVID-19 were addressed by the World Bank's support (figure 2.3); in about 45 percent of countries, there was a very high alignment with country needs (appendix D).

In the early response, there was less attention to child welfare and demand-side engagement of communities. Less emphasis was given to continuing child learning and nutrition when schools and services in communities were closed. Demand-side investments in the community response, in areas of social cohesion and citizen engagement, were also limited (figure 2.2, panel a). Risk communication was planned in two-thirds (66 percent) of countries, but case studies found that the intensity of these activities was limited early in the response. Psychosocial care, essential health services, and vaccines also received less emphasis. Examples of interventions can be found in countries in each of these areas, for example, projects in the Democratic Republic of Congo and Sierra Leone both planned in-depth support to build community trust based on lessons learned from the previous Ebola outbreak. Evaluations conducted by governments and other multilateral organizations identify similar challenges of limitations in support to child welfare, community engagement, and risk communication early in the COVID-19 response (Johnson and Kennedy-Chouane 2021; OECD 2022; DPME, GTAC, and NRF 2021). Box 2.1 describes the main types of interventions in the early health and social response covered to different extents across countries.

Box 2.1. Examples of Health and Social Support for the Early COVID-19 Response

Health response:

- » Case management: equip and repurpose health facilities with ventilators, oxygen cylinders, and isolation and quarantine units to care for patients with COVID-19
- » Essential health services: finance supply logistics for essential medicines and telehealth to minimize disruptions to health service delivery

(continued)

Box 2.1. Examples of Health and Social Support for the Early COVID-19 Response (Cont.)

- » Infection prevention and control: equip health workers with medical masks, N95 masks, gloves, eye protection, gowns, hand sanitizer, and other hygiene materials and help facilities develop infection prevention and control protocols
- » Laboratories: train laboratory staff, update and set up laboratories, and coordinate management of testing data and specimens
- » Surveillance: strengthen community and event-based surveillance for COVID-19, assess risk, and monitor and evaluate the effectiveness of activities to reduce transmission
- » Health risk communication: execute communication strategies and campaigns and assess messages for population segments, such as the elderly and vulnerable groups
- » Vaccination: equip countries through procurement and distribution of vaccines and essential equipment, such as syringes, cold chain, and vaccine carriers

Social response:

- » Child welfare: implement safe school reopening plans with sanitation and hygiene protocols, teacher professional development programs, and continuity of child learning
- » Psychosocial care: establish telepsychiatry systems, toll-free mental health hotlines, and psychosocial support for those in isolation
- » Informal economy: implement public works projects, job training, and informal apprenticeships and improve information systems for informal economic activities
- » Social protection: provide emergency cash transfers to vulnerable households with an emphasis on women, and pension schemes for the elderly and people with disabilities
- » Citizen engagement: engage nongovernmental organizations to monitor COVID-19 response, community-based early-warning networks, and SMS communication on services

(continued)

Box 2.1. Examples of Health and Social Support for the Early COVID-19 Response (Cont.)

- » Social cohesion: execute campaigns on gender-based violence, support girls to prevent dropouts, and support community groups and projects to promote behavior change

Source: Independent Evaluation Group portfolio analysis.

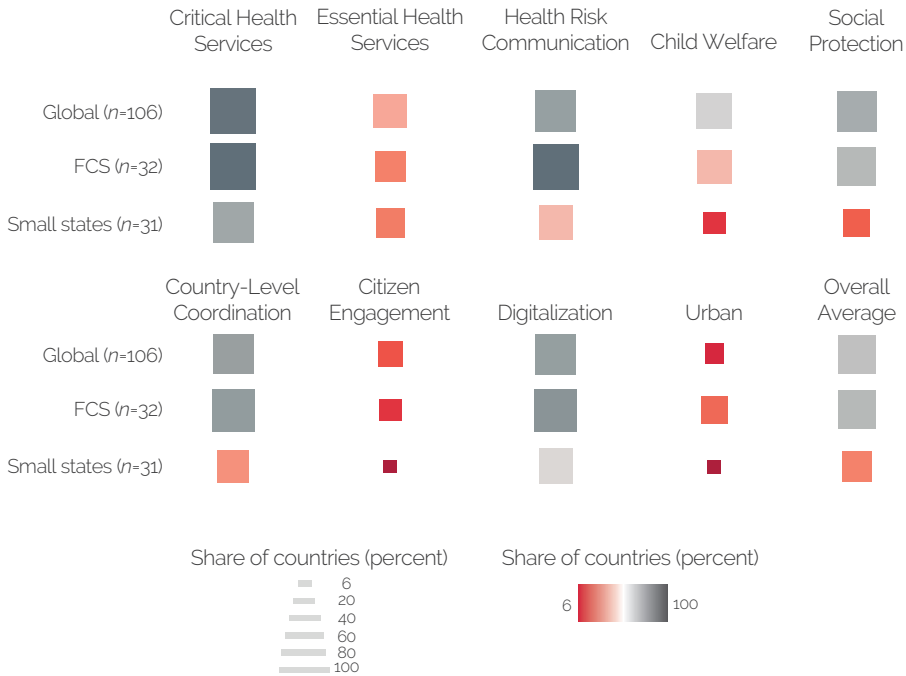
Note: Economic response interventions that complemented the health and social response are covered by another Independent Evaluation Group evaluation. SMS = short messaging service.

About half of countries complemented emergency support with early response actions in essential health services for maternal and child health and education to protect human capital. Other countries had limited early emphasis on essential health services and education, key for protecting human capital, especially FCS countries and small states (figure 2.3). A challenge was the lack of preparedness of countries to quickly take actions to address needs to continue essential health and education services in communities in a crisis and support urban risks, especially for vulnerable groups and in countries with weak capacities to deliver services (box 2.2). Case studies and the portfolio review highlight that MPA's investments in critical health services likely had some spillover effects that supported essential health services. For example, in India and Haiti, the increased infection prevention and control, oxygen, laboratory, and surveillance capabilities likely helped strengthen health systems and networks to deliver services.

- » In health, attention to continuing essential health services in the early response was challenging with governments requiring urgent support to expand critical health services for COVID-19 case management—needs in these areas were only met in about 48 percent of countries, which contributes to development losses in maternal and child health, especially for vulnerable groups (GFF 2021; World Bank 2022). Efforts to continue health services were later added to strengthen the COVID-19 response in some countries, building on existing health projects, where available.
- » Regarding COVID-19, identified needs related to urban risks for the spread of the virus, such as in slums, were addressed in about 16 percent of countries.

» In education, where the government requested it, World Bank support helped quickly expand remote learning nationally across countries; however, needs to protect against learning losses were vast, with economic losses estimated in the trillions of dollars (Global Education Evidence Advisory Panel 2022). World Bank education interventions met needs in about 55 percent of countries.

Figure 2.3. Alignment of Project Portfolio with Identified Country Needs



Source: Independent Evaluation Group portfolio and needs analysis.

Note: The figure shows the percentage of countries with needs in areas where the World Bank supported interventions. A need is defined as the underlying needs variable in an area falling in the bottom 50 percent of its distribution across countries. Interventions are based on the analysis of 203 projects coded for the evaluation in 89 countries that had data on needs and World Bank support. Red shading indicates that needs were addressed in less than 50 percent of countries. Gray shading indicates that needs were addressed in 50 percent or more of countries. Small states follow the World Bank definition. Data to assess the need for critical health services, risk communication, and country-level coordination use International Health Regulations data on capacities in the country before COVID-19; needs for essential health services, social protection, community engagement, digitalization, and urban support use data on access and vulnerabilities in these areas from the INFORM COVID-19 Risk Index. Appendix D describes the needs analysis. FCS = fragile and conflict-affected situation.

Box 2.2. Key Areas to Strengthen Preparedness to Address Needs in Crisis Response

Health preparedness: Comprehensive support was necessary to ensure both critical health services for preventing the spread of disease and essential health services for protecting against health-related human capital losses of women and children. World Bank support to help countries address these needs in an integrated manner was a lesson from the Ebola crisis and could have helped strengthen response efforts. The case studies and country situation analyses (appendixes C and D) show that the focus on the health emergency diverted attention from essential health services, such as maternal and child health care for vulnerable groups. Health systems were not prepared to continue essential health services during the crisis, given the need for surveillance and case management for COVID-19. Moreover, the intensity of support to frontline health workers and communities for risk communication was limited. Disruptions in the use of essential health services as a result of COVID-19 caused a secondary crisis in some countries, with drops in key maternal and child health indicators. Nutrition was also missed to protect child welfare.

Urban preparedness: Few countries with needs at the onset of COVID-19 in terms of urban risks for the spread of disease were prepared with relevant World Bank sanitation and health support for vulnerable populations, such as in slums.

Education preparedness: Case studies and the portfolio show good support to expand learning for children in countries receiving such support. The challenge was the limited coverage of this support across countries in the early response. Moreover, the education sector was underprepared for the situation and lacked a strategy to prevent learning losses among vulnerable groups and girls. Partly, this may be because the sector was often not part of previous multisector crisis response planning. The consequence is a worsening crisis with girls out of school and learning outcomes potentially reduced.

Sources: GFF 2021; Global Education Evidence Advisory Panel 2022; Independent Evaluation Group portfolio; World Bank 2021e.

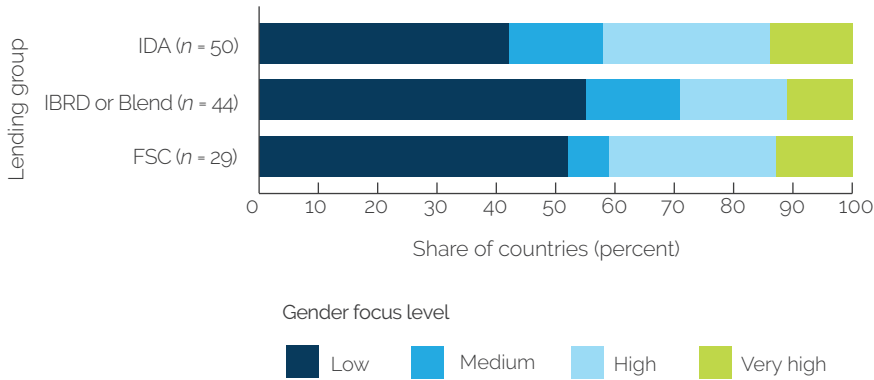
Addressing Gender

The World Bank's preparedness to help protect women and girls from the shock of the COVID-19 crisis varied across countries. About half of countries had medium to very high World Bank support for gender equality, with more than 25 percent of projects in the portfolio addressing gender to some extent as part of their crisis response. The greater focus on gender in IDA and FCS countries was promising (figure 2.4). Support to protect women and girls was key to ameliorate impacts on health workers (often women), women caring for children, and adolescents, especially girls. For example, countries are concerned about adverse pregnancy outcomes, school dropouts, early marriage, and pregnancy, which may have adverse long-term consequences (Barış et al. 2021; Nieves, Gaddis, and Muller 2021; World Bank 2022b). However, psychosocial support, sexual and reproductive health, income and asset accumulation, reduction of gender-based violence, continued learning for girls, and community engagement were areas of limited support identified as important in past lessons (Gold and Hutton 2020; World Bank 2021e) and evidence (appendix E). The Social Protection and Jobs GP has shown the strongest address of gender issues as a core element of social protection support (about 95 percent of projects supported gender). Gender-related support of other GPs was limited; however, all GPs focused more on gender in FCS countries compared with other countries, which is promising. Evaluations from other multilateral and bilateral development organizations highlighted that addressing gender in a crisis requires building on existing approaches and systems already in place (Johnson and Kennedy-Chouane 2021; Vancutsem and Mahieu 2020). Examples of positive outliers are countries that built on their earlier experiences responding to gender equality challenges and received hands-on support:

- » In Kenya, gender-based violence increased during COVID-19. Joint work between the Social Sustainability and Inclusion and Health, Nutrition, and Population GP teams sought to enhance the quality of gender-based violence services, with a focus on care and treatment by health-care providers, data collection and analysis, health sector systems for response, and the safety of female frontline health workers.

- » In India, women’s organizations helped ensure the availability of personal protective equipment. Engaging these self-help groups, which have had a long history of World Bank support, ensured the provision of personal protective equipment in communities and directly benefited female-headed households.

Figure 2.4. Extent of Gender Equality Support in Country Portfolios



Source: Independent Evaluation Group portfolio.

Note: Gender focus is defined as the share of projects in a country that were designed to address determinants of gender equality. Gender focus levels: Very low = 0 to 24.9 percent of World Bank projects in the country supporting COVID-19, medium = 25 percent to 49.9 percent of projects, high = 50 percent to 74.9 percent of projects, and very high = 75 percent to 100 percent projects. The figure excludes three countries with only regional projects (Grenada, St. Lucia, and St. Vincent and the Grenadines). N = 94 countries. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association; FCS = fragile and conflict-affected situation.

Building on Human Capital Capacities

Previous World Bank support to human capital helped ensure that countries were prepared to respond to needs for the COVID-19 response. Previously developed relationships in human development sectors, ongoing policy dialogue, and earlier investments in human development systems were a good basis on which COVID-19 project support was built. The country needs analysis for the evaluation (appendix D) found that medium to high levels of previous support to human capital development in health, social protection, and education made it almost 1.5 times more likely that the country would address health and social needs during COVID-19 at high or very high levels.¹ The strong return on previous investments in human development

systems helped build resilience in countries. For example, sustained investments countries made in their social protection systems in digital payments and social registries were used by the World Bank's COVID-19 support, for example, in India, Jordan, and Morocco. Areas not addressed in the response were often those with limited attention before COVID-19, such as to address urban health risks, psychosocial care, and remote platforms to monitor community services. Case studies show that World Bank country programs with a long history of support and policy dialogue in a sector were well-situated to support the government to quickly draw on existing health and social investments for a fast response to COVID-19. For example:

- » World Bank projects in Djibouti expanded on education sector networks of teachers and parents' groups in communities to support remote learning. This reinforced a new platform to help learning in the sector.
- » World Bank programs in India and Tajikistan built on earlier analytic work and projects in social protection to help the government rapidly expand national social protection systems to mitigate COVID-19 shocks.
- » Senegal drew on its multisectoral One Health platform developed through earlier World Bank and partner investments to assist the COVID-19 response. The World Bank's support to COVID-19 was able to reinforce this platform quickly and help multisectoral coordination of actions.
- » World Bank teams supported the government in Uganda in fast-tracking planned reforms in the water sector to create an umbrella organization of service providers to help improve water access in local areas during COVID-19.

Alignment with Country Plans

Early World Bank support was well aligned with COVID-19 health responses in countries, with some complementary support to responses of other sectors. Country COVID-19 response plans often focused on emergency critical health and social protection support. Country responses aligned with WHO guidance (box 2.3). Other responses were fragmented across ministries, with each sector leading its own actions with limited communication across sectors. Where support was identified by the sector as important, World Bank

teams often provided support. For example, in Djibouti, Senegal, and Uganda, the World Bank supported education sector strategies to expand remote learning. In Uganda, the World Bank also supported agriculture sector strategies to expand nutrition support and inputs to farmers for planting materials, and areas such as child protection policy, water services, and local government services based on government requests.

Where there was integrated cross-sector planning of health and social response actions, World Bank teams could support needs more comprehensively. Based on experiences in India and Senegal, among others, the integrated planning of health and social response support across sectors— involving health, education, social protection, government, agriculture, water, and so on—shows potential to improve crisis planning to address needs more comprehensively (appendix D). For example, in Senegal, coordinated planning across sectors (including health, social protection, agriculture, water, and others) allowed sectors to take on strategic roles in the response to cover a wide range of emergency and human capital needs.

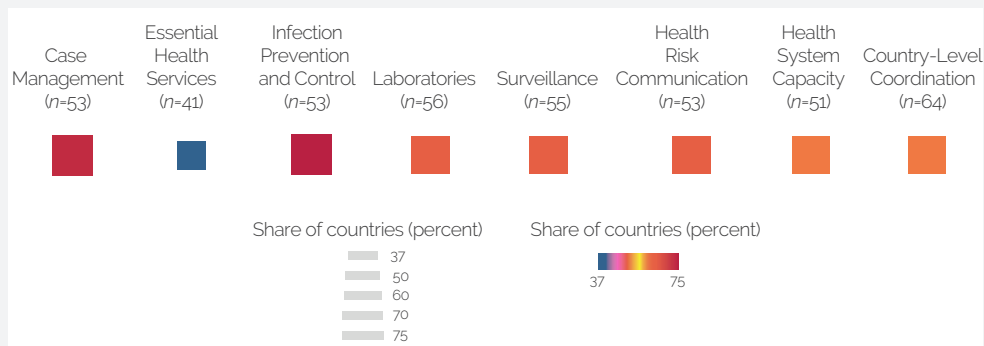
Box 2.3. Alignment of COVID-19 Support with Health Response

The World Bank's early support aligned with national COVID-19 plans, which covered countries' emergency health responses, typically in alignment with World Health Organization (WHO) guidance on strategic preparedness and response areas based on International Health Regulations (WHO 2021a). About 70 percent of priority areas in national COVID-19 health responses were supported by the World Bank. Figure B2.3.1 shows the alignment of World Bank support with country COVID-19 health priorities. The main area with limited support was essential health services because this was added to WHO's global guidance later in the response, through discussions with the World Bank and other partners. Aligning with WHO guidance was critical for coordination with partners to support countries, but health responses were often not well integrated with responses of education, water, agriculture, and other sectors to help address broader needs of countries to protect human capital and vulnerable groups.

(continued)

Box 2.3. Alignment of COVID-19 Support with Health Response (Cont.)

Figure B2.3.1. Alignment of World Bank Support to Health Priorities in Country COVID-19 Plans



Sources: Independent Evaluation Group portfolio; country COVID-19 plans from World Health Organization action checklists (WHO 2021d).

Note: Early World Bank health support provided limited coverage of vaccination, given the priority of prevention and control in early COVID-19 plans. Vaccination committees were set up in countries in the later months of 2020 and in early 2021. The figure shows the percent of countries that had World Health Organization plans in a response area and received at least one World Bank intervention in that area. The analysis covers 66 countries with complete data on COVID-19 plans.

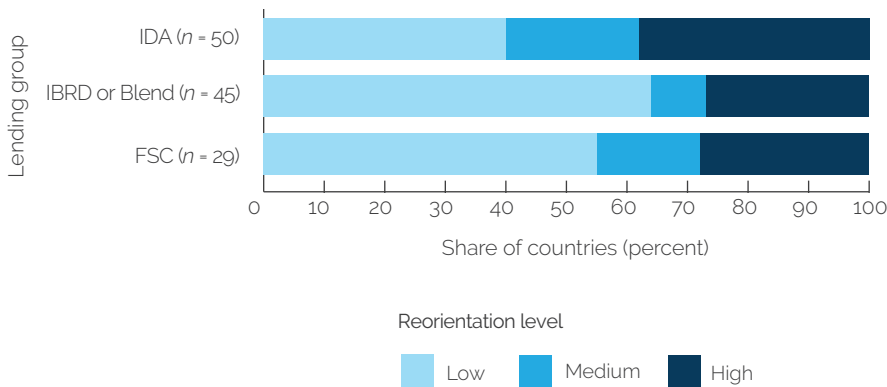
Reorientation of the World Bank Portfolio to Respond to Needs

Repurposing existing World Bank support in addition to adding new interventions helped quickly address the early needs of the crisis response. About 60 percent of World Bank country programs had a medium to high extent of portfolio reorientation to address changing needs because of COVID-19, with extensive repurposing of projects and ASA in relevant sector areas and adding new support (figure 2.5). Repurposing projects already in place allowed the World Bank to rapidly address needs, often within a few days, because it built on existing structures and relationships. It also drew on surge capacities across sectors by mobilizing relevant existing support in the portfolio for the COVID-19 response. GPs were often able to repurpose relevant projects by adjusting components to strengthen the project’s relevance in the evolving context and, in some cases, fast-tracking previously planned support. For example, Djibouti adjusted urban support for slums to support health risk communication and to prevent the spread of infection. India adjusted

existing state-level projects to support needs related to education, health, and urban risks, complementing new project support. Uganda adjusted its nutrition support to include health risk communication and ensure continued promotion of nutrition practices throughout COVID-19.

Reorientation of the portfolio to address needs was quick in countries with crisis preparedness. Case studies show that World Bank country programs with previous crisis experience had a high extent of portfolio reorientation—reorienting five or more projects and ASA in the portfolio—to engage the support of multiple GPs in the COVID-19 response to address needs. Sixty percent of IDA countries reoriented four or more projects and ASA in their portfolios. About half of countries had a low extent of portfolio reorientation, with limited repurposing of projects to add to new support for the early COVID-19 response. In addition, portfolio reorientation was slightly lower in FCS countries (figure 2.5).

Figure 2.5. Extent of Portfolio Reorientation in Countries



Source: Independent Evaluation Group portfolio.

Note: Reorientation is defined as the number of projects per country identified by the evaluation as responding to COVID-19, including financing projects and advisory services and analytics (ASA) support. Reorientation levels are defined as terciles of its distribution across countries. Low: reorientation ≤ 3 projects or ASA; medium: reorientation = 4 projects or ASA; high: 5 projects or ASA ≤ reorientation ≤ 17 projects or ASA. Figure includes countries with both project and ASA support and excludes three countries with only regional projects (Grenada, St. Lucia, and St. Vincent and the Grenadines). The total number of countries is 95. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association; FCS = fragile and conflict-affected situation.

Prioritization of Support to Needs in Countries

Prioritizing World Bank support to address urgent needs was easier in countries with better health systems capacity and readiness to respond, though case studies show good efforts across most countries to focus response actions progressively on areas of need and vulnerable groups. The clustering analysis for the evaluation (appendix D) found that the portfolio included countries that fall into three main situations in terms of their prioritization of World Bank support to the COVID-19 response to align with needs (box 2.4 describes these three situations). The analysis shows that prioritization was most challenging in countries with weaker health systems, which lead to slower government responsiveness to act on emergency measures, such as gathering restrictions, masks, testing, and contact tracing, and extensive health and social needs. These countries often needed support to expand the health response and had multiple needs for protecting human capital losses of vulnerable groups as a result of COVID-19. Case studies show that in countries such as Mozambique and Uganda, where initial prioritization of the response to address the many urgent needs was challenging, there was a progressive effort to focus COVID-19 support (such as risk communication, essential health services, and nutrition support) on vulnerable groups. Focusing interventions on vulnerable groups, local health services, and hot spot geographical areas was an important complement to helping government to quickly expand national disease response capacities.

Box 2.4. Country Situations Regarding Prioritization of COVID-19 Response Actions

Countries where prioritizing World Bank support to address needs was facilitated by strong government responsiveness and preparedness:

- » About 11 percent of countries in the evaluation portfolio quickly tailored World Bank support to priority needs, including a focus on vulnerable groups. For example, India had early government responsiveness and some existing epidemic response capacities (relative to other countries in the evaluation) to put health measures in place; India focused the World Bank's support on the national expansion of social protection systems, health services in urban areas, and education for vulnerable groups. The government of Honduras quickly focused World Bank support on laboratories and developing epidemic response capacities. Djibouti had rapid government leadership to focus on needs related to urban slums, education networks in communities, and development of disease response capacities, including early support to vaccines. In Senegal, early government response and preparedness helped quickly focus the World Bank's support to reinforce the country's multisectoral response, which included health, nutrition, social protection, education, and other support to address multiple needs.

Countries where prioritizing World Bank support to address needs was facilitated by better capacities to deliver health services before COVID-19:

- » About 53 percent of countries in the portfolio had better health systems capacities to deliver services before COVID-19, which helped them focus their response in a few areas to address needs relating to health and social shocks among vulnerable groups. These countries often faced a high number of cases of COVID-19 in the early response and also had good levels of government responsiveness to put prevention and control measures in place. For example, the World Bank's response in Tajikistan focused on expanding social protection, laboratories, early vaccination, and citizen engagement. In the Philippines, the World Bank focused its response on community engagement, redeveloping dialogue with the government to strengthen health systems, and expanding social protection for vulnerable groups.

(continued)

Box 2.4. Country Situations Regarding Prioritization of COVID-19 Response Actions (Cont.)

Countries where prioritizing World Bank support to address needs was challenging and progressive throughout the early response, given limited health systems capacities and extensive human capital needs:

- » About 36 percent of countries in the portfolio had extensive health and social development needs before COVID-19 and low human capital; the key for these countries was protecting against losses of human capital. These countries also often had a lower number of reported cases early in the response and limited surveillance capacities to track cases. Among these countries, health service capacities were often limited, even when there was preparedness before COVID-19. Some countries in this groups (such as Mali and Mauritania) worked with World Bank regional projects during COVID-19, which helped engage government and supported progressive decisions to focus attention on geographical hot spots (such as border areas), laboratory interventions, and case management. Countries such as Niger and Uganda had support across sectors to address needs, but the health response was limited by existing health system capacities; prioritization to focus on the needs of girls and vulnerable youth, for example, was through the progressive strengthening of actions and often through the use of advisory services and analytics to inform actions.

Source: Independent Evaluation Group situation analysis.

Note: Appendix D includes the clustering analysis.

Use of Knowledge Work to Inform Needs

Just-in-time ASA to assess emerging needs was key to reorient and prioritize support. ASA was used in about 60 percent of countries. Key in countries was having ASA with some immediate, just-in-time outputs to inform the response. ASA was mainly for diagnostic analysis, technical assistance, studies to monitor the impact of COVID-19, and policy analysis (table 2.1). Conducting just-in-time ASA jointly with the government and partners helped support agreement on response needs and develop actionable strategies. Previous evaluations show that preparatory ASA undertaken to

support crisis response helps design effective crisis lending and analytic projects (World Bank 2012, 2017). Moreover, countries need to balance longer-term ASA to inform actions for recovery and just-in-time ASA, which can provide more rapid diagnostics for immediate response needs. The production of global and country knowledge products has continued to increase after the evaluation period to inform the evolution of response actions, for example, the 2022 *World Development Report* (World Bank 2022c). Examples of just-in-time ASA included the following:

- » In Djibouti, a gender analysis supported the response to COVID-19 in slums.
- » In India, the Transport GP conducted a just-in-time diagnostic of supply chain logistics during COVID-19 that helped the government plan for the delivery of oxygen and address the challenge of short supplies.
- » In Uganda, an assessment of COVID-19 communication helped the government develop a strategy to better engage vulnerable youth and women and girls.

Table 2.1. Examples of Advisory Services and Analytics Supporting the Response

Type of ASA	Examples
Diagnostic analysis 93 percent (17 percent multicountry)	» Inform the government about options to create fiscal space within existing financial resources to accommodate investments for the pandemic and continue routine health-care delivery.
Policy influence 67 percent (9 percent multicountry)	» Inform the government on the likely impact of COVID-19 and the implications for policies and programs regarding poverty reduction and economic growth
Monitoring of COVID-19 response 63 percent (13 percent multicountry)	» Identify COVID-19 and disaster hot spots using spatial data analysis and social media data and monitor responses using digital payment modalities.
Technical assistance 61 percent (15 percent multicountry)	» Help the government strengthen the adaptive social protection system to increase the resilience of vulnerable households to climate-related and other covariant shocks.
Knowledge sharing 42 percent (12 percent multicountry)	» Exchange knowledge across countries on emerging guidance and good practices for remote learning to reduce the learning losses caused by COVID-19.

(continued)

Type of ASA	Examples
Knowledge generation 29 percent (11 percent multicountry)	» Document experiences across countries on actions taken to control COVID-19, including lessons learned and any disruption to routine service delivery.
New evidence on effectiveness 28 percent (8 percent multicountry)	» Research implementation challenges and successes associated with the integration of gender-based violence prevention programming into social safety net systems.

Source: Independent Evaluation Group portfolio.

Note: ASA are ordered based on the weight of their use in the COVID-19 response. Regional is used to describe multicountry ASA. Percentage in parentheses refers to ASA that addresses more than one country in a region or globally. ASA were coded by their main uses; thus, one ASA could include multiple types of analyses. Thirty percent of ASA support was regional. ASA = advisory services and analytics.

Integration of Support for Institutional Strengthening and Recovery

The integration of institutional strengthening in the COVID-19 response framework emphasized the importance of starting to build longer-term preparedness capacities from the early emergency response. Early institutional strengthening covered more than 90 percent of countries and focused on basic capacities for the immediate crisis, such as strengthening multisector coordination, surveillance, laboratories, remote learning structures, and social registries (box 2.5), with the portfolio analysis showing particular attention to institutional strengthening in FCS countries and countries with regional project support (appendix B). Support commonly went to early efforts seeking to improve coordination and health systems at the national level. Less attention in the early response was on strengthening local government systems and improving policy and financing (figure B2.5.1). The emphasis on institutional strengthening in the World Bank's COVID-19 response brought the advantage of a longer-term systems rebuilding focus into the COVID-19 emergency, which has not been seen in past emergencies, such as for avian influenza. Other evaluations of COVID-19 responses note that institutional strengthening has so far been limited and requires further emphasis to sustain efforts (Johnson and Kennedy-Chouane 2021).

World Bank projects for the COVID-19 response often planned to help address the relief stage and to provide some support for restructuring systems. For example, in health, World Bank project support was for laboratory equipment and training and strengthening laboratory networks. World Bank teams used analytic work and existing projects to help countries plan next steps to strengthen health systems (the Philippines, Senegal, Tajikistan, and Uganda); however, these efforts remain at an early stage. Some countries, such as India and Tajikistan, have also been supported to reconfigure supply chains. In education, projects planned remote learning, which also included safe reopening of schools (Djibouti, Senegal, and Uganda), but learning losses will need to be addressed. In social protection, projects supported emergency cash transfers and systems strengthening, building on lessons from past crises (World Bank 2012). This support has started to expand public health functions, although much attention has gone to helping manage continued cycles of emergency with waves of COVID-19 infection.

Box 2.5. Examples of Institutional Strengthening Support in COVID-19 Response

Country-level coordination: support to national and subnational COVID-19 planning, multisectoral coordination, emergency operation units, assessments to enable coordination, operating procedures across sectors and actors, and online tracking of partner contributions

Health system capacity: support to health referral systems, human resource planning and development, use of geographic information systems to track diseases, improvements to coordination of surveillance and reporting systems, and laboratory quality

Basic service delivery: improvements to education services (such as pedagogy and building safety), and social protection systems, including social registries to cover vulnerable groups such as migrants

Policy and finance: policies to protect women and children, disaster and risk mitigation policies, expenditure reviews in human capital sectors, and costing of education sector reform needs

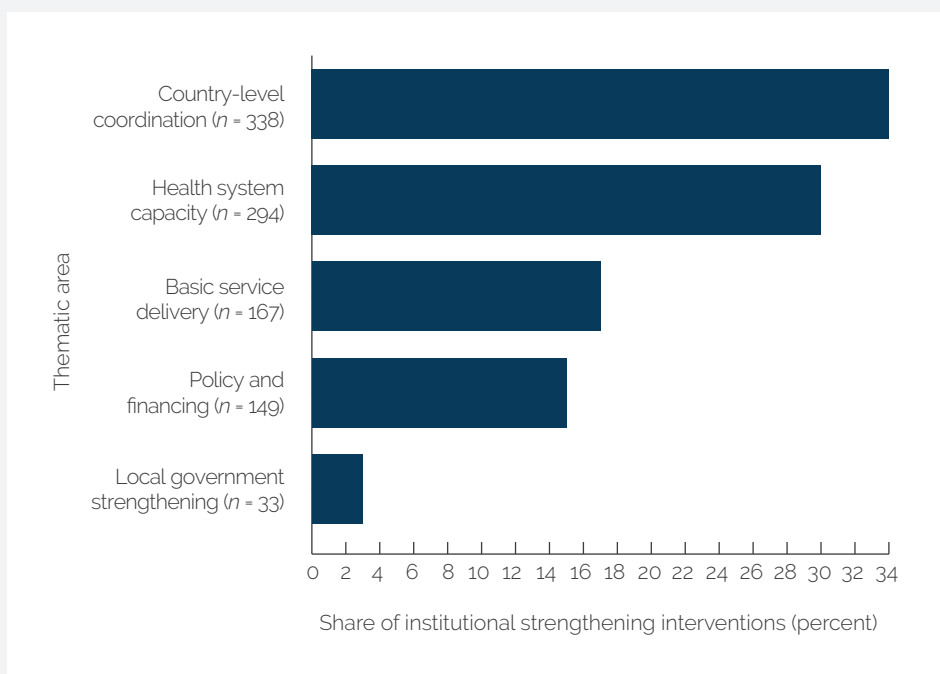
(continued)

Box 2.5. Examples of Institutional Strengthening Support in COVID-19 Response (Cont.)

Local government strengthening: information and communications technology platforms for local government, community disease surveillance, expenditure management and budgeting processes to improve service delivery, delivery of essential services (waste management, electricity, and water), and municipal performance grants for civil works.

Figure B2.5.1 shows areas of early institutional strengthening support.

Figure B2.5.1. Areas of Early Institutional Strengthening Support



Source: Independent Evaluation Group portfolio.

Note: Interventions in the chart are based on 253 projects coded for the evaluation. The number of coded interventions for institutional strengthening support is 981; the number of projects is 253.

Education and social protection support strongly emphasized strengthening digitalization (more than 80 percent of projects), converting systems and business models to digital technology, often building on work before COVID-19. From the relief stage, a key part of institutional strengthening

was support for digitalization (66 percent of projects addressed digitalization, and 40 percent of innovations identified included digitalization), especially in FCS countries. In health, 59 percent of projects planned digital support, often for surveillance or case management (appendix B). Digitalization was expanded quicker where it could build on early foundational work before COVID-19, which was often the case for social protection, where there had been years of sustained investments countries made in creating national identification systems, digital payments systems, and integrated management information systems and social registries (such as in Brazil, Morocco, Senegal, Türkiye, and many other countries). In some countries, such as Senegal, digitalization actions were anchored in national development improvements. The evaluation could not assess the effectiveness of digital solutions to support outcomes. Examples of digitalization include the following:

- » In education, countries supported television, radio, and online pedagogy resources for student learning. In Honduras, this included packages for children and parents to follow up on television and radio classes. India developed a digital platform for teacher training. Support of Education Technology thematic group helped rapidly scale up digital education solutions across countries from early in the COVID-19 response.
- » In health, countries supported health information systems, contact-tracing applications, and digital surveillance. Mozambique, the Philippines, and Tajikistan developed digital tracking systems for vaccine rollout. In Tajikistan, health sector assistance enabled information hotlines and electronic supply chain management.
- » In social protection, countries supported expanding digital beneficiary databases and payment systems. India and the Philippines strengthened their national identification systems, with links to digitalized payments for social benefits, social registry data on vulnerable groups, and data on migrant laborers. Djibouti supported an online platform for tracking food vouchers.

Countries do not yet have strategies that will help them develop more resilient systems and sustained capacities for better crisis response preparedness. The needs for capacity building to sustain COVID-19 investments are vast and fall across sectors—health, education, social protection, agriculture, and so on. Case studies and regional project analyses

suggest that countries with regional disease-focused projects (such as Senegal and Zambia) often already had approaches for building public health preparedness, which were being developed before COVID-19. Incipient World Bank strategies to help prioritize investments arise from World Bank papers and recent work, for example, in health, social protection, and education (Bariş et al. 2021; World Bank 2020e; World Bank Group 2021a, 2021b). Analysis of the cost-effectiveness of interventions fell outside the scope of this evaluation, although it may be useful to optimize the use of resources in the future. Few projects considered the efficiency of scarce resources in the crisis response.

¹ The human capital data on investment before COVID-19 was coded as part of a separate Independent Evaluation Group analysis. The human capital data cover Health, Nutrition, and Population; Social Protection and Jobs; and Education Global Practice projects between July 3, 2014, and January 15, 2020 (World Bank, forthcoming). Interventions to support human capital in countries before COVID-19 were reviewed in six areas: (i) essential health services (child survival and maternal mortality and improved equitable health access); (ii) critical health services (improved pandemic preparation capacity); (iii) protecting the vulnerable (connecting workers to jobs, expanded social program coverage, improved job skill readiness, improved targeting of lowest quintile, increased birth and social registration, and integrated social protection systems); (iv) ensuring child welfare and social services (inclusive education, learning outcomes, quality of teaching, school environment, early childhood development, and stunted growth of children); (v) gender (fertility and adolescent pregnancy, gender-based violence, female higher education and science, technology, engineering, mathematics enrollment, and female labor participation); and (vi) digitalization (information and communication technology policies, information and communication technology for better targeting and for quality service, and digital skills). The total number of areas supported in a country before COVID-19 was used to identify countries with different levels of human capital support by quartiles: 1 (very low), 2 (low), 3 (high), and 4+ (very high). The analysis includes 80 countries in the evaluation portfolio with available data on human capital support before COVID-19.

3 | Quality of Response: Early Successes, Challenges, Learning, and Adjustment


||| About half of projects had satisfactory implementation status. About 40 percent of countries had support to monitoring, critical health services, essential health services, and community activities—key for satisfactory implementation and a proxy indicator suggesting that countries are on track for results.

||| Case studies point to early successes in countries across health, education, and social protection sectors, with continuous efforts to improve targeting of vulnerable groups and better reach frontline workers.

||| The World Bank made good use of learning from past crises and is implementing intervention types with positive evidence of effectiveness from previous responses, although community activities and the intensity of risk communication were limited.

||| Innovations in World Bank support to the early COVID-19 response offer an opportunity for systematic learning about how to implement new approaches for crisis preparedness and systems resilience.

||| Response was swift where World Bank teams and government engaged in useful dialogue and where relationships and national and subnational structures had been developed for coordination and delivery of services before COVID-19.



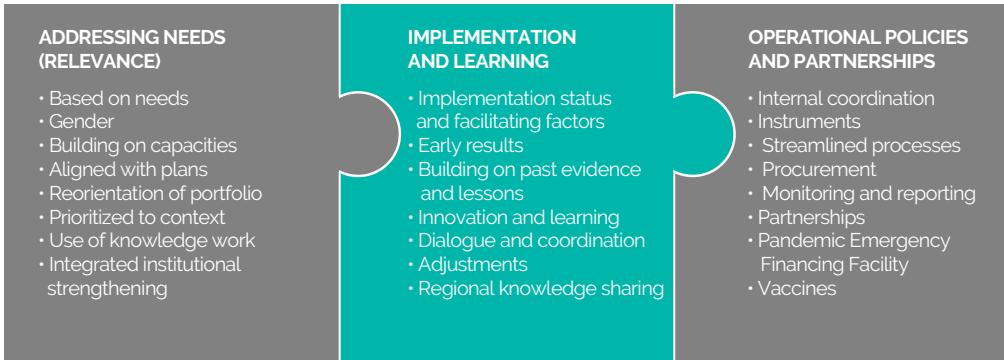
World Bank teams strongly engaged with governments to make iterative adjustments to improve project implementation. Having real-time data on the quality of crisis-related activities in communities facilitated corrective action; however, data systems capacity in countries was limited.



Regional projects helped countries act rapidly to implement health interventions, but support to regional approaches was limited, despite the readiness and experience of some regional organizations, particularly in Africa. Regional approaches were key for convening, knowledge sharing, and cooperation among government leaders and technical actors implementing responses.

This chapter assesses the quality of the World Bank's implementation of the early COVID-19 response, including successes and challenges (which can point to early results) and learning to adjust and improve actions in countries. The assessment is based on dimensions of quality from the theory of action in figure 3.1.

Figure 3.1. Dimensions Assessed for Quality of Implementation and Learning

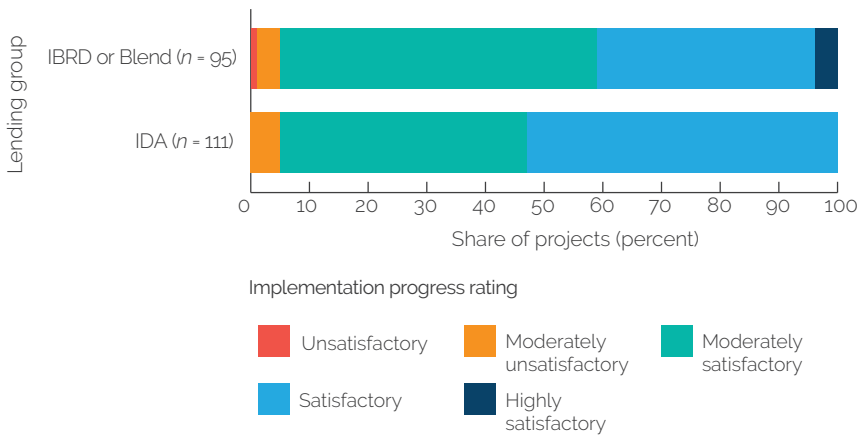


Source: Independent Evaluation Group portfolio.

Implementation Status and Facilitating Factors

About half of the health and social projects during the early response to COVID-19 had a satisfactory implementation progress rating, with IDA projects reporting better progress than the International Bank for Reconstruction and Development (figure 3.2). At the same time, as could have been expected, the proportion of projects with satisfactory implementation progress is lower than the period before COVID-19, likely as a result of the challenges World Bank teams and countries faced in implementing projects during a pandemic. In countries with more than 40 weeks of community spread of COVID-19 per the WHO classification, more projects have moderately satisfactory or lower implementation progress ratings, suggesting that implementation challenges increase when cases peak.

Figure 3.2. Implementation Progress Ratings of Projects in Countries



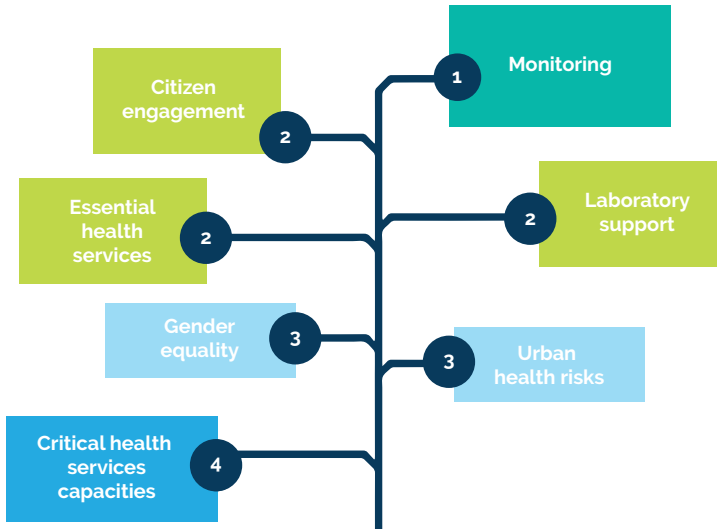
Source: Independent Evaluation Group portfolio.

Note: Projects with no implementation progress rating and projects with financing other than IBRD, IDA, and blend were excluded from the analysis. Implementation Status and Results Report data were from November 5, 2021. The total number of projects is 206. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

A mix of interventions in a few key areas, such as monitoring, critical health services (especially for laboratories), essential health services, and community activities, suggest that a World Bank country program is on track to facilitate results for the COVID-19 response. Having a mix of interventions appears to be a factor contributing to satisfactory implementation of the World Bank’s response in countries. The decision tree analysis (appendix D) found that countries with support to monitoring, critical health services (especially laboratories but also in areas of infection prevention and control, case management, and surveillance, where capacities were limited before COVID-19), essential health services such as maternal and child health, and community activities (citizen engagement, gender equality, and urban health, such as communication and sanitation) were more likely to have projects with satisfactory implementation ratings (figure 3.3). About 40 percent of countries had support in most of these areas. Critical health services were well supported, but coverage of citizen engagement, essential health services, gender equality, and urban support was limited (figure 3.4). Interventions in critical health services were especially important in countries less prepared to deliver these services, pointing to the value of supporting countries to prepare for crisis. Case studies and evidence from the literature review

(appendixes C and E) also reinforce the finding that essential health services are key for preventing losses of human capital among women and children in a crisis, community activities for health and nutrition messaging, and citizen engagement for trust and communication. A challenge in some case study countries was the limited capacity of the health system to deliver local-level health services, even when there was some crisis preparedness. Addressing gender equality was important in countries where this was a need before COVID-19, pointing to the value of using a gender lens in crisis preparedness and response measures. Providing urban health support within the crisis response was important in countries (such as Haiti, India, Tajikistan, and Uganda) with higher urban risks for the spread of COVID-19 in populations in cities in terms of population density and sanitation, for example.

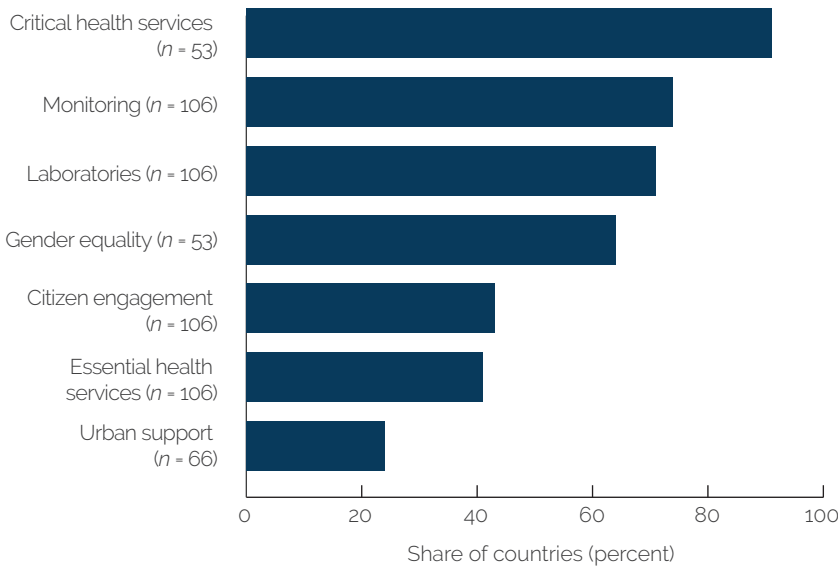
Figure 3.3. Factors Important to Satisfactory Implementation of Country Support



Source: Independent Evaluation Group portfolio and decision tree analysis.

Note: The size of the leaf corresponds to its importance for predicting the likelihood that projects in that country will be deemed to have satisfactory implementation progress (satisfactory or highly satisfactory): (i) countries with high monitoring and tracking of early evidence of progress (top 50 percent of distribution) were more likely to have projects with satisfactory implementation progress; (ii) countries undertaking even one intervention in these areas were more likely to have projects with satisfactory implementation progress; (iii) in countries with needs in these areas, support to address gender equality and urban health risks was important—having better situations in terms of gender equality (top quartile) and urban health risks (top two quartiles) made it more likely to have projects with satisfactory implementation progress; and (iv) countries with greater preparedness to deliver critical health services (top 50 percent of the distribution) were more likely to have projects with satisfactory implementation status.

Figure 3.4. Coverage of Country Support to Areas Important to Facilitating Satisfactory Implementation



Source: Independent Evaluation Group portfolio and needs analysis.

Note: Percentages reported for critical health services, gender equality, and urban support measure the extent to which World Bank support was aligned with a country's needs in those areas. The number of countries reported for each of those three areas (53, 53, and 66 countries, respectively) corresponds to the number of countries with needs in those areas in the bottom two quartiles. For all other areas, the number of countries reported is the number of eligible countries for the evaluation (106). Monitoring reflects countries with any indicators on the COVID-19 response monitored, not the level of monitoring. Urban needs consider urban health risks related to sanitation and water access, household size and type, and population density. Urban support includes health and social activities focused on urban communities. Critical health services include infection prevention and control, case management, surveillance, laboratory support, and risk communication. Needs related to critical health services are based on International Health Regulations data on laboratory, surveillance, and human resource capacities in the country before COVID-19 (appendix D).

Early Results

Although it is too early to observe outcomes, case studies provide some evidence of early outputs, which point to successes of country support (appendix C). Examples of early successes include the expansion of critical health services such as COVID-19 testing, social protection benefits, and remote learning for children (box 3.1).

Box 3.1. Examples of Early Results from Case Study Countries

Ensuring Health Services

In Djibouti, the Multiphase Programmatic Approach (MPA) enabled the development of guidelines and standardized sample collection methods and identified sites for introduction of point-of-care diagnostics. The MPA also helped with supplies for health facilities, such as polymerase chain reaction machines and COVID-19 test kits. By December 2020, the MPA was helping support the investigation of suspected cases of COVID-19 based on national guidelines, in a context of very limited capacity to deliver critical health services. Health workers were also trained in infection prevention and control per nationally approved protocols, and all acute health-care facilities had triage capacity.

Protecting Poor and Vulnerable People

In the Philippines, at the onset of COVID-19, the World Bank helped the government to expand existing cash transfer support to provide monetary and food support to vulnerable households, including people with disabilities and indigenous persons and migrant workers. The support targeted 70 million households, of which 85 percent of recipients were women. The government also fast-tracked the use of digital payment and verification systems and links to the national identification system to improve coverage of vulnerable households and build longer-term capacities for managing emergency assistance. The long-running KALAHI Disaster Response Operations Modality Project was adjusted to provide cash transfers to protect populations during COVID-19, including for employees who lost their jobs and returned to their communities and support for community-run projects focused on building local resilience during COVID-19, such as communal gardens and cleaning of facilities.

Ensuring Child Welfare

In Uganda, the COVID-19 Emergency Education Response Project developed online, paper-based, and radio home-based learning materials for preprimary, primary, and secondary school children and students with social needs, and guided standards and improved sanitation and other conditions in more than 20,000 schools for safe reopening. The project trained more than 10,000 teachers on psychosocial support to counsel learners and school workers on COVID-19 and challenges associated with the lockdown. The World Bank teams also helped the government to develop parenting education and support for early learning continuity, including radio programs.

(continued)

Box 3.1. Examples of Early Results from Case Study Countries (Cont.)

Risk Communication and Community Engagement

In Senegal, the pandemic meant that community mobilization activities and household visits had to be scaled down to avoid close contact. As soon as the government confirmed the urgency of prevention measures, the Early Years for Human Development Project developed and disseminated guidelines on how to conduct community activities in the context of COVID-19. Communication about preventing the spread of COVID-19 used existing networks, including local radio, to get nutrition information to households. The information also accompanied the provision of food and hygiene kits to high-risk groups, reaching more than 90 percent of targeted populations with messages.

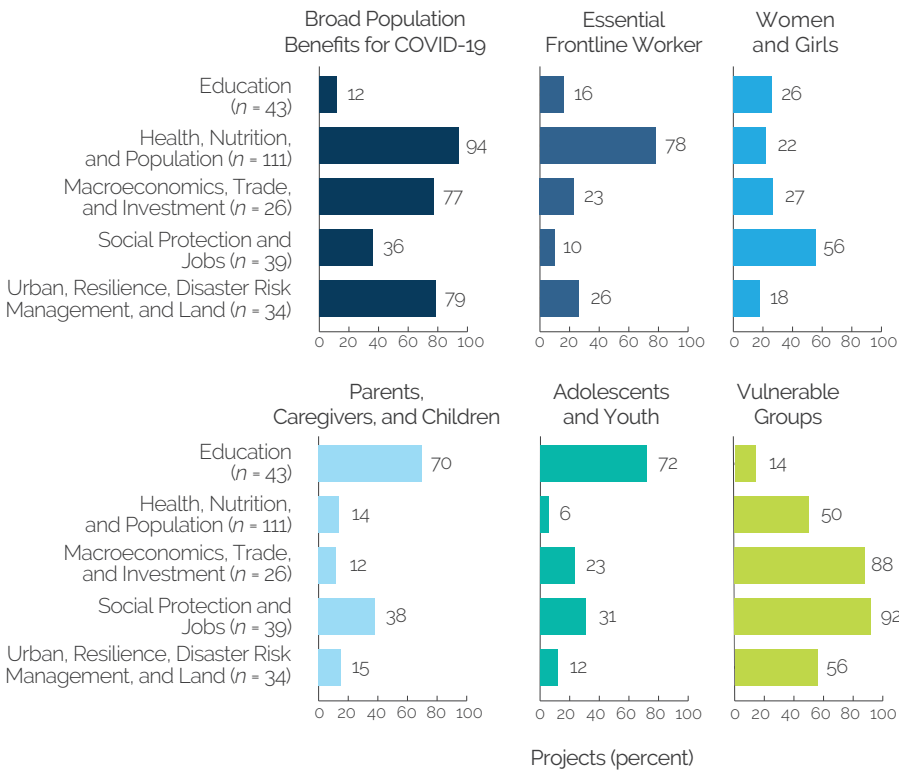
Source: Independent Evaluation Group case study analysis.

Supporting national responses was complemented by adaptive actions during implementation to reach vulnerable groups and support frontline workers. An early success was the focus on vulnerable groups by the Social Protection and Jobs GP and the Macroeconomics, Trade, and Investment GP (more than 90 percent of projects; figure 3.5) and a greater focus on vulnerable groups in FCS countries (appendix B). In Urban, Disaster Risk Management, Resilience, and Land (58 percent of projects); Health, Nutrition, and Population (50 percent of projects); and Education (14 percent of projects), fewer projects targeted vulnerable groups from the onset, though there were efforts to continuously improve support to better reach vulnerable groups. Health and education actions had broad population benefits through rapid expansion of COVID-19 services and online learning. This needed to be complemented with actions to ensure the reach of vulnerable groups, such as women and children, communities with elevated risks of infection, and children in vulnerable households but also frontline workers who were overwhelmed by the crisis. Evidence from the Asian Development Bank, Enabel, the United Nations Children’s Fund (UNICEF), and the International Labour Organization confirms that vulnerable groups needed to be better targeted in the initial design of interventions (Johnson and Kennedy-Chouane 2021; Vancutsem and Mahieu 2020). Case studies also suggest challenges in both

health and education in the intensity of support to frontline health workers and teachers to continue to provide services in communities during the crisis. However, in health, about 78 percent of countries had some support (such as to train health workers), and there was large-scale procurement of personal protective equipment across countries for health facilities, which likely benefited frontline workers.

- » Health, Nutrition, and Population support offered broad population benefits by financing national plans, but the success of national support in reaching local services was rarely monitored, and there was a need to adapt actions during implementation to ensure the reach of vulnerable local-level groups. For example, in Senegal and Uganda, supporting frontline health workers and communities and vulnerable women and children required the adjustment of actions during implementation.
- » Education support was often decentralized (63 percent targeted subnational areas and 19 percent communities; see appendix B) to benefit networks of parents, youth, and children in communities and schools and in some cases, children with special needs. Case studies and the portfolio analysis found that continuous attention was needed to focus actions on the most vulnerable groups, such as children in poor households and girls. Some countries started teacher coaching networks to better support teachers at the front line of the response (such as Djibouti and Uganda).
- » Social Protection and Jobs, by expanding systems to migrant workers and female head of households, stands out for its focus on women and girls and vulnerable groups.
- » Macroeconomics, Trade, and Investment and Urban, Disaster Risk Management, Resilience, and Land financing had broad population benefits and often supported policies and actions to benefit vulnerable groups, such as farmers, women, informal sector workers, migrant workers, and people in urban slums.

Figure 3.5. Intended Beneficiaries of World Bank Country Support by Global Practice



Source: Independent Evaluation Group portfolio.

Note: Bars indicate the percentage of projects with at least one World Bank intervention that targeted the beneficiary group. Analysis included 97 countries and 253 coded projects.

Case studies point to some early successes where World Bank support contributed to helping to target vulnerable groups in countries, but challenges remain (box 3.2). The data from available surveys in case study countries suggest some early success with helping countries with risk communication and social protection—key areas to which the World Bank and other partners contributed by, for example, helping to expand social protection responses during COVID-19. Challenges of the early response in terms of reaching vulnerable groups included facilitating access to essential health services (such as for women and children), learning for children, livelihoods of informal workers, and trust and social cohesion.

Box 3.2. Examples of Successes and Challenges of Early COVID-19 Support

Ensuring Health Services

Challenges:

- » Surveys in Djibouti and India reported challenges in access to health care. In India, households reported forgoing health care because of fears associated with COVID-19. In Djibouti, Mozambique, Tajikistan, and Uganda, issues with ongoing access to health care were felt more severely by vulnerable groups. In Djibouti and Mozambique, those issues were more acute for women than men.

Protecting Poor and Vulnerable People

Successes:

- » Social protection benefits were identified in surveys from Djibouti, India, the Philippines, Senegal, and Tajikistan. For example, India's social protection response covered a little more than 87 percent of poor households between May and August 2020.

Challenges:

- » Negative impacts on the livelihoods of informal workers were reported in Djibouti, India, Mozambique, the Philippines, and Uganda.
- » Disparities were reported in Djibouti's social assistance, with residents outside urban areas less likely to receive food stamps.

Ensuring Child Welfare

Challenges:

- » In Honduras, Mozambique, and the Philippines, children reported being unable to access virtual schooling because of issues related to the internet, equipment, and teachers.

(continued)

Box 3.2. Examples of Successes and Challenges of Early COVID-19 Support (Cont.)

- » In Djibouti, India, and Mozambique, respondents highlighted negative mental health issues among minority groups. In India and Mozambique, female respondents reported increased mental health issues linked to COVID-19.
- » In Uganda, after school reopening, less than half of the children returned to school.

Risk Communication and Community Engagement

Successes:

- » In Djibouti, the Philippines, and Tajikistan, high proportions of respondents reported adopting COVID-19 preventive measures, such as social distancing and handwashing.

Challenges:

- » In Senegal, disparities in awareness of COVID-19 were reported among women; rural dwellers; and less educated, younger, and poorer populations.
- » In Uganda, preventive behaviors declined then stabilized by April 2021, except for handwashing, which continued to decline.
- » In Mozambique, Senegal, and Uganda, distrust of government was a reported challenge.

Sources: Afrobarometer 2021a, 2021b, 2021c, 2021d; Bau et al. 2021; Bautista, Balibrea, and Bleza 2020; Bhattacharya and Roy 2021; Grover et al. 2020; Ipsos 2020; Sumalatha, Bhat, and Chitra 2021; Tuppal et al. 2021; WHO 2021b; World Bank 2021c, 2021d, 2021g; World Bank Microdata Library Database (<https://microdata.worldbank.org/index.php/catalog/4055>; accessed September 2021); UN Women 2021.

Building on Lessons and Evidence from Past Crises

Compared with past crises, the World Bank's COVID-19 support to countries was stronger in responsiveness to needs; however, some lessons from past crises were not fully integrated. The evaluation analyzed operational lessons from World Bank projects that supported crises over 20 years and benchmarked these against the early COVID-19 response (appendix F) and evaluations of crisis response (World Bank 2012, 2017, 2019a). Close navigation of the response with government is a key implementation success of the COVID-19 response that stands out against past crisis support, especially given the vast scale of the response compared with past crises (table 3.1). However, persistent challenges related to implementation and learning were carried over from past crises in terms of reaching vulnerable groups, multisector coordination in countries, and engaging government in monitoring and using data to set priorities and inform risk communication messaging and behavior change. Success factors in these areas were limited to a few countries. Routine oversight of implementation was challenging because internet connectivity was limited, and it was difficult to communicate with subnational project implementers. These challenges were evident in case studies and in the analysis of success and challenge factors reported in project Implementation Status and Results Reports (figure 3.6).

The World Bank is implementing intervention types with positive evidence of effectiveness from responses to past crises. The evaluation reviewed evidence on effective crisis interventions from systematic reviews and country studies to understand the extent that the current portfolio is positioned to support outcomes in countries (appendix E). The review of evidence identified 70 relevant articles covering 50 interventions relevant to areas of the COVID-19 response framework. Most of the portfolio had interventions with positive evidence of effectiveness from past crises (such as surveillance, case management, infection prevention and control, laboratories, and country-level coordination).

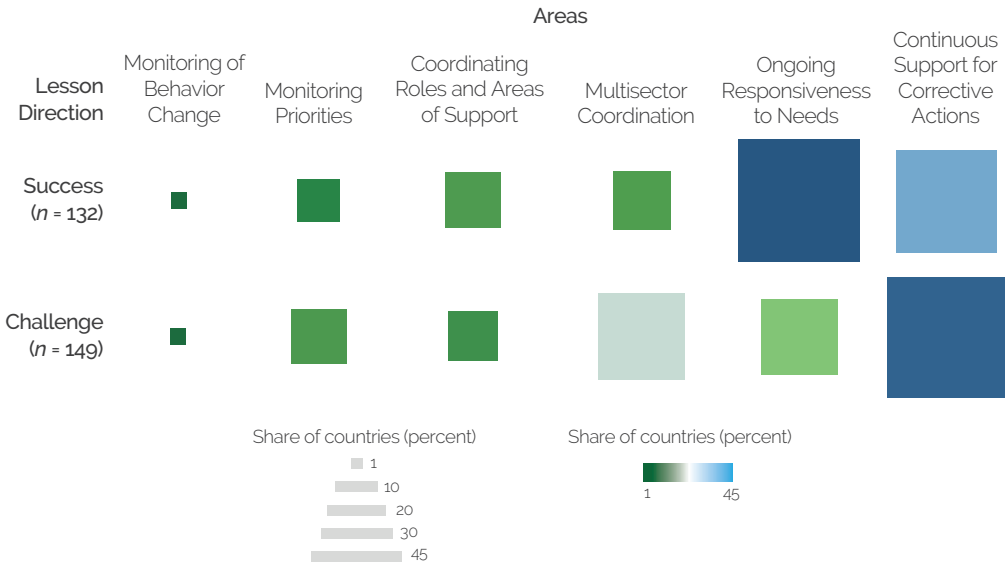
Table 3.1. Application of Operational Lessons from Past Crises in COVID-19

Past Lessons to Improve Crisis Response	Application in Early COVID-19 Response	Challenges in Early COVID-19 Response
Ongoing responsiveness to needs during crises was supported by frequently engaging with clients to navigate in-the-field realities.	<ul style="list-style-type: none"> » Continuous dialogue with governments on response » Focus on sectors with the highest potential impact—health, social protection, and education 	<ul style="list-style-type: none"> » Reach of vulnerable groups required adapting actions during implementation.
Coordinating roles and response areas with government and partners throughout implementation was important to address emerging priorities.	<ul style="list-style-type: none"> » Engaged in existing national platforms to help coordinate implementation 	<ul style="list-style-type: none"> » Coordination capacities of government were often not well developed.
Consistent monitoring of behavior change was important for effective communication approaches.	<ul style="list-style-type: none"> » Some country support included demand-side activities for communities. 	<ul style="list-style-type: none"> » The intensity of communication activities and monitoring of behavior changes was limited.
Continuous engagement with government helped support corrective actions.	<ul style="list-style-type: none"> » Supported corrective actions through weekly exchanges in countries 	<ul style="list-style-type: none"> » Data use to inform decisions was limited.
Engaging government in ongoing monitoring and review helped prioritize support.	<ul style="list-style-type: none"> » Virtual supervisions of projects conducted 	<ul style="list-style-type: none"> » Some issues were likely missed as a result of challenges engaging subnational actors; data on local responses were limited.
Multisector coordination at national and subnational levels helped ensure an effective response.	<ul style="list-style-type: none"> » Support provided to existing coordination structures in countries 	<ul style="list-style-type: none"> » Multisector coordination was limited.

Source: Independent Evaluation Group lessons analysis and case studies.

Note: Lessons were extracted from 170 closed past projects that supported crisis response. Those shown in the table relate to the ongoing efforts to address needs during implementation and learning, which are compared with actions and challenges of the early COVID-19 response. Refer to appendix F for lessons analysis.

Figure 3.6. Areas of Implementation Successes and Challenges in COVID-19 Response



Source: Independent Evaluation Group review of project Implementation Status and Results Reports for lessons analysis.

Note: The COVID-19 portfolio includes 132 successes and 149 challenges in the selected areas of the figure, extracted from 119 projects coded with those areas. "Ongoing responsiveness to needs" looks at ongoing support to dialogue, diagnostics, drawing on existing capacities, prioritization of support to sectors, and targeting vulnerable groups. "Coordinating roles and areas of support" looks at the alignment with development actors and plans. "Monitoring of behavior change" looks at communication and the monitoring of barriers and behaviors. "Continuous support for corrective actions" looks at adjustments made through project supervision and management. "Monitoring priorities" looks at use of monitoring data with clients to improve the quality of the response in local areas. "Multisector coordination" looks at coordination across sectors nationally and of subnational actors (appendix F).

Some interventions with positive evidence of effectiveness from past crises, such as risk communication and demand-side activities in communities, were limited in the response. Box 3.3 summarizes interventions with positive and consistent evidence from the systematic reviews and country studies early in the COVID-19 pandemic. Citizen engagement, risk communication, social cohesion, continuation of essential health services, sexual and reproductive health services, and psychosocial support together account for only about 15 percent of the early response portfolio, despite positive evidence of the effectiveness of these approaches. Psychosocial care in communities is an intervention with positive evidence, which may have helped address increasing distress among children (Loperfido et al. 2020). These areas are important to a prevention-oriented response to protect human capital; they also aligned with lessons for crisis response from Ebola and avian influenza (Gold and Hutton 2020; World Bank 2021f). Interventions that have limited

evidence in a crisis context offer opportunities for systematic learning, such as remote learning in schools and use of social media.

Box 3.3. Intervention Areas with Positive Evidence and Areas for Learning

Intervention areas with positive evidence:

- » Building the capacity of community health workers
- » Provision of masks, respirators, and face coverings and infection prevention and control training for health workers
- » Combining community prevention measures (masks, hygiene, and physical distancing)
- » Telehealth for continuation of essential health services
- » Providing sexual and reproductive health services in emergencies
- » Surging capacity of human resources and adaptation of health facilities for case management
- » Active case surveillance and contact tracing, combined with rapid diagnosis and management, and quarantine measures
- » Strengthening health information and surveillance systems
- » Community engagement for risk communication, infection prevention and control, hand hygiene, use of masks, and social distancing
- » Combining prevention communication with community-based messaging
- » Engaging existing community leaders and community-based structures
- » Mental health and psychosocial support programs in community and health structures
- » Unconditional cash transfers for social protection

(continued)

Box 3.3. Intervention Areas with Positive Evidence and Areas for Learning (Cont.)

- » Financial and social support for protection of vulnerable girls in humanitarian settings
- » Point-of-care diagnostics, rationing medical supplies
- » Support for prompt and consistent policies in epidemics and regional coordination

Intervention areas where evidence is inconsistent or lacking:

- » Digital and automated tools for case management and surveillance
- » Health workers' use of other personal protective equipment (gloves, gowns, and eyewear)
- » Community-based surveillance
- » Social media for risk communication and monitoring of response and needs
- » Remote learning and school reopening measures for vulnerable populations
- » Models for supporting logistics and medical supply in crisis
- » Workplace mental health

Source: Independent Evaluation Group portfolio.

Innovation and Learning

Innovations to which the World Bank's financing and technical support to the early COVID-19 response contributed offer important learning that could be used to build more resilient systems for recovery. Stocktaking analysis identified innovations in more than 80 percent of countries in the portfolio, often reflecting new approaches or practices to strengthen systems (World Bank 2022a). Innovations to support the response were positively associated with the reorientation of World Bank country portfolios, suggesting that reorientation opens opportunities for innovation. Innovations were also encouraged through regional projects, often building on experiences

and investments before COVID-19. Assessing the effectiveness of these innovations to understand the benefit that they provided in the country was outside the scope of the evaluation but will be important. Monitoring the quality of health services and expanding delivery (such as through telehealth), expanding social registries using data analytics to identify vulnerable groups, and public-private partnerships to expand digitalization of systems were common areas of innovation. The engagement of local actors, multiple sectors (such as water, technology, and social sectors), and partnerships was observed across innovations (box 3.4). Innovations and ASA often addressed areas where evidence-based learning is important, such as remote learning support for schools. Innovations also often involved civil society and the private sector and point to opportunities to expand engagement of these groups in recovery to strengthen preparedness for crisis response.

Further learning could help World Bank teams address areas that are important but received limited attention in the early response. Few innovations (less than 5 percent) were found to support continuation of essential health services, the informal sector, risk communication, psychosocial support, citizen engagement, and social cohesion, which are limited in the World Bank's early COVID-19 response. Moreover, only 10 percent of innovations identified in the COVID-19 response addressed gender disparities (World Bank 2022a). Evidence from the literature and past lessons also emphasize the importance of these areas for crisis response (Gold and Hutton 2020; World Bank 2021f). Support to manage burnout among local health-care workers, handle misinformation, and garner trust, which case studies and interviews identified as challenges, received very little attention.

Learning about the effectiveness of interventions, especially where evidence is inconsistent or lacking, could help ensure the right mix of support to countries. Remote learning support in crises stands out as a widespread intervention undertaken across countries for which the rapid review conducted by the evaluation did not identify evidence, although there may be evidence from noncrisis contexts that is transferable. Other interventions for which evidence of effectiveness is inconsistent or lacking include the use of social media in crises to communicate messages, the use of digital and automated tools for case management, and logistics supply management. Community-level surveillance has also been important in countries where

it has been supported. Deepening of evidence could also be helpful in areas with few studies, such as for the expansion of social protection in emergencies. For example, evidence was collected on social protection interventions during the early COVID-19 response (Gentilini 2022).

Box 3.4. Examples of Innovations Supporting the COVID-19 Response

- » In Uzbekistan, people receive information about COVID-19 through SMS messages, Telegram, WhatsApp, video clips, and infographics. In addition, health services are adapting for telemedicine where possible.
- » In Mali, a new national 24-hour-a-day, 7-day-a-week call center dedicated to COVID-19 enables free calls and offers advice for implementing coronavirus protocols.
- » In Senegal, community-based disease surveillance and multistakeholder engagement allow community health workers and volunteers to detect COVID-19 and report cases to health facilities and local government agencies.
- » In Latin America, projects track the presence of COVID-19 in wastewater. Wastewater-based epidemiology supplies real-time information on the extent of virus spread in a community, including asymptomatic cases. Each sample represents a large portion of the community, which is served by a sewerage network; this allows for rapid and cost-effective tracking of disease trends at the population level.
- » In Cambodia and India, instructional videos, conference calls, and social media supplement coaching services for teachers. Rural teachers receive video lessons on teaching culturally relevant, curricula-aligned content.

Source: Independent Evaluation Group innovation stocktaking.

Note: SMS = short messaging service.

Coordination, Dialogue, and Adjustment in Countries

Good pre–COVID-19 relationships were a factor for good dialogue and smoother implementation. Previous evaluations related to financial, social, and environmental shocks also establish the importance of country dialogue in crisis response (World Bank 2012, 2017). Commitment to dialogue with government was strong, often with weekly discussions of emerging challenges and urgent reforms. Good relationships before COVID-19 prepared countries for strong implementation. Examples include the following:

- » In Honduras, the country’s social response built on long-standing policy dialogue with the government, which deepened through daily exchanges and was informed by ASA. In health, a new policy dialogue developed about emergency measures, which initially slowed the response but later transitioned to a dialogue aimed at ensuring better health systems. In education, the dialogue helped with quick project adjustments.
- » In the Philippines, the MPA supported the first health project after years of no project. Hence, health dialogue with the World Bank deepened in the early COVID-19 response and then expanded to develop early access to vaccines and planning of health systems strengthening.
- » In Mozambique, without a centrally organized government response, the World Bank led sector-specific responses in dialogue with relevant ministries and other development partners. Support focused on the health, education, urban, and social protection sectors. The response built on existing sector relationships and accelerated the pace and direction of measures underway before the pandemic.

Where available, national platforms helped engage government sectors and development partners to coordinate implementation. Case studies show good engagement in national coordinating structures of government during implementation, even though multisector coordination structures were rare (box 3.5). For example, in India, the Philippines, and Uganda, the World Bank supported coordination platforms during COVID-19. Some World Bank teams helped reinforce government’s coordination capacity, although it

was challenging to reinforce amid the crisis. For example, Tajikistan hired a consultant to help with coordination. In Uganda, a dedicated staff member in the World Bank office supported partner coordination with government. Moreover, an important weakness of the World Bank’s support to the response was the limited engagement with nongovernmental organizations—an issue identified with many COVID-19 responses (OECD 2022).

Box 3.5. Lessons on Multisector Coordination for an Integrated Response

Where countries had established coordination structures to engage government sectors, partners, and other stakeholders, the World Bank supported them, and the government used them to plan and track integrated COVID-19 actions. About 10 percent of countries had support to multisector coordination groups to implement the response, such as One Health committees. Having these structures set up before COVID-19 to organize the response was key because setting up coordination for the first time is challenging. Having multisector coordination structures was also important for crisis preparedness. The World Bank’s COVID-19 recovery efforts are emphasizing the establishment of One Health coordination within countries to support multisector responses and strengthen coordination structures. This aligns with the efforts of other agencies—the Food and Agriculture Organization, the World Organisation for Animal Health, the United Nations Environment Programme, and the World Health Organization.

When multisector structures were developed, they provided a platform for countries to plan, report on, and take rapid actions with more integration across sectors:

- » In Haiti, the government created a multisectoral commission to coordinate the COVID-19 response, integrating mechanisms for civil society and the private sector to contribute to emergency preparedness actions, and specific units for crisis response in the health sector. This helped align sector and stakeholder support to the response.
- » In the Philippines, the national response was coordinated by an intersectoral task force initially led by the health sector, but early in the response, the task force transitioned to central government leadership to ensure multisector support across ministries.

(continued)

Box 3.5. Lessons on Multisector Coordination for an Integrated Response (Cont.)

- » In Senegal, the World Bank supported a One Health multisectoral approach to coordinate the COVID-19 response. This approach grew to include ministries responsible for finance, health, social affairs, livestock and animals, agriculture, rural development, environment and sustainable development, and water and sanitation. Since COVID-19, the approach has included education.

Knowledge work in COVID-19 reinforced coordination by helping inform how to operationalize crisis response actions. Previous evaluations also found that coordinating support with government and partners, combined with knowledge work, enabled the World Bank to develop well-designed financing projects expeditiously (World Bank 2017). For example, the multisectoral response in the Philippines built on long-term knowledge work in social protection and community development.

Sources: Independent Evaluation Group portfolio and case studies; FAO et al. 2022.

Where available, networks that reached communities were instrumental in risk communication, detecting COVID-19 cases, and providing referrals to health services, but overall, the connection to local government—especially at the community level—was not strong enough. Enabling local government and community groups to support crisis response and ensure frontline service delivery was a challenge in case study countries, with breaks in communication, coordination, and disruptions in implementation. Evaluations of the responses by Chazaly and Goldman (2021) and the German Institute for Development Evaluation (Schneider et al. 2020) also noted similar issues. Examples of coordination support reaching local levels to a greater degree include the following:

- » Structures for nutrition (Honduras, Senegal, and Uganda) facilitated COVID-19 messaging to communities and helped engage nongovernmental organizations in the COVID-19 response. The World Bank is undertaking similar work in developing community networks in other countries (Subandoro, Holschneider, and Ruel-Bergeron 2021).

- » One Health platforms with networks that reach the community level (Senegal and Zambia) supported contact tracing, case management, communication, and other activities to prevent the spread of disease.
- » Support to local government (Senegal and Uganda) helped ensure continued delivery of local services, such as health, water, and education.

Implementation Adjustment

Throughout the early response, World Bank teams strongly engaged with governments to make iterative adjustments to improve implementation. These adjustments were informed by frequent meetings and virtual supervision support, findings from studies, and field supervision by the governments when travel was possible. Discussions often identified implementation bottlenecks and led to corrective actions to adjust projects, such as the following:

- » In Djibouti, the package of services delivered to vulnerable groups by social protection agents was adapted to include COVID-19 messages and distribution of hygiene kits, based on a challenge identified in country discussions.
- » In Senegal, the health project added support to help the government recruit contractual staff to surge resources for patient care and provide computer and video equipment for communication between health offices.
- » In Tajikistan, the country strengthened its support to community engagement and risk communication as part of its vaccine response based on learning from the early response.
- » In Uganda, the country added COVID-19 training support for the private sector based on challenges in support to these facilities.

Real-Time Data for Decision-Making

Real-time data, where available, were key to informing decision-making about project adjustments. Geo-enabled monitoring, iterative beneficiary monitoring, short messaging service (SMS) texts, online surveys, and dashboards are tools that supplied timely data to support implementation decisions in the early COVID-19 response (box 3.6). Global surveys provided

valuable real-time information on the socioeconomic impact of COVID-19, which informed policy dialogue and country economic updates and were critical for discussion with civil society forums in countries. However, these surveys often did not offer real-time information to support immediate course corrections of projects or develop data capacities in countries. In some countries, real-time surveys were adapted to better link to social protection, vaccine promotion, and education projects to inform course corrections. Evaluations of COVID-19 responses have also found the application of real-time data collection methods to be useful in adapting projects (Johnson and Kennedy-Chouane 2021; OECD 2022; Vancutsem and Mahieu 2020), and a range of innovative data tools have been used in COVID-19. A challenge is supporting governments to continue real-time data methods that enhance country-level information systems and to coordinate data collection that ensures that the most helpful information for implementation decisions is being collected.

Box 3.6. Examples of Real-Time Data Systems and Tools for Decision-Making

Monitoring of country situations:

- » In Cambodia, Myanmar, and other countries with high mobile phone coverage, high-frequency phone surveys provided rapid, real-time data and evidence on the socioeconomic impact of COVID-19 to inform World Bank responses.
- » In Colombia, a COVID-19 Safe Economic Reactivation Dashboard provides decision makers with real-time information for 1,100 municipalities on key epidemiological indicators. To date, the dashboard has more than 15,000 unique users.
- » In Fiji, the World Bank supported the Ministry of Health and Medical Services to improve communication and data reporting systems with frontline health workers and health facilities, including internet connectivity for case reporting and public health surveillance across health facilities.
- » In Iraq, Lebanon, Libya, Tunisia, and West Bank and Gaza, a low-cost, just-in-time survey was deployed via a Facebook chatbot to understand attitudes toward vaccines among different social groups. To ensure a degree of national

(continued)

Box 3.6. Examples of Real-Time Data Systems and Tools for Decision-Making (Cont.)

representativeness, the survey targeted clusters of individuals according to region, age, and gender.

Monitoring of implementation quality:

- » In Lesotho, a phone-based application sends an SMS message to those who are vaccinated to collect information on the quality of care and track minor side effects that would otherwise not be reported.
- » In Tunisia, COVID-19 cash transfers are remotely monitored using iterative beneficiary monitoring.
- » In Mexico, Nicaragua, and other countries, the Geo-Enabling Monitoring and Supervision (GEMS) initiative has been introduced as a project supervision and monitoring tool for continuous engagement with communities and project supervision. The governments undertook the capacity-building program on GEMS and internalized the technology tools for monitoring. For example, in Uganda, GEMS is used for real-time project monitoring of support to schools and community groups to promote nutrition. In Mali, GEMS is a platform for third-party monitoring in conflict-affected remote areas. Tajikistan is using GEMS to monitor cash transfers.
- » In India, the Gujrat Command and Control Centre provides an example of real-time performance data for schools, covering online attendance, assessment test results, and a vehicle tracking system.

Sources: Independent Evaluation Group portfolio and case studies; World Bank 2022a.

Note: SMS = short messaging service.

Data on implementation quality in subnational and community responses by local governments remain a key gap in the early COVID-19 response. Few countries had systems established before COVID-19 that could be used to provide beneficiary feedback on services or data on the quality and coverage of services delivered by health workers, schools, and community actors, especially for vulnerable groups. Another challenge in the response was

tracking the success of messaging and communication activities in promoting behavior changes in the community related to COVID-19. Strengthening country systems to supply more real-time information on the implementation quality of local government and community-level support could facilitate preparedness efforts.

Regional Knowledge Sharing and Cooperation

Regional projects strongly supported implementation of responses. The evaluation reviewed the four main regional disease-focused projects that worked on the COVID-19 crisis in countries with weak health systems or limited capacities to respond to crises, highlighting strong early results (box 3.7 and appendix G). Coordination facilitated by these regional projects supported political leadership; real-time technical learning to operationalize and review progress of COVID-19 plans; cooperation for efficiencies across countries, such as for procurement of medical goods and equipment; joint training to expand COVID-19 surveillance data and testing; and high-level dialogue to develop public health guidelines. The peer learning of ministries and technical experts across countries that engaged in regional activities helped expand leadership for the response and had a spillover effect on countries not covered by regional projects that joined the activities. Leaders and technical experts from public health institutions engaged in regional exchanges and then adopted new practices learned from these engagements to expand COVID-19 actions in their countries. Despite the strong positive early results of regional projects during the COVID-19 response, support to regional projects was limited to only 23 percent of countries in the portfolio, although there has since been some effort to expand regional support in Africa in the second year of the response. A previous IEG evaluation highlighted the untapped potential in fostering regional integration initiatives as the World Bank can leverage its global knowledge, financing instruments, synergies from acting as one Bank Group, and its ability to catalyze regional actors (World Bank 2019c).

Box 3.7. Examples of Early Results Contributed by Regional Projects

The evaluation conducted interviews with country actors and teams involved in regional projects. Among the four projects reviewed, Regional Disease Surveillance Systems Enhancement Project in West Africa and East Africa Public Health Laboratory Network had established networks in countries before the COVID-19 pandemic started, whereas the Africa Centres for Disease Control and Prevention and Organisation of Eastern Caribbean States regional health projects were at early stages of implementation. For all projects, the knowledge exchange and real-time dialogue and coordination facilitated by regional engagement was viewed consistently as valuable to help support country actions.

Early results were identified for all four regional projects, although there was more evidence in countries with a longer duration of regional support before COVID-19 (such as Senegal and Togo, covered by early phases of the Regional Disease Surveillance Systems Enhancement Project). Regional projects were especially well-situated to support critical health services for the COVID-19 response when projects were already established and well-integrated with project support in their respective countries. Early results supported by regional projects include the following:

- » Regional coordination facilitated rapid country responses to COVID-19, whether of ministerial committees, public health institutes, or project leaders. Coordination mechanisms were used to share real-time information and knowledge on disease detection and best practices, engage with regional and international partners, develop guidance on surveillance, and exchange knowledge with peers to help countries implement COVID-19 support. For example, governments in the Eastern Caribbean used regional knowledge sharing about health waste management and installation of laboratory and health equipment to respond faster. In Africa, public health institutes and health ministries used the Africa Centres for Disease Control and Prevention regional Extension for Community Healthcare Outcomes platforms for interdisciplinary knowledge exchange and training on COVID-19.
- » Human resources capacities supported by regional projects helped implement the COVID-19 response. For example, countries in West Africa and the Eastern Caribbean deployed field epidemiology graduates in leading strategic and front-line roles for COVID-19. Capacities developed before COVID-19 were crucial to

(continued)

Box 3.7. Examples of Early Results Contributed by Regional Projects (Cont.)

rapid responses in East and West Africa. In East Africa, governments deployed lab technicians, assessors, and disease surveillance officers trained through East Africa Public Health Laboratory Network to be at the front line in COVID-19 rapid response teams, conducting testing and contact tracing. Countries used rapid response teams supported by the Regional Disease Surveillance Systems Enhancement Project to implement the COVID-19 response.

- » Regional coordination and capacity building facilitated the expansion of surveillance, testing, border screening, case management, and infection prevention and control for the COVID-19 response. For example, East Africa countries deployed laboratory capacity built by the East Africa Public Health Laboratory Network project for COVID-19 testing. The Africa Centres for Disease Control and Prevention contributed to the rollout and expansion of COVID-19 testing in Africa. At the start of COVID-19, only two laboratories in Africa (Senegal and South Africa) could reliably test for the disease. By mid-March 2020, 43 countries had testing capability, and by August, almost all African Union countries could conduct testing.

Source: Independent Evaluation Group regional project review.

Regional projects were well situated to support countries in efficiently cooperating to expand critical health services but were less prepared to help countries plan actions to mitigate COVID-19 impacts. Regional projects helped countries expand testing, surveillance, and case management quickly. They were less helpful in sharing knowledge to implement interventions for risk communication, citizen engagement, gender equality, urban public health risks, and essential services. Discussion is ongoing on expanding attention to these areas in regional disease-focused projects, based on learning from the early COVID-19 response. Capacities could be developed across countries, such as for citizen engagement, through learning to facilitate actions. Improving essential health services in countries may also be important to address regionally because having this capacity helped countries respond quicker.

Strengthening developing capacities of regional organizations for disease response coordination proved to be important. Institutional strengthening before COVID-19 prepared regional organizations to support results during COVID-19, particularly the Economic Community of West African States. Setting up dialogue across countries for the first time during a crisis was more difficult for newer regional projects because actors have limited experience coordinating support and need time to set expectations and develop partnerships and trust. Nevertheless, new platforms (such as the Regional Coordination Center in Zambia for Southern Africa, supported by the Africa Centres for Disease Control and Prevention [Africa CDC] project) were important for learning and cooperation during COVID-19. The Caribbean Public Health Agency, supported by the Organisation of Eastern Caribbean States Regional Health Project, played an important coordination role in facilitating country responses during COVID-19.

The World Bank did not strengthen support to regional approaches early in COVID-19. In Africa, expanding regional support at the onset of COVID-19 may have facilitated the response, such as through including regional projects in the MPA and by providing financing to regional organizations for knowledge sharing and coordination across countries. The Regional Disease Surveillance Systems Enhancement Project in West Africa and the East Africa Public Health Laboratory Network project already had extensive experience before COVID-19 in demonstrating learning about how to work regionally with countries on disease preparedness and response. Moreover, before COVID-19, there was already extensive preparatory work on the Africa CDC project; although the project was at an early stage of implementation and had limited disbursement, much important work to develop coordination and knowledge sharing structures was already in place and could have been drawn on by the World Bank to facilitate the early actions in countries.

Hands-on technical support and facilitating learning, convening, and cooperation across countries were important for regional capacity building. Developing the capacity of regional organizations to facilitate high-level country exchanges among leaders and technical learning and cooperation was critical. Project financing to implement interventions was often from a country-level project, and minimum regional project financing and disbursement often were required to influence the leadership and implementation

improvements observed through regional engagement. For example, regional support of the Africa CDC was linked to financing of World Bank projects in Ethiopia and Zambia. Expanded regional support could help develop leadership and coordination in countries, which could then help scale up preparedness capacities and improve the efficient use of resources in World Bank country projects. Learning across countries could be supported through regional projects or ASA focused on regional capacity building and South-South knowledge sharing (World Bank 2019b).

4 | Quality of the Response: Operational Policies and Partnerships

Strong leadership at multiple levels in the World Bank enabled innovations and information sharing across sectors, and policy guidance and operational frameworks helped steer the response in the early months.


Coordination of country support was done through portfolio review meetings and typically included the health, education, and social protection sectors. In some countries, coordination might have been improved by including sectors beyond human development.

Crisis instruments, repurposed projects, regional projects, trust funds, and grants, where available, were important for rapid financing in the early days and weeks of the crisis. The Multiphase Programmatic Approach was innovative and useful to quickly expand new lending for the health response.


Operational flexibilities have improved since past crises, but the processing of new projects took several months. Flexibilities in new project processing helped process the Multiphase Programmatic Approach. Countries needed more help with corporate requirements related to gender and citizen engagement.

Procurement was successfully expedited; however, tracking procured goods to ensure that they were received by health facilities was challenged by weak country systems.

Project monitoring systems provided some timely information during the crisis, but integrated country-level monitoring was not always in place.



Existing partnerships involving the World Bank supported preparedness for global and country-level collaboration. Technical partnerships, even though they had limited country coverage, helped expand implementation of interventions.



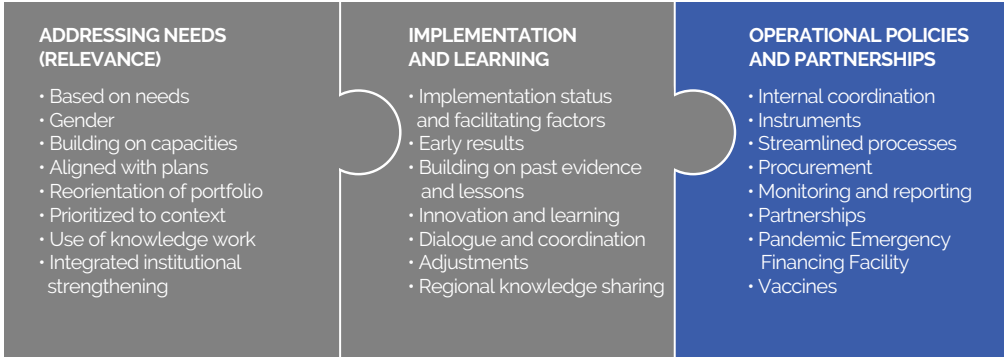
Pandemic Emergency Financing Facility grants supported COVID-19 plans in collaboration with United Nations partners, although funding was small and not rapid.



The World Bank engaged in close dialogue with partners in the uncertain early months but lacked a financing instrument to help expedite advance market commitments for countries to access vaccines. Multiphase Programmatic Approach vaccine financing was prompt in countries, but supply constraints slowed initial implementation. Stronger regional support in Africa on vaccines earlier in the response may have helped facilitate access to vaccines.

This chapter assesses the quality of the World Bank's operational policies and partnerships in support of countries during the early response to COVID-19. The assessment is based on dimensions of quality from the theory of action in figure 4.1.

Figure 4.1. Dimensions Assessed for Quality of World Bank Operational Processes and Partnerships to Support Country Responses



Source: Independent Evaluation Group portfolio.

Internal Coordination

Strong internal leadership at multiple levels enabled innovations and information sharing that helped coordinate the response. World Bank leadership led a large-scale response supported by a strategy and undertook internal innovations (box 4.1). IDA spending allocations were front-loaded to ensure resources for COVID-19 through an unprecedented move to start Replenishment discussions one year ahead of schedule in April 2021. An emergency operations center led by the Human Development GP and chaired by the Health, Nutrition, and Population GP facilitated technical coordination, adaptive management, and problem-solving for the response. Information sharing among technical staff and across GPs and operational support units increased through, for example, the production of guidance and technical notes, regular learning seminars, and listing answers to frequently asked questions. For example, Social Protection and Jobs; Education; and Health, Nutrition, and Population engaged in the center and developed complementary actions to support the response, building on human capital work done before COVID-19 (World Bank Group 2020a). The Poverty and Equity GP

worked with other GPs and the Development Economics Vice Presidency on rapid phone surveys focused on COVID-19. A challenge noted in some cases was aligning actions to draw on technical capabilities of other GPs, such as Water, Transport, Agriculture and Food, and Social Sustainability and Inclusion. These sectors had technical knowledge to support risk communication, vaccine delivery, transport of goods, and sanitation—a first line of defense against COVID-19 before vaccines.

Box 4.1. Cross-Sectoral and Unit Teams Supported Internal Innovations

Internal innovations were stimulated when internal expertise was marshaled rapidly across sectors and units to solve technical issues. The following three examples illustrate the importance of diverse expertise and flexibility for the early response:

- » **Emergency Operations Center (EOC):** The EOC was set up in early 2020 to provide internal global technical coordination among Global Practices (GPs) and operational policy and country service units and subcommittees working on specific technical issues. The EOC brought together World Bank experts in health, epidemiology, social protection, agriculture, education, water, operational, legal, and fiduciary functions and staff working with Gavi, the Vaccine Alliance; Pandemic Emergency Financing Facility; Global Financing Facility; Global Partnership for Education; World Health Organization; and countries from all regions. The EOC developed a shared understanding of what the World Bank was doing and coordinated decisions in real time. The EOC had an agile governance structure with a director-level steering committee and members from the GPs and operational support units, and it aimed to work in a nonhierarchical manner and break down operational silos. The EOC successfully mobilized teams across the World Bank through weekly meetings to share information on the COVID-19 response. Interviewees praised the EOC's role in solving problems and providing guidance on technical issues. The GP leadership and ownership inspired knowledge sharing among technical experts across units. Later, the EOC was transferred to the Operations Policy and Country Services of the World Bank to focus on vaccines. This decision limited GP leadership in the problem-solving and adaptive management of the response and likely missed an opportunity to build on the achievements of the EOC to strengthen GP collaboration for early COVID-19 vaccine support.

(continued)

Box 4.1. Cross-Sectoral and Unit Teams Supported Internal Innovations (Cont.)

- » Country program flexibility: Good coordination of cross-sector GP engagement at the country level was critical to developing a real-time strategy for individualized responses in dialogue with governments to reorient their portfolios to support country needs. The flexibility given to country teams in the early months of the response was key to rapidly adapting their existing portfolio of projects and advisory services and analytics in different sectors based on local policy dialogue. This adaptation was best done through internal discussion across GP teams where the portfolio before COVID-19 had set a foundation for supporting human capital, and the response could draw on existing partnerships, projects, and relationships. Having relevant cross-sector support in place before COVID-19 facilitated country preparedness. Moreover, ongoing discussions across World Bank GPs in countries were key for continuous adjustments to address bottlenecks and strengthen the response, adding new elements such as communication or urban sanitation.
- » World Bank-facilitated procurement: Global supply chains for medical goods were severely disrupted early in the pandemic, with countries unable to obtain needed supplies, such as personal protective equipment. In response, the World Bank assembled a team of procurement, human development, legal, and governance experts, which expanded on previous hands-on implementation support. The multidisciplinary team helped countries access critical goods that they could not obtain on the market. For example, World Bank-facilitated procurement helped deliver personal protective equipment for Honduras, oxygen for India, and personal protective equipment and respiratory and diagnostic equipment for Mozambique. Completed World Bank-facilitated procurement was valued at just under US\$170 million in those early months, despite challenging turnaround times and complicated logistics and contracting processes. This mechanism accounted for about 4 percent of all procurement of goods delivered to 28 countries. To obtain urgently needed goods quickly, the World Bank team collaborated with partners from United Nations agencies and the private sector. The model could be deployed in future emergencies.

Source: Independent Evaluation Group interviews and case studies.

Policy guidelines and frameworks helped guide World Bank teams early in the response. Policy notes developed by GPs and other internal units helped guide actions in the first months of the response. A series of internal learning events for staff also helped. In March 2020, the Health, Nutrition, and Population GP approved its Strategic Preparedness and Response Program MPA, the first phase of which committed \$6 billion in funding (World Bank 2020b). The MPA, anchored in a cross-sector response framework, helped guide World Bank teams planning the health and social response in countries. Social Protection and Jobs guided technical planning of World Bank teams by providing a continuously updated database and survey of global social protection responses, including a “Living Paper” detailing the design of support to share country experiences and a social response framework. Country directors and World Bank staff and clients highlighted these social protection resources as being useful in their early policy dialogue to guide response actions. The Education team engaged with partners to develop tools that helped clients implement quality responses, such as modules for phone surveys, COVID-19 impact assessment tools, technical notes for school reopening and teacher performance, and examples of content for remote learning and reports on policy responses (World Bank 2020e, 2021e). The Gender Group, with staff from across GPs, provided a range of resources that defined entry points to address gender in the early response, for example, for vaccination projects. Interviewees reported that these frameworks and tools provided timely and useful guidance to help shape country responses. The early documents and learning developed by GPs and other units also helped shape the Bank Group COVID-19 response framework in June 2020 (World Bank Group 2020b).

The portfolio review process, led by country management, coordinated GP support and was important to identify ways to reorient the portfolio quickly and process requests in the early months of the response. Senior staff in countries noted that in the first months of COVID-19, real-time communication between World Bank country management and global technical teams—especially on the health response—was critical, such as on how to involve key sectors to help identify solutions for reorienting assistance in the country portfolio. In Honduras, project implementation and procurement plans were reviewed through weekly exchanges, and

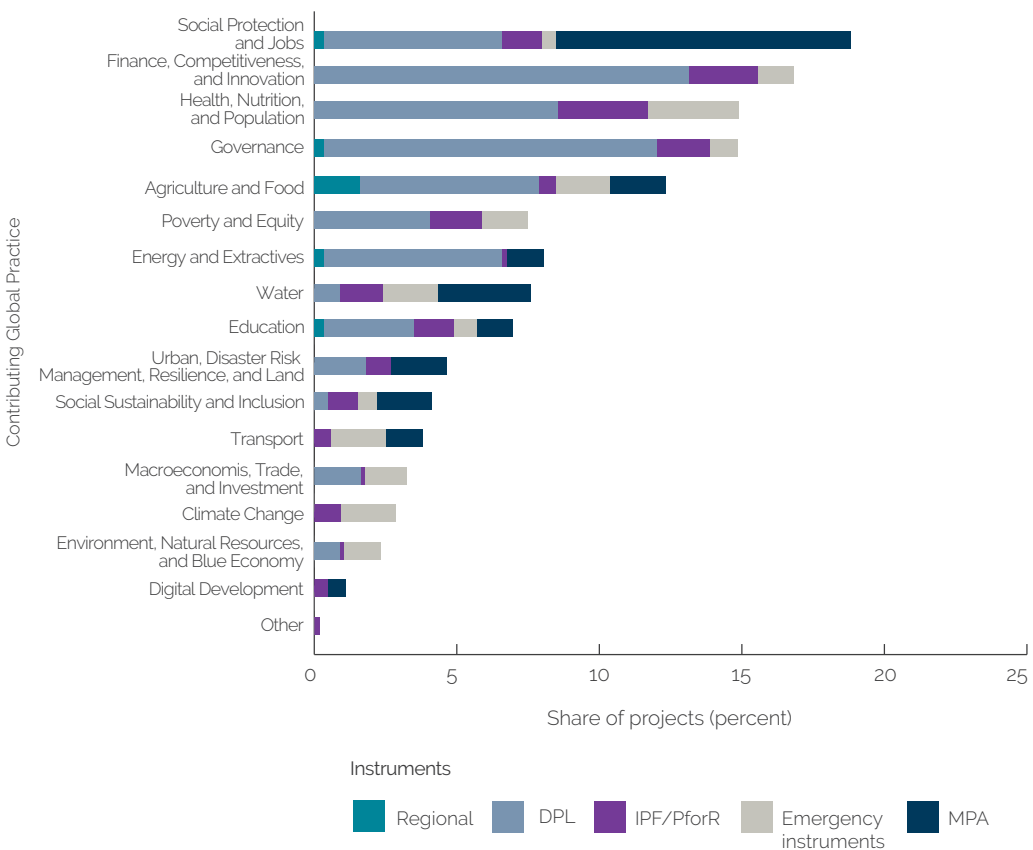
collaboration across GP teams helped reorient the portfolio quickly and process requests from the government. In Madagascar, by repurposing project support, the Urban, Disaster Risk Management, Resilience, and Land; Health, Nutrition, and Population; and Social Protection and Jobs GPs collaborated to facilitate social distancing, hygiene services, and handwashing stations for public transport and to provide cash transfers and cash-for-work activities. India and the Philippines conducted frequent portfolio reviews to coordinate support.

Case studies and the portfolio review suggest that drawing on a wider range of World Bank sectors helped the response. Forty percent of projects collaborated with one other GP (figure 4.2). Collaboration varied by instrument—development policy financing (DPF) and catastrophe deferred drawdown option (CAT DDO) had the highest collaboration, as did CERC and regional projects, although to a lesser extent (more than half of these projects had GP collaboration). About 60 percent of World Bank country programs had collaboration involving at least one sector beyond the Human Development GPs, such as Finance, Competitiveness, and Innovation; Agriculture and Food; Social Sustainability and Inclusion; Water; and Governance. More frequent collaboration with a range of GPs would have helped support local government, sanitation, gender, psychosocial support, nutrition, citizen engagement, and other areas. One way that collaboration was encouraged was through joint projects that engaged Health, Nutrition, and Population, but it was also important to align support across GPs, such as to the MPA, to help address interrelated needs. Examples of where Health, Nutrition, and Population collaborated with other GPs to draw on a wider range of support include the following:

- » In Tajikistan, the MPA led by Health, Nutrition, and Population collaborated with Social Protection and Jobs to implement social protection support that included an aligned ASA led by the Governance GP to assist third-party monitoring of the health response.
- » In the Philippines, the MPA led by Health, Nutrition, and Population collaborated with Digital Development to digitalize systems and with Social Sustainability and Inclusion to support stakeholder consultations.

- » In West Africa, Health, Nutrition, and Population and Agriculture collaborated in regional project support to train One Health agents in community-based surveillance.
- » In Uganda, the DPF led by Macroeconomics, Trade, and Investment provided support across sectors to ensure basic utilities and water services, expand social registration, provide vouchers for farmers, enact a child protection policy, and procure medical supplies, in collaboration with Health, Nutrition, and Population; Agriculture and Food; Social Protection and Jobs; Social Sustainability and Inclusion; Water; Energy and Extractives; and Governance.

Figure 4.2. Global Practices Contributing to Projects for Early Health and Social Response



Source: Independent Evaluation Group portfolio.

Note: Percentages can add to more than 100 percent across contributing Global Practices or Global Themes because a single project may have multiple contributing Global Practices or Global Themes. The analysis looks at collaboration in parent and additional financing projects. Emergency instruments include COVID-19-activated Contingency Emergency Response Component and catastrophe deferred drawdown option projects. N = 253 parent and 67 additional financing projects. DPL = development policy loan; IPF = investment project financing; MPA = Multiphase Programmatic Approach; PforR = Program-for-Results.

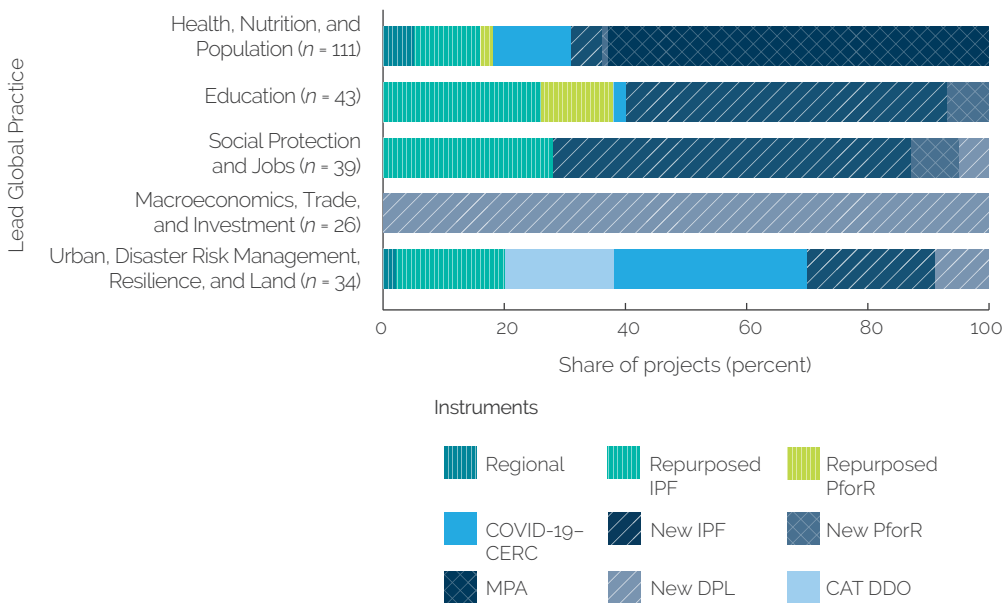
Instruments Supporting COVID-19 Crisis Response, Streamlined Processes, Corporate Requirements, and Procurement

The MPA provided an innovative and rapid approach to expand new lending for the health response. The first MPA, approved in April 2020, included project financing in 51 countries, mainly investment project financing (IPF). The additional financing approved in October 2020 expanded support to 70 countries by April 2021. The MPA offered an umbrella approach with a menu of areas that eligible countries could adapt to their needs and build on to address subsequent stages of the response. This allowed projects to maintain some uniformity in content, which increased the speed of design, processing, and approval while adapting content to country demands. The first MPA projects in countries disbursed in April 2020, then disbursement increased gradually throughout the first 15 months of the response as more projects became active. By the end of May 2020, three months after the crisis was declared, all approved MPA projects had made initial disbursements, with subsequent disbursement by August 2020 (appendix H analyzes the early support of the health MPA).

Complementing new project support with advisory services, the use of DPFs and immediate release of financing in the early days and weeks of the response was important to support quick actions. Ministries of health were overwhelmed and often needed immediate financing and health advisory and technical support to respond to COVID-19. In some countries, such as India, Mozambique, and Senegal, crisis and repurposed resources were used for the immediate response, which provided an opportunity for staff to support the early health dialogue. Drawing on crisis instruments, regional projects, ASA, and repurposed projects, where available, ensured quick financing by March 2020, which new project support could build on later. The minimum time for countries to process and disburse MPA financing was about two months. New DPFs first disbursed in May 2020 and were useful for rapid expansion of crisis support for vulnerable groups, surveillance systems, or new policies to protect child welfare, but they were limited in coverage. New IPF projects to support social protection and education were processed

throughout the first year of the response, with the first disbursement in July 2020. The portfolio analysis shows the mix of instruments used across countries to support the response (figure 4.3). Findings from the portfolio review, case studies, regional project analysis, and operational process review (appendixes B, C, and G, respectively) point to the use of instruments for supporting different time frames and aspects of crisis response (box 4.2).

Figure 4.3. Mix of Instruments Used by Global Practices to Support the Response



Source: Independent Evaluation Group portfolio.

Note: The analysis is based on 253 projects coded for the evaluation. COVID-19-activated CERC includes 26 projects in eligible countries and selected lead Global Practices with COVID-19 emergency response tags or keywords "COVID" or "corona" in their titles, project development objectives, indicator, or summary text. This excludes 13 COVID-19-activated CERC projects: 10 projects reported in the Global Facility for Disaster Reduction and Recovery CERC dashboards (May 5, 2021, and June 1, 2021) in eligible countries and lead Global Practices that did not have COVID-19 emergency tags or keywords at the date of data extraction (May 12, 2021), and 3 projects identified separately by the Independent Evaluation Group later in the evaluation. CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component; DPL = development policy loan; IPF = investment project financing; MPA = Multiphase Programmatic Approach; PforR = Program-for-Results.

Box 4.2. Examples of Instrument Use

Regional projects (discussed in chapter 3) could have been used more widely to assist with the health response, especially in Africa (appendix G). Regional projects, where used, provided resources in about one month, by March 2020, to support the response—for example, by establishing links between regional projects in Africa and new Multiphase Programmatic Approach projects in countries for COVID-19, as was done in Mauritania, Senegal, Togo, and Zambia. These projects could have also supported early cooperation on vaccines.

Development policy financing (DPF) funded reforms to restructure policies and systems, drawing extensively on dialogue before COVID-19 to support just-in-time policy actions that could be carried out rapidly. New DPFs, where used early in the response, supported financing by May 2020 and then disbursed quickly. Countries with human development-related DPFs increased from about 20 percent before COVID-19 to 27 percent in the evaluation portfolio during COVID-19. The operational processes review noted wider opportunities to use DPFs across more countries to expand policy actions to protect against health and human capital losses. It also noted that some countries could have benefited from supplemental DPFs during COVID-19, which were limited. The challenge was ensuring that DPFs supported relevant policy actions with measurable results, beyond providing rapid financing to national plans.

Program-for-Results projects (about 5 percent of countries) and projects with disbursement-linked indicators (about 5 percent of new projects) were rare. Although the evaluation did not analyze the benefits of performance-based financing approaches, the operational process review noted a missed opportunity to use these approaches within the health sector to improve early COVID-19 support, given the heavy focus on procuring goods over attention to the quality of services. Tajikistan and Uganda are strengthening performance-based approaches in health systems, for example, for disease management and for infection prevention and control.

Repurposed projects were used in about 51 percent of countries and could provide immediate financing (by March 2020) for education, water, communication activities, and health services, though drawing on repurposed projects happened at different time frames of the response. Use of repurposed projects often built on existing policy dialogue and local government or community networks supported by World Bank projects. The projects also procured medical or education goods. These projects

(continued)

Box 4.2. Examples of Instrument Use (Cont.)

performed well in adjusting to the crisis and in addressing needs such as nutrition, although their implementation progress rating may not reflect this because important components for project development objectives were paused. For example, the nutrition project in Uganda successfully added COVID-19 communication, but there were challenges initially to conduct planned nutrition support in schools. The value of repurposing projects has been reinforced in other evaluations of the COVID-19 response.

Advisory services and analytics support was available in about 60 percent of countries (discussed in chapter 1). Key was having advisory services and analytics available in the first months of the crisis to inform response actions. Global partnerships and regional projects also provided knowledge and learning support in some countries. Better linking the Multiphase Programmatic Approach to advisory services and analytics (as in Tajikistan) could have helped address advisory needs of government and supported the implementation of critical health services.

Sources: Independent Evaluation Group portfolio, case studies, and regional project analysis; Johnson and Kennedy-Chouane 2021.

Crisis instruments helped World Bank country programs to provide resources to governments rapidly and flexibly in the early months of the COVID-19 response, yet few countries were prepared with good coverage of these instruments in their portfolios. About 65 percent of countries had CERCs in their portfolios in the 15 months leading up to COVID-19. Twenty two percent had a high proportion of CERCs in their portfolios (figure 4.4), and about 6 percent had CAT DDO to support the early health and social response. Case studies found that multiple CERCs in a variety of sector projects provided flexibility to manage resources across the portfolio, but few World Bank country programs had planned CERCs in this way. Moreover, innovating on the design of CERCs—for example, to support local government responses—could improve their use in crises. In the Philippines, an innovative community-based disaster response modality supported by the World Bank provided resources for subnational COVID-19 responses. Challenges in using CERCs were related to their activation timeline, which required countries to declare an emergency to make resources available.

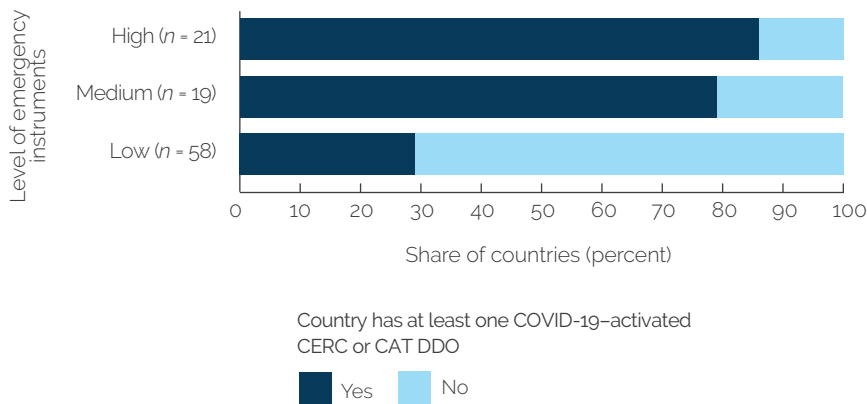
Case studies found that this meant it was not possible to access funds for planning activities before the crisis struck—adjusting this requirement could be important to improve the flexibility of CERCs to provide immediate resources for prevention activities to avert a future crisis. There was also concern about crisis instruments diverting financing from projects, without commitments to replenish those resources. However, in countries with experience using crisis instruments, CERCs provided rapid financing, and there was good preparedness with multiple CERCs in the portfolio:

- » In India and Mozambique, multiple CERCs allowed for flexible management of resources across sectors. Previous crisis experience in Mozambique led to careful planning of CERCs before COVID-19, ensuring availability of resources from these and from repurposed projects for immediate response and creating space to develop an MPA project by June 2021 focused on vaccines and continuity of health services. Where available, countries often used CERCs to procure medical supplies at the onset of the crisis.
- » In Honduras, the adjusted country portfolio drew on CERCs and a CAT DDO, which supported collaboration across GPs to tackle the impact of hurricanes in addition to COVID-19. The CAT DDO included prior actions to help the national and subnational emergency response plans and to strengthen health surveillance systems.

About 70 percent of countries successfully received disbursements from COVID-19 projects in the first three months of the response, starting immediately when the crisis was announced in March 2020—a rapid pace for the World Bank. Key was having some early financing from crisis instruments, repurposed projects, regional projects, trust funds, or grants resources within days. The fastest disbursements in the first days and weeks, before other project financing started, were from crisis instruments, repurposed projects, and regional projects, pointing to their role in swift early disbursement in a crisis (figure 4.5, panels a and b). MPA and DPF financing started to disburse several months into the crisis. New IPF and Program-for-Results slowly increased their share of disbursements, indicating their ongoing role in supporting countries for recovery, along with later phases of the MPA. Having flexible World Bank–executed trust fund resources was key to provide just-in-time assistance to countries, such as to plan activities at the start

of the crisis and even before it was officially announced. Case studies also noted the importance of having grant resources for quickly processing new projects in some countries where government was hesitant to use scarce IDA resources for the crisis. In some countries, it took parliament about a year to approve new emergency projects, limiting their value for the emergency response, whereas grant financing could be approved rapidly.

Figure 4.4. Crisis Instruments in Country Portfolios



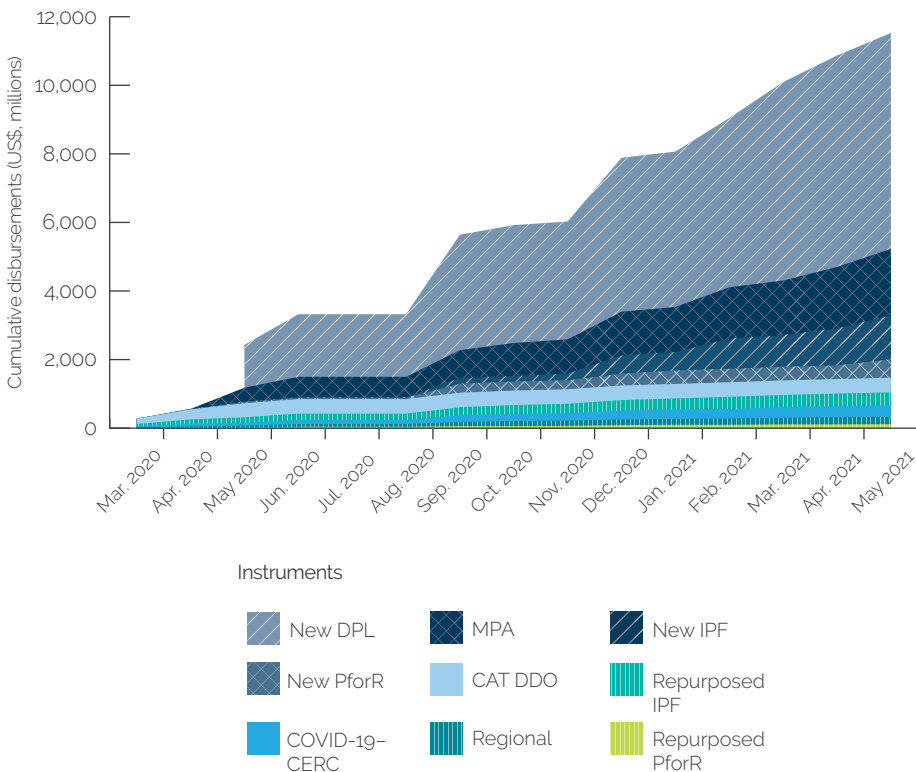
Source: Independent Evaluation Group portfolio.

Note: The figure is based on a combined 167 parent and additional financing projects from eligible countries tagged with CERC (152 projects) or a CAT DDO (15 projects), irrespective of Global Practice and active between February 1, 2020, and April 30, 2021. The figure includes an estimated COVID-19-activated CERC of 55 projects across Global Practices: 47 projects from the Global Facility for Disaster Reduction and Recovery CERC dashboards updated on May 5, 2021, and June 1, 2021, plus an additional 8 projects identified by the Independent Evaluation Group portfolio analysis. Regional projects with CERC are excluded. The level of emergency instruments is based on the quantity of overall CERC and CAT DDO projects per country, with levels broken down by tercile. Low level of emergency instruments: 0 to 1 CERC or CAT DDO project; medium level of emergency instruments: 2 CERC or CAT DDO projects; high level of emergency instruments: 3 to 10 CERC or CAT DDO projects. The total number of countries is 98. CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component.

Having a mix of instruments in the portfolio that could be used at different times frames in the early weeks and later months of the crisis response was important. Table 4.1 synthesizes findings on various instruments used in the COVID-19 response in terms of their timing, constraints, and opportunities. Countries with regional projects, better embedding of crisis instruments in the portfolio, experience using a range of instruments to support human capital, and trust funds were often better prepared for the crisis response.

Figure 4.5. Disbursement of COVID-19 Resources by Instrument and Time

a. Cumulative disbursements by month



b. Application of operational lessons from past crises in COVID-19

Instrument	Median Time in Months	Minimum Time in Months	First Disbursement Month and Year
COVID-19-CERC	1.0	1.0	March 2020
CAT DDO	1.0	1.0	March 2020
Regional	1.0	1.0	March 2020
Repurposed IPF	2.0	1.0	March 2020
New IPF (additional financing)	2.6	1.1	March 2020
MPA	4.1	2.2	April 2020
New DPL	7.6	3.5	May 2020
New IPF	10.5	5.2	July 2020

Source: Independent Evaluation Group portfolio.

Note: Disbursement data are retrieved from the World Bank's Standard Reports. In panel a, disbursements reported are adjusted using the share of COVID-19 response content estimated in the coding of each project by the Independent Evaluation Group and combines parent projects and additional financing. New projects (approved on or after February 1, 2020) are assumed to have a 100 percent share of COVID-19 response content. Refer to appendix B for portfolio description. Panel b is organized from fastest to slowest time to first disbursement from the start of the crisis. The time to first disbursement is defined as the number of months between February 1, 2020, and the first disbursement date during the evaluation period. CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component; DPL = development policy loan; IPF = investment project financing; MPA = Multi-phase Programmatic Approach; PforR = Program-for-Results. *N* = 246 projects.

Table 4.1. Constraints and Opportunities of Instruments in COVID-19 Response by Timing of Financing

Instruments	Constraints	Opportunities
Early weeks and first month of COVID-19 response		
CERC and CAT DDO (about 7 percent of financing)	Emergency activation May divert funds Needed in portfolio before crisis	Innovation of crisis instrument design Can be used to move resources across the portfolio Prior actions and immediate financing for emergency plans More flexible processing
Regional disease projects (less than 2 percent of financing)	Limited across countries Capacity of regional networks before COVID-19	Expansion of regional capacity for crisis preparedness

(continued)

Instruments	Constraints	Opportunities
Repurposed projects (about 24 percent of countries)	The extent of human capital portfolio before COVID-19	Built on existing institutional structures and relationships in sectors to provide rapid support
World Bank-executed trust funds (less than 1 percent of financing)	Limited availability	Immediate diagnostic or technical support to carry out emergency plans
Several months into COVID-19 response		
Multiphase Programmatic Approach (20 percent of financing)	Several months of response before new projects processed Grant financing processed quicker in some countries	The Multiphase Programmatic Approach enabled rapid approval of new projects, drawing on technical lessons, and can be built on for later phases of recovery.
Pandemic Emergency Financing Facility (less than 1 percent of financing)	Needed to be processed in a project for use by World Bank teams	Financing of United Nations partners to support crisis coordination was often faster. Making available emergency financing for just-in-time advisory services and analytics Grant access was key for countries.
Development policy financing (23 percent of financing)	Experience with prior actions for human development	Clarity on type and mix of prior actions to support crisis response Support to expand services and policies for vulnerable groups
New investment project financing (24 percent of financing)	New projects take time	Strengthening results orientation New systems and institutional strengthening support in a crisis

Sources: International Evaluation Group portfolio; World Bank 2012, 2017.

Note: The evaluation did not assess the extent of use of trust funds. CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component; PforR = Program-for-Results.

Streamlined Operational Processes

Operational flexibility facilitated rapid processing of new projects for the health response. All projects followed processing guidelines for emergency situations, which bypasses the concept stage—this flexibility was in place before COVID-19. Guidance to process new projects was provided by the fast-track facility. GPs set up technical committees for quick peer review of projects. Additional flexibilities that helped process the MPA quickly were

shortened clearance deadlines and delegated approvals to speed up project processing, paused gender tagging for the first MPA, waivers for financing food expenditures under the IPF policy, and encouragement to use project preparation advances without submitting individual requests. These flexibilities helped Health, Nutrition, and Population process new projects for the response, but these flexibilities did not apply to other GPs, and additional steps were introduced for some new projects. For example, new two-page justifications were sometimes required of staff before regional operations committee meetings for projects viewed as risky or large. Given the emergency and its extensive impact, flexibilities applied to the MPA could have been applied to all new financing to help GPs support countries quickly. This was especially important, given the limited use of additional financing compared with past crises. A previous evaluation reported the median time from approval to first disbursement as 4.8 months for new crisis projects, 7.1 months for noncrisis projects, and 1.5 months for DPFs (World Bank 2019a). MPA projects and new DPFs for COVID-19 were very quick to disburse, compared with past crises—the median time from approval to first disbursement for MPA projects was 1.5 months, and the median time was less than 1 month for DPFs. The median time was about 5 months for new IPFs, similar to past crises. However, some projects disbursed in less than 1 month from approval.

Compared with past crises, the World Bank’s operational agility improved in COVID-19, but challenges remained. Implementation Status and Results Reports identified new project processing as a challenge in COVID-19, though less so than in past crisis (figure 4.6; appendix F). There was strong hand-holding support to staff, but templates, technical specifications, and guidance on safeguards and procurement were often developed in real time, resulting in confusion. Templates and guidance were often developed several months into the response and then revised, requiring countries to retrofit project information to the templates. Once guidance stabilized, and there was agreement on how to proceed, project teams often reported easier processes. Teams that processed MPA projects later in the response reported smoother processes because problems had been resolved. Interviewees noted the need to review emergency processes to eliminate confusion on guidance in future crisis responses. A previous evaluation identified the importance of a road map for crisis engagement that defines, for example, broad divisions

on roles and responsibilities and the rationale, modalities, and instruments in responses (World Bank 2012). Furthermore, the Organisation for Economic Co-operation and Development emphasizes that pandemic preparedness requires detailed and up-to-date operational plans and processes describing the different roles of staff, procedures, and uses of instruments in responding to crises (OECD 2022).

Figure 4.6. Operational Process–Related Success and Challenges Reported by Projects



Source: Independent Evaluation Group review of project Implementation Status and Results Reports for lesson analysis.

Note: The COVID-19 portfolio includes 120 successes and 165 challenges in the selected areas of the figure, extracted from 113 projects coded with those areas. "Partnership and collaboration" looks at partnerships to support implementation, information sharing, and joint analyses. "Flexibility in operational procedures" looks at the timely processing of new financing for the response. "Streamlining implementation support to projects" looks at factors that facilitated clients to rapidly implement support in projects (appendix F).

World Bank staff responded to enormous demands to deliver extraordinary support in unprecedented circumstances. Staff worked for long hours to deliver new and repurposed operations, without travel, while learning to use remote connectivity and geospatial tools and adapting to home-based work amid evolving family arrangements and stresses. Some staff suffered personal losses; many coped with pandemic-related anxiety. Heavy work pressures stemmed not only from mounting the COVID-19 response but also from other ongoing considerations: the locust response, natural disasters, debt relief efforts, the July 2020 staff realignment, other internal reorganizations (such

as splitting the Africa Region into two Regions), and a leadership rotation in the Human Development Practice Group.

Access to surge capacity to process early health support was critical, but internal mobilization of this capacity was challenging. As the crisis continued, managers in health mobilized surge capacity—using retirees, exchanging overloaded staff, and increasing the responsibilities of country office staff—to help quickly process projects. The operational process review suggests that further surge capacity to process early health support could have come from within the World Bank. Social Protection and Jobs; Education; and Health, Nutrition, and Population were processing 240 percent to 480 percent more projects, whereas other GPs were processing fewer projects than before. The operational process review findings also point to a challenge in the incentives to collaborate across GPs at the operational level to help process and implement emergency project support, such as a DPF or MPA led by one sector, as each GP has its unique sector focus.

Gender, Citizen Engagement, and Safeguards

GPs addressed gender requirements more consistently when support predating COVID-19 could be adjusted. Addressing gender requirements with new support in a crisis was challenging for World Bank teams without technical assistance to help consistently incorporate gender approaches in the response. In Social Protection and Jobs, earlier analysis of gender equality was applied in COVID-19 projects, including the expansion of registries with an emphasis on female-headed households and women with young children. Opportunities to address gender in the health response were missed, and gender analysis in the Health, Nutrition, and Population response is rare. An internal review by the Gender Group of 27 MPA projects highlighted 3 projects that intentionally addressed gender equality (about 10 percent): projects in Pakistan and Sierra Leone defined gender activities as part of project components, and the Mongolia project included a section on gender differentials. Project teams noted a need for more technical support to implement well-developed gender approaches in health and education projects. In Uganda, Social Sustainability and Inclusion reviewed COVID-19 projects to identify opportunities to address gender, which helped GPs to plan support.

Outside specific innovations, citizen engagement received limited emphasis across GPs. Some interviewees noted that the current approach to citizen engagement had limited applicability in a crisis and often was not developing country systems that could be drawn on during COVID-19. For example, the citizen engagement intranet site has very few updates and little content on COVID-19. Helpful innovations used by health and education projects included SMS feedback from citizens about services. Having platforms fostering citizen engagement in place before the next crisis could be important because lack of trust and accountability and the weak roles of citizens were challenges to mobilizing demand for services during the COVID-19 response.

The new Environmental and Social Framework was challenging amid the early months of the crisis. Extensive support was provided to World Bank teams to implement the Environmental and Social Framework, including help with completing documents. COVID-19 guidance released early in the pandemic (in response to operational realities) allowed for the Environmental and Social Framework requirements to be met after the project was approved, although they needed to be completed before processing procurement of medical goods. Despite this much appreciated support, because the Environmental and Social Framework was new, interviews noted that developing the required outputs and processes involved on-the-job learning, which was challenging because clients—especially in health for processing the MPA—were overwhelmed with urgent COVID-19 demands. The outputs required from clients included the Environmental and Social Review Summary, Environmental and Social Commitment Plan, Stakeholder Engagement Plan, and documents for risk-related topics, such as medical waste, social inclusion, and nondiscrimination. The World Bank used additional financing in other crises to provide flexible and fast-disbursing support, which built on existing safeguards to avoid adding new steps in a crisis. However, the use of additional financing was initially limited in COVID-19 operations because projects approved under the previous safeguards policies were required to transition to the new Environmental and Social Framework until a waiver was issued in June 2020. More streamlining of safeguard requirements for new projects in the early crisis response could have been helpful.

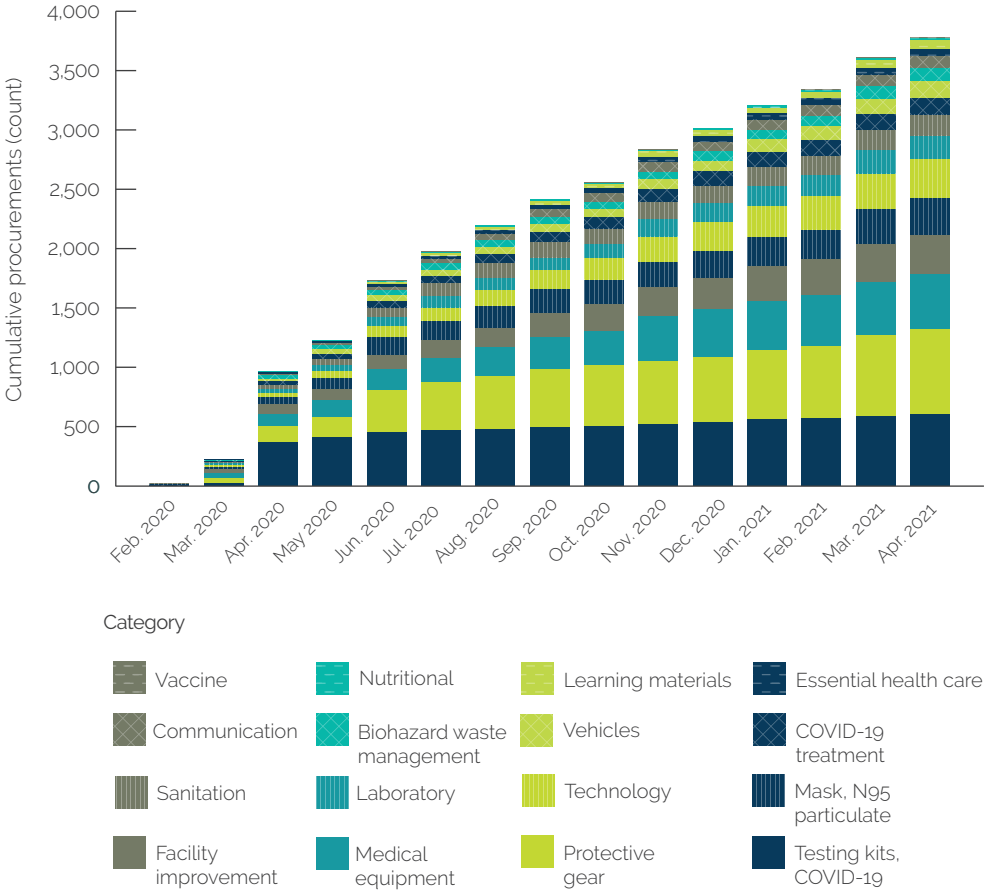
Procurement of Goods

The relief stage supported emergency procurement of medical and other goods, with successful efforts to expedite processes. By June 2020, five months into the response, almost 50 percent of procurement contracts supporting the early COVID-19 response were signed, ensuring that countries received protective gear and medical supplies and equipment. In alignment with the World Bank's *Guidance on Procurement in Situations of Urgent Need of Assistance or Capacity Constraints*, procurement was supported through countries adopting accelerated procedures, World Bank–facilitated procurement, and collaboration with United Nations organizations. Accelerated processes included allowing for retroactive financing, direct selection, electronic bidding by email, and larger up-front payments to secure goods on global markets. Although steps were not always clear, and case studies noted an opportunity to clarify guidelines on accelerated procurement procedures, procurement in COVID-19 was quick and smooth compared with past crises, helping to obtain needed medical supplies. A previous IEG evaluation of support to natural disasters identified procurement as a main constraint (World Bank 2006), whereas in COVID-19, procurement was not a main challenge reported in Implementation Status and Results Reports or interviews, despite global supply chain difficulties.

In COVID-19, countries successfully employed a variety of mechanisms to procure needed goods quickly, including procurement using United Nations agencies and World Bank–facilitated procurement. This may have been difficult before the World Bank's procurement reform in 2016. Close support from World Bank procurement specialists was key, and in some cases, senior procurement staff tracked health goods to ensure that they arrived rapidly in the intended country. Direct selection was used for almost 60 percent of contracts. There was World Bank–facilitated procurement of scarce medical goods. Some World Bank teams preferred to use United Nations agencies for procurement, given their simplified processes, but countries that used World Bank–facilitated procurement reported that the service helped reduce the cost and speed of receiving goods where it was used. In total, the World Bank procured just under \$1.9 billion of critical goods in the early response, including COVID-19 test kits, personal protective equipment,

facility improvements, laboratory and medical equipment, and technology (figure 4.7). About 67 percent of the procurement of goods for the health and social response was supported by the MPA, making it a critical vehicle for emergency financing.

Figure 4.7. Cumulative Procurements for Goods by Category, by Date



Source: Independent Evaluation Group portfolio.

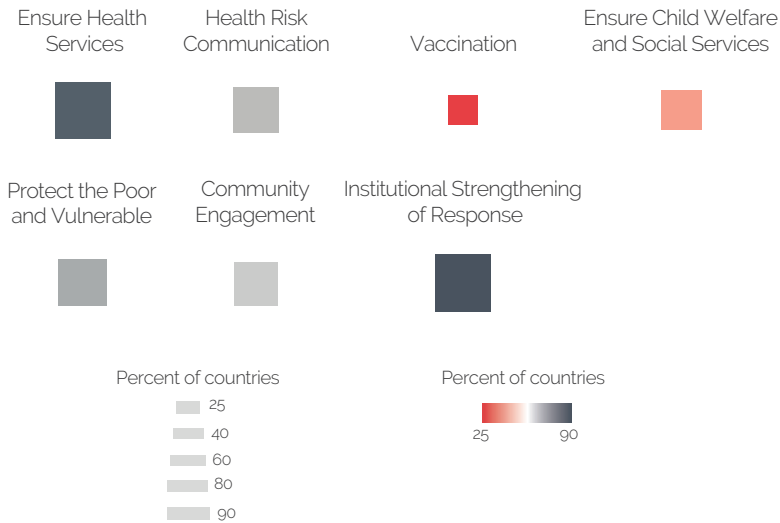
Note: The data include signed procurements only, which means active contracts with a signature date between February 1, 2020, and April 30, 2021, and a status of signed, under implementation, completed, or under review. Signed procurements also include active contracts with a signature date after February 1, 2020, no contract sign date, and a status of signed or under implementation. For procurements without a contract sign date, the sign revision date was used. The number of procurements per category was calculated by separating 2,690 individual goods procurements into components against a defined taxonomy using text analytics. The number of procurements of each good is 8,565.

Key challenges to procurement included the coordinated planning and tracking of goods until their arrival in health facilities, and limited emergency preparedness of procurement systems in countries. World Bank teams worked closely with partners to plan what was procured, but it was challenging, and in some cases, goods were already procured by another partner by the time they arrived, and another item was needed more urgently. In some countries, World Bank teams helped develop systems to plan and track goods until the arrival at health facilities, which helped monitor what was purchased by different partners and ensured accountability of goods arriving to benefit communities. In Paraguay, the health ministry used georeferenced data to plan procurement. Tajikistan and Zimbabwe developed electronic tracking systems, including an SMS platform to verify receipt of goods. In these countries, health sector supply chains were strengthened in real time. World Bank teams also worked with the government to adopt accelerated procurement processes so they could procure goods more quickly using country systems. Such support was provided in Djibouti and by the Africa CDC and Organisation of Eastern Caribbean States regional projects.

Monitoring and Reporting

World Bank projects planned indicators, although timely monitoring was challenging. The review of indicators shows that countries planned indicators to measure 60 percent of response areas (figure 4.8). Few indicators measured child welfare and social services, and measurement of community engagement was even more limited. Vaccination is measured less, mainly because vaccine projects were developed later in the response. However, less than 40 percent of indicators were tracked during the response, given that project reporting is every six months. A review on the first year of the pandemic highlights that nearly every report identifies the lack of data collection as an important constraint in understanding funding, activities, and results (Johnson and Kennedy-Chouane 2021). Monitoring of indicators from new projects was especially challenging; however, the health response stands out as having good monitoring, compared with other areas because Health, Nutrition, and Population monitored the new MPA projects closely (figure 4.9).

Figure 4.8. Country-Level Alignment of Indicators to Measure the COVID-19 Response

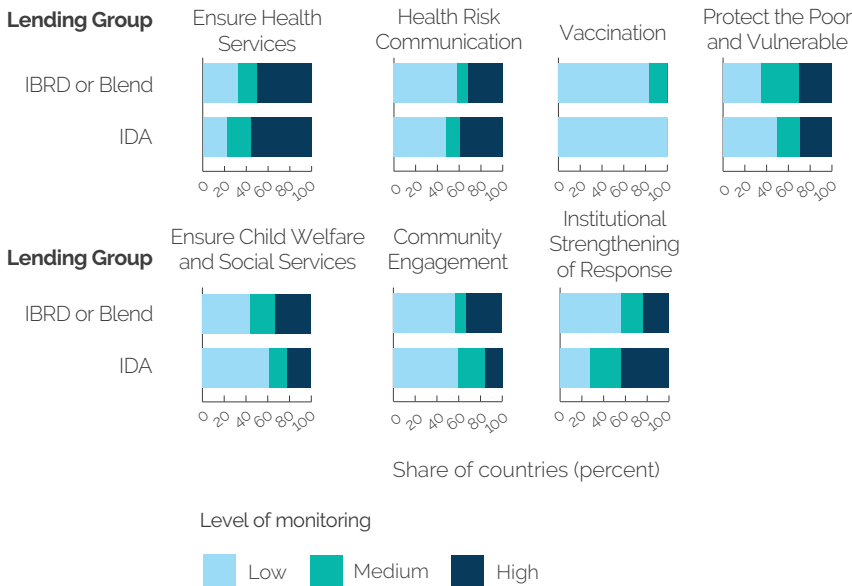


Source: Independent Evaluation Group portfolio.

Note: The figure shows the proportion of countries with at least one indicator in a project in their portfolio to monitor a planned COVID-19 thematic response area. "Ensure health services" includes indicators measuring achievements of health support in the COVID-19 response. "Protect the poor and vulnerable" includes indicator measuring social protection and informal sector improvements. "Ensure child welfare and social services" includes indicators measuring education, nutrition, and psychosocial improvements. "Community engagement" includes indicators measuring aspects of social cohesion and citizen engagement. "Institutional strengthening of response" includes indicators measuring system and policy improvements. The total number of indicators is 2,219 and countries is 92.

Indicators frequently measured outputs, but measurement of the quality of services, social cohesion, and systems improvement was limited. Indicators often measured materials received, such as equipment, and in some cases, the delivery of the service. These data will need to be complemented by data collection on quality improvements and outcomes to assess the achievements of support to restructure systems (box 4.3). Moreover, there is limited measurement of and support to community activities, especially social cohesion.

Figure 4.9. Extent of Monitoring in Countries by Response Area



Source: Independent Evaluation Group portfolio.

Note: The figure reports the share of countries within each lending group and response area by level of monitoring. Level of monitoring is based on the tracking or progress share of indicators in a country response area: low (0 percent to 22 percent); medium (22 percent to 52 percent); high (52 percent to 100 percent). IBRD and blend: $n = 39$ countries; IDA: $n = 49$ countries. $N = 88$ countries. Regional projects are excluded from the analysis. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

About two-thirds of countries show evidence of positive progress on tracked indicators. Early progress is most notable in IDA countries (figure 4.10), where a medium to high share of tracked indicators show early progress, especially for Africa. A little more than 40 percent of all indicators assessing the health response (ensuring health, risk communication, vaccination, and strengthening of health systems and coordination) show early progress. There is less progress for indicators measuring results in social protection and education, with only about one-quarter showing evidence of progress.

Box 4.3. Examples of Indicators Monitoring the Response

For the health response, indicators focus on surveillance, case management, and essential health services. Indicators include outputs measuring numbers of equipment (ventilators, COVID-19 test kits, and sanitation kits) and health workers and lab staff trained, and some examples of measuring the quality, knowledge, and systems improvements:

- » Hospitalized patients with COVID-19 who are treated per national guidelines
- » Health facilities providing 75 percent of the essential package of services
- » Suspected COVID-19 cases diagnosed by laboratories within 24 hours
- » Population able to identify three key symptoms and prevention measures of COVID-19
- » Health workers fully vaccinated against COVID-19
- » Contracting and deployment of surge capacity health workers
- » Hospitals with triage and isolation capacity per a quality checklist
- » Coordinated disease surveillance systems in place in the animal health and public health sectors for zoonotic diseases or pathogens identified as joint priorities

For the social response, common themes monitored are social protection and child welfare. For the relief stage, social protection indicators often monitor outputs related to the delivery of immediate assistance, improvements in social registries and systems, and in some cases, changes in beneficiaries receiving the assistance. Child welfare indicators include tracking children returning to school, opening of schools, and the inclusion of vulnerable groups. Examples of indicators measuring the response include the following:

- » Children whose learning was assessed to evaluate loss of learning during school closure
- » Primary schools reopened after implementation of safety plans
- » Coverage of hygiene promotion activities

(continued)

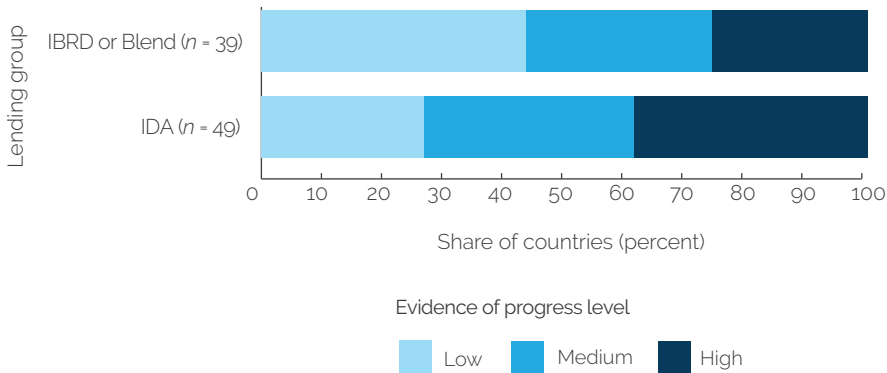
Box 4.3. Examples of Indicators Monitoring the Response (Cont.)

- » Female students provided access to psychosocial support services
- » Frontline health-care workers with the knowledge to care for survivors of gender-based violence
- » Workdays created for women to work by local contractors
- » Beneficiaries receiving COVID-19–related cash assistance
- » Schools where parents reported improvements in learning during COVID-19
- » Local governments implementing participatory planning processes
- » Households benefiting from shock-responsive safety net programs
- » Citizen engagement messages distributed via radio

Source: Independent Evaluation Group portfolio.

Note: Health response included ensuring critical health services, continued essential health services, health risk communication, vaccines, and health systems strengthening. Social response included ensuring social protection of vulnerable and informal workers, learning of vulnerable children, nutrition, psychosocial support, community engagement, and social systems strengthening.

Figure 4.10. Countries by Extent of Level of Progress on COVID-19 Response Indicators



Source: Independent Evaluation Group portfolio.

Note: The figure shows the percentage of countries by levels of evidence of progress of indicators, where levels correspond to terciles of the distribution of the evidence of progress share of total indicators across countries: low (0 percent to 16.67 percent), medium (16.67 percent to 51.76 percent), and high (51.76 percent to 100 percent). Indicators were coded based on whether the monitoring value showed no change or adverse change from the baseline or evidence of progress toward the target. The total number of countries is 88. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

Integrated reporting of data on various areas of the World Bank’s COVID-19 response was important to discussions with the country government, World Bank teams, partners, and headquarters. World Bank country management noted that it was challenging to compile data across projects to get a full picture of progress on the response for weekly or monthly meetings. Staff faced many fragmented requests from headquarters, GPs, and others to report on projects. The challenge of monitoring during the crisis reinforces the value of investing in better routine data systems for adaptive implementation of country support (discussed in chapter 3), such as geo-enabled monitoring, SMS, and dashboards, which were used in some countries in Africa and Latin America. The operational process review suggests that improving integrated reporting could benefit World Bank portfolio monitoring and policy dialogue during a crisis but also more routinely. The systems set up for monitoring the vaccine response provide an example of a coordinated approach to country program monitoring that aligns with partners and strengthens country systems (Chazaly and Goldman 2021). Box 4.4 provides examples of integrated reporting by World Bank GPs.

Box 4.4. Examples of the Global Mobilization of Data and Knowledge Resources

Compilation of countries' social protection responses. The Social Protection and Jobs Global Practice team monitored projects supporting COVID-19 and innovations supporting social protection.

Monitoring of Multiphase Programmatic Approach and health portfolio. The World Bank Health, Nutrition, and Population team closely monitored the Multiphase Programmatic Approach, including indicators and areas of implementation, by country task teams. The Health, Nutrition, and Population portfolio was also closely monitored by regions to track project support for COVID-19, Contingency Emergency Response Components activation for COVID-19, and additional financing for vaccines.

Education portfolio tracking. The Education Global Practice tracked projects supporting COVID-19, including estimated financing allocations.

Source: Independent Evaluation Group internal operational process review.

Partnerships to Facilitate Response

Partnerships between development organizations and the World Bank helped preparedness and crisis responses in countries. Partnerships developed by GPs and country management units before COVID-19 often provided technical knowledge and financing for the health and social response. Having such relationships defined before COVID-19 helped the partners to align strategies to rapidly collaborate on COVID-19 support in countries, as other evaluations have also found (Johnson and Kennedy-Chouane 2021). Important partnerships identified in interviews, documents, and case studies included development organizations such as United Nations' agencies, multilateral development banks, bilateral donors, foundations, nongovernmental organizations, and global partnership organizations (Global Partnership for Education [GPE]; Global Financing Facility; Education Technology; Gavi, the Vaccine Alliance; and the Global Partnership for Social Accountability). The World Bank engaged in four main types of partnerships to support the COVID-19 response:

- » Financing partnerships to provide grants within World Bank projects or aligned complementary financing support to the World Bank's response in countries
- » Technical partnership activities to innovate and expand knowledge for quality implementation of response activities, often supporting analytic work to understand the status of the response
- » Procurement and supply chain partnerships to improve the purchase and delivery of goods
- » Nongovernmental partnerships to support provision and feedback on services at the front line of the response

At the global level, partnerships also provided guidance on emergency plans and quality standards for the health response in countries. Key global partnerships are described in box 4.5.

Box 4.5. Examples of Global Partnerships Supporting COVID-19 Response

Health response:

- » The Global Financing Facility (GFF) provides financing and technical assistance for essential health services with a commitment to ensure that all women, children, and adolescents can survive and thrive. GFF grants supported knowledge work and learning exchange in partner countries to prioritize and plan for continued essential health services, strengthen frontline service delivery, and meet demand for sexual and reproductive health and other lifesaving services. GFF briefs in more than 60 countries highlighted severe reductions in the provision of oral antibiotics, vaccinations, childbirth, and family planning resulting from the pandemic. In Uganda, the GFF helped assess the communication strategy for COVID-19 health service disruption, in partnership with the Development Economics Vice Presidency. It also supported expansion of the national performance-based financing program to better address infection prevention and control in essential health services to manage waves of COVID-19.

(continued)

Box 4.5. Examples of Global Partnerships Supporting COVID-19 Response (Cont.)

- » Gavi, the Vaccine Alliance provided immediate grants to countries in response to COVID-19. The World Bank is an alliance member, sits on the board, and has agreements in place on financing and supporting countries to deliver vaccines. In Pakistan, based on its long-term relationship, Gavi, the Vaccine Alliance and the World Bank undertook joint missions to support the national immunization program to manage its COVID-19 response. In Tajikistan, the organizations partnered to provide COVID-19 vaccines to cover the first 16 percent to 20 percent of the population and financing to the United Nations and international nongovernmental organizations for technical assistance and cold chain improvements.

Education:

- » Global Partnership for Education provided a large grant program dedicated to the COVID-19 response, and projects working with these grants collaborated with consortium partners, including the United Nations Educational, Scientific, and Cultural Organization and United Nations Children's Fund. These grants-supported schools provide distance learning, teacher training, and school reopening. Across the portfolio, focus areas included the use of technology and gender equity. In Djibouti and Uganda, grants addressed gender-based violence, remote learning, and return to school efforts.
- » The Education Technology (EdTech) thematic group in the Education Global Practice, drawing on a global partnership, shared tools and produced research and experiences to accelerate digital learning. Using global EdTech tools in World Bank loans led to enhanced knowledge on remote learning. Technical advice was deployed to projects through a network of regional staff drawing on the EdTech Hub, supported by the World Bank, the United Nations Children's Fund, and United Kingdom's Foreign, Commonwealth and Development Office.

Gender:

- » The World Bank's Gender Group collaborated with UN Women and others in preparing a report on strengthening gender measures and data in the COVID-19 era.

(continued)

Box 4.5. Examples of Global Partnerships Supporting COVID-19 Response (Cont.)

Citizen engagement:

- » The Global Partnership for Social Accountability facilitates collaboration of civil society organizations with governments and engagement of citizens to solve development problems, strengthen accountability, and improve governance. During COVID-19, the Global Partnership for Social Accountability supported monitoring of the COVID-19 response in Tajikistan through civil society organizations.

Procurement:

- » The World Bank and United Nations agencies work in partnerships that enable joint procurement of goods and other collaborations within projects. Across more than 40 countries, the World Bank procured medical equipment and supplies for the response with the Food and Agriculture Organization, the United Nations Children's Fund, the United Nations Development Programme, the United Nations Office for Project Services, the United Nations Population Fund, the World Food Programme, and the World Health Organization (WHO). The World Bank also collaborated with WHO and the World Food Programme on the COVID-19 Supply Chain Task Force. These relationships provided a helpful procurement option to complement World Bank-facilitated procurement support.

Health standards and guidance:

- » The World Bank worked with WHO to set standards for COVID-19 response plans; these guided the strategic areas planned and supported by partners and countries globally. WHO was also the key agency to provide guidance to countries on medical goods.

Sources: Independent Evaluation Group portfolio; Aslam and Rawal 2021; Rodriguez et al. 2021; Muñoz-Najar et al. 2022; World Bank Group and United Nations 2021.

Global partnerships in health and education were quickly adapted to support the COVID-19 response in countries. In education, working with the GPE partnership consortium (which includes World Bank, UNICEF, and the United Nations Educational, Scientific, and Cultural Organization), partners coordinated technical and financing support rapidly to support the response

with wide coverage of countries. Case studies highlighted the success of GPE grants to quickly expand education support, collaborating with UNICEF and other partners. In Rwanda, GPE supported approaches to remote learning, including broadcasting lessons on the radio and free SMS messages. The Education Technology team facilitated rapid sharing of technical knowledge with partners and countries to expand technology-based learning. For example, more than 30 continuity stories from around the world highlighting countries' remote learning solutions were developed in partnerships with the Organisation for Economic Co-operation and Development, Harvard Global Education Initiative, and HundrED. The approach it employed is a model that could be expanded to other sectors. In health, the Global Financing Facility provided just-in-time knowledge support for health services and strategies. However, countries could have benefited from earlier technical knowledge to continue essential health services and for gender and risk communication. The World Bank's partnership with Gavi, the Vaccine Alliance was key in countries such as Tajikistan, but more countries could have benefited from this type of early support on vaccines during COVID-19—a theme that also arose in IEG's Global Program Review (World Bank 2014). Global Partnership for Social Accountability support in citizen engagement stands out for addressing a key need, but the limited coverage of countries was a challenge to strengthening accountability mechanisms, trust, and participation. Procurement partnerships were helpful across sectors. Health guidance partnerships with WHO were important for aligning health actions in countries; nevertheless, challenges arose because of the emphasis of this guidance on the health sector and less so on the social impacts of COVID-19 (discussed in chapter 2) and of alignment on vaccines (discussed under vaccine support).

Financing and technical partnerships helped expand response actions quickly in countries, although technical partnerships were rare. Funding partnerships were common for coordinating support. In India, engagement with the Asian Development Bank provided an additional \$500 million that followed prior actions similar to those of the World Bank's social protection and education support. Also in India, financing for the World Bank's health project was coordinated with the Asian Infrastructure Investment Bank. In Honduras, the World Bank collaborated with the Inter-American Development Bank in financing the social response, including joint missions. In the Philippines,

the Asian Development Bank and the World Bank also complemented each other by jointly financing civil works for laboratory structures and equipping laboratories. Technical partnerships were important for expanding COVID-19 support, although rare in countries, especially in the health sector. For example, the World Bank and UNICEF jointly expanded remote learning and psychosocial services in Djibouti, and the World Bank helped the government expand its vouchers and school feeding interventions with the World Food Programme.

Collaboration with nongovernmental organizations and the private sector, even though limited, helped expand community-based implementation and use of technology. For example, in Tajikistan, the World Bank worked with the Open Society Assistance Foundation to support civil society capacities to prevent and respond to COVID-19 and with the Aga Khan Development Network to train health workers. In Togo, the new Novissi social protection program helps citizens who lost their income and were pushed into poverty by the pandemic. Supported by the World Bank to undertake phone surveys, the government partnered with the University of California and the nonprofit GiveDirectly to prioritize those most in need by using satellite imagery, mobile phone data, and nationally representative household consumption data (World Bank 2022a). In Belize, the World Bank project partners with the national bank and telecommunications company to deliver cash transfers. Beneficiaries are notified of the funds by SMS message, and they collect their payment through a network of agents. A few examples of partnerships with nongovernmental organizations also occurred. Further collaboration with nongovernmental organizations could have helped expand technical learning and community activities.

Case studies noted a challenge in providing technical assistance to help countries expand quality critical health services. Partnerships in this area were limited. Countries required technical learning to implement new surveillance and case management approaches. Where World Bank teams already had technical knowledge implementing critical health services, they could apply that to COVID-19. Some countries benefited from technical knowledge partnerships through projects before COVID-19. For example, the 18th Replenishment of IDA (IDA18) and the 19th Replenishment of IDA committed to support pandemic preparedness plans in 25 countries (IDA

2017, 2020). During COVID-19, the Regional Disease Surveillance Systems Enhancement Project in West Africa coordinated technical learning through its cross-country exchanges, including with the Africa CDC, UNICEF, and WHO. Similarly, the Organisation of Eastern Caribbean States Regional Health Project supported technical knowledge learning with the Pan American Health Organization and the US Centers for Disease Control and Prevention. Technical learning partnerships to improve preparedness may be scaled up to other countries through such regional collaboration.

Pandemic Emergency Financing Facility

In coordination with partners, PEF grants provided support for COVID-19 plans; however, the amounts were small, and the funding did not support just-in-time actions in the first weeks of the response. The PEF was set up in 2016 through partnership and working with the private sector, with funding provided by Australia, Germany, IDA, and Japan and also insurance coverage through World Bank catastrophe bonds and insurance-linked swaps (World Bank 2020c). PEF provided surge financing to IDA countries facing large cross-border disease outbreaks, such as Ebola, and to catalyze the creation of a global market for pandemic insurance instruments. The WHO pandemic declaration triggered the PEF's insurance window, and allocations were defined in a little more than a month. All \$196 million of the fund was transferred to support COVID-19 responses in 64 countries by September 2020 (World Bank 2020c). The timeliness of PEF resources for just-in-time use by World Bank teams was limited by the need to declare an emergency to access the funding and by the processing requirement that PEF had to be included in a World Bank financing project for recipient execution. The amount of PEF financing might have been more useful with payment divided among fewer countries. Alternatively, PEF might have been more useful and timely had it been provided to health teams as a World Bank-executed trust fund for just-in-time financing of joint ASA to inform country and partners responses. Many governments struggled with how to respond to COVID-19 and sought just-in-time ASA in health, especially diagnostics and technical assistance, to refine strategies and planned actions. Such support was critical throughout the early response for adaptive management but especially so in the early weeks and months of the pandemic. Flexibility to use PEF in this

way could have increased financing for just-in-time ASA by about threefold, given the limited allocation of about \$60 million to ASA.

The flexibility of PEF to finance United Nations partners to facilitate coordination in countries and the quick processing of its grants were key assets. More than 60 percent of PEF grants were used to finance United Nations partners; the rest were processed in World Bank projects. In Honduras, the Pan American Health Organization received World Bank PEF support to adapt and equip seven health establishments for COVID-19 between July 2020 and March 2021. In Mozambique, the United Nations Population Fund received PEF resources to continue support to sexual and reproductive health services during COVID-19. In Uganda, PEF was integrated in MPA financing, allowing for faster processing over IDA credit resources, and the funding was used to procure health-related goods, training, and other support for the national COVID-19 plan.

Vaccine Support

In a context of high uncertainty in the early months, the World Bank engaged with global partners in efforts related to vaccines but lacked an instrument to help expedite country vaccine access. In the first months of COVID-19, Health, Nutrition, and Population convened with global partners to explore ways to help low-income countries to access vaccines when they became available on global markets (see table 4.2 for a timeline of vaccine response). In addition to competing with wealthier countries, securing advance access to vaccines carried a significant risk because it was not known if vaccines would be successful—IDA countries could not assume this burden of risk without global assistance. Earlier, for the pneumococcal vaccine, the World Bank had gathered grant resources together to aggregate demand for vaccines across countries (Cernuschi et al. 2011). However, a World Bank instrument was not available for quick use in a crisis context to aggregate demand across countries for advance market commitments other than convening actors for grant resources. Another approach could have been to secure earlier commitments for donations from high-income countries, as advocated outside the evaluation period by the Multilateral Leaders Task Force on COVID-19 in June 2021. Organizing these actions would have re-

quired strong commitments from high-income countries to act quickly early in the response.

The World Bank's early convening with partners helped form the Access to COVID-19 Tools Accelerator partnership and coordinate support to vaccines and health systems at the country level. In June 2020, the World Bank committed to co-convene the Access to COVID-19 Tools Accelerator health systems and vaccine pillars (the vaccine pillar became Country Access to COVID-19 Vaccines [COVAX]), but in July 2020, the World Bank decided not to co-convene COVAX and focused on country-level support through the health systems pillar. The health systems pillar could be supported through the MPA and existing country relationships. The World Bank remained involved in COVAX but not as a co-convener, and it focused on the country level, where it had good access to financing and country relationships to support response actions. This decision was taken within a challenging global context marked by much uncertainty about vaccines and extensive internal discussion about how to support advance market financing for vaccines without an appropriate global-level instrument. At the country level, the focus was on the MPA financing for vaccines and engagement in country-level committees to plan for vaccines. Having a global-level instrument that allowed for advance market commitment could have helped increase the value added of the COVAX partnership to help low-income countries access vaccines one year earlier. Stronger global-level engagement of World Bank expertise in COVAX early on, as was seen later in response, may have helped facilitate earlier access to global supplies, manufacturing, and risk pooling arrangements for IDA countries.

Table 4.2. Summary Timeline of World Bank Vaccine Response

Date	Description
February–June 2020	<ul style="list-style-type: none"> » In early 2020, the World Bank's Emergency Operations Center and the Coalition for Epidemic Preparedness Innovations convened a global vaccine development task force. » In the World Bank, Health, Nutrition, and Population took a lead role with other partners (including Gavi, the Vaccine Alliance and WHO) to prepare for COVID-19 vaccines and supported working groups on vaccine supply, manufacturing, and deployment. » In April 2020, this task force was folded into the ACT Accelerator—a global collaboration to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines, of which the World Bank is a founding partner. » In June 2020, the World Bank committed to co-convene the ACT Accelerator vaccine pillar (which later became COVAX) and health systems pillar.
July–December 2020	<ul style="list-style-type: none"> » The World Bank engaged with the vaccine pillar of the ACT Accelerator, though it did not co-convene COVAX, given the uncertainty about vaccines and extensive internal discussion about the need for an appropriate instrument to finance advance commitments at the global level. The World Bank focused on the health systems and response pillars, which seek to ensure that countries have the necessary technical, operational, and financial resources to translate new COVID-19 tools into national response interventions. The World Bank also focused on helping governments plan for vaccines with partners in countries. » The World Bank approved additional financing in October 2020 of US\$12 billion for the Multiphase Programmatic Approach to meet a critical need to strengthen systems to manage vaccines; this later expanded to US\$20 billion. The financing also provided the option for countries to purchase from COVAX. » Internal leadership of the COVID-19 response on vaccines shifted from the Emergency Operations Center (led by Health, Nutrition, and Population and other Global Practices) to Operations Policy and Country Services. » The World Bank, through the ACT Accelerator, supported consultations with countries related to strengthening health systems, participated in vaccine planning to assess national readiness, and supported the development of vaccine tracking and distribution. A joint assessment of country readiness for COVID-19 vaccines with UNICEF and WHO started in November 2020 and was published in March 2021 (World Bank 2021a).

(continued)

Date	Description
January–July 2021	<ul style="list-style-type: none"> » From January 2021, the World Bank increased its engagement in global partnerships on vaccines, as signaled by management speeches and in internal reporting to the World Bank Board of Executive Directors emphasizing the role of partners in the World Bank’s response. » In February, with the first approvals of vaccine projects, the World Bank Board emphasized the need for strong cooperation with COVAX and other development partners. It also stressed the importance of a regional perspective. » In April 2021, the safeguards guidance of the World Bank on vaccines was revised to align with WHO standards. » In June 2021, culminating from many months of discussion, the World Bank fully engaged with Africa CDC, African Export-Import Bank, and UNICEF in the Africa Vaccine Acquisition Task Team to help countries access vaccines, as a complement to COVAX. Furthermore, during this period, the Multilateral Leaders Task Force on COVID-19 was also launched that involved the International Monetary Fund, WHO, the World Bank, and the World Trade Organization; the predecessor to this was a High-Level Task Force for Vaccines that acted as a vehicle for monitoring, sharing, and coordinating information, data, and activity regarding vaccine availability. An advance market mechanism was launched with COVAX in July 2021 based on aggregated demand across countries using World Bank and other multilateral development bank financing.

Sources: Independent Evaluation Group portfolio; Dalberg Advisors 2021; Van Trotsenburg 2021; WHO 2021c; World Bank 2021a, 2021b, 2021h.

Note: The COVAX partnership within ACT Accelerator is for COVID-19 vaccine development, manufacturing, and equitable access for countries. ACT = Access to COVID-19 Tools; Africa CDC = Africa Centres for Disease Control and Prevention; COVAX = Country Access to COVID-19 Vaccines; UNICEF = United Nations Children’s Fund; WHO = World Health Organization.

Engagement of regional organizations in COVID-19 vaccines was important for coverage in Africa. The World Bank also engaged in early discussions in 2020 with the Africa CDC to help facilitate cooperation among countries in Africa for the procurement and delivery of vaccines. Research published by the World Bank in April 2021 identified that multilateral action, including action by the African Union on vaccines that could supply enough vaccine to cover 60 percent of population by March 2022 (Agarwal and Reed 2021). It was not until June 2021, however, following months of discussion, that the World Bank announced that it was partnering to support the Africa Vaccine Acquisition Task Team of the Africa CDC with resources to help countries access vaccines, as a complement to COVAX. The formal announcement of the World Bank and Africa Vaccine Acquisition Task Team partnership was the culmination of months of work invested by World Bank management (World

Bank 2021h). Earlier partnership on vaccines with the Africa CDC would have helped countries in Africa with limited capacities to act independently to aggregate demands and take earlier actions to pool efforts to procure and plan for vaccines across countries. The regional project analysis (appendix G) exposes the strong added value of support to regional organizations for engaging political leadership and helping countries plan and cooperate on procurement and technical actions for disease response, which could have been extended to vaccines. The Africa CDC partnership was key to help countries such as Mozambique, which has fully vaccinated 42 percent of its population (World Bank 2022a; box 4.6).¹

Box 4.6. Vaccination in Mozambique

The World Bank is supporting the government of Mozambique to acquire, manage, and deploy COVID-19 vaccines through the COVID-19 Multiphase Programmatic Approach project that was approved in June 2021. This project enables the government to procure vaccines against COVID-19 while supporting vaccine distribution and administration for the country's national vaccination campaign and continuity of essential health services. Through this project, the country was among the first to sign an agreement with the United Nations Children's Fund and the Africa Vaccine Acquisition Trust of the Africa Centres for Disease Control and Prevention. Consequently, financing has already been committed to acquire approximately 9.3 million single-dose COVID-19 vaccines and related supplies for Mozambique. Additionally, supported by a Global Financing Facility grant, the project seeks to maintain essential health, specifically to address disruptions in routine essential maternal, child, and adolescent health services at the primary health-care level and services for communicable diseases.

Source: Independent Evaluation Group portfolio and case studies.

World Bank teams supported planning for vaccines in countries in collaboration with partners. Work through the Access to COVID-19 Tools Accelerator at the country level provides an example of global partners aligning to coordinate planning, tracking, and diagnostics of vaccines at the country level. In countries, World Bank teams engaged in committees to plan and track vaccine support. In Djibouti, Honduras, the Philippines, and Tajiki-

stan, the World Bank coordinated with partners to prepare for early vaccine deployment. In Mozambique, the Philippines, and Tajikistan, the World Bank supported digital tracking systems for vaccine rollout and communication about vaccines. More early emphasis could have been put on communication plans and activities to strengthen vaccine delivery in countries.

The World Bank's MPA financing for vaccines provided prompt country-level support that coincided with the approval of the first vaccines, but it took time to develop country vaccine projects. In October 2020, the World Bank approved additional financing for vaccines of \$12 billion for the MPA, which later grew to \$20 billion. The financing was in anticipation of the upcoming emergency approval of the first COVID-19 vaccines by WHO (including \$6 billion for IDA, of which \$294.97 million was grant and \$6 billion for International Bank for Reconstruction and Development countries). The first vaccines to receive emergency approval by WHO were Pfizer-BioNTech on December 31, 2020; Johnson & Johnson on March 12, 2021; and Moderna on April 30, 2021. The financing aimed to support the full vaccination of 1 billion people, or about 20 percent of country populations. The 20 percent coverage corresponded to the WHO Allocation Framework target for priority immunization that focused first on frontline health workers and caregivers, then the elderly and younger people with underlying conditions, which place them at higher risk for COVID-19 (WHO 2020a). The MPA emphasized community engagement and risk communication, which were limited in the early COVID-19 response. However, the approval of MPA vaccine projects in countries took time because a second step of the World Bank Board decision was required for the first five projects—after the restructuring of a project in Lebanon to purchase vaccines (January 20, 2021), the first five MPA vaccine projects were approved by the World Bank Board in Cabo Verde, Mongolia, and Tajikistan (February 1, 2021) and in Afghanistan and Nepal (March 18, 2021). Projects of \$100 million and more also required board approval; Bangladesh, Ethiopia, the Philippines, and Tunisia were approved in March 2021. After these projects, approvals in other countries increased quickly in subsequent months, with vaccine projects approved in 19 countries by April 30, 2021.

Vaccine supply constraints on global markets and safeguards were challenging for the first MPA vaccine projects. Without earlier advance market commitments at the global level, countries with limited resources were often

unable to access global supplies of vaccines, despite the well-designed and prompt country-level financing of the MPA. Of the countries with less than 20 percent COVID-19 vaccine coverage, 89 percent are IDA recipients, and 75 percent are in Africa. Vaccine supply remained constrained well into 2021, in part as a result of manufacturing issues and the emergence of the Delta variant that led to export restrictions on India's vaccine supply. In 2021, the MPA financing for vaccines helped countries access vaccines from manufacturers and through donations, COVAX, and the Africa CDC, but supplies were often limited, and timing of receiving vaccines from different sources was difficult to manage and link to campaigns. Early use of MPA financing to procure vaccines in the first months of 2021 was also slowed by added safeguard policies. The procurement of vaccines needed to follow additional World Bank guidance and safeguards beyond those of WHO. The operational process review and case studies (appendix C) acknowledged the rationale of caution in financing new, unproven vaccines. However, this guidance meant that in early 2021, World Bank vaccine projects could not process government requests to pool vaccine purchases with partners or often support the distribution of donated vaccine resources. After several months, the World Bank adjusted its actions (on April 16, 2021), recognizing the challenge, and aligned with WHO guidelines and Gavi, the Vaccine Alliance. A waiver was also provided for the first vaccine project to encounter this challenge in Lebanon.

¹ COVID-19 Vaccine Deployment Tracker. <https://covid19vaccinedeploymenttracker.worldbank.org/tracker>.

5 | Conclusions and Way Forward

The quality of the health and social response was good, given considerable uncertainty in the early months. The emergency response was particularly swift in the most vulnerable countries. Among countries with medium to high vulnerability to human capital and development losses, the World Bank financed an estimated \$30 billion in the early health and social response to COVID-19—about 40 percent of the World Bank’s total commitments to COVID-19 in fiscal years 2020 and 2021. Staff globally and clients in countries worked tirelessly to support the response.

Although it is too early to observe outcomes, the evaluation points to promising evidence of early successes, such as the expansion of critical health and social protection capacities. The World Bank used its experience from past crises to respond quickly and effectively, and teams innovated and engaged in frequent dialogue to adjust actions. Operational flexibility facilitated rapid financing for the MPA, which was critical to expanding health support, and procurement was smooth, compared with past crises. World Bank country programs also drew on existing partnerships, crisis instruments, and regional projects to facilitate timely actions.

Nevertheless, and notwithstanding preparedness efforts over the years, the World Bank and many client countries were not adequately prepared for the crisis. Countries with better capacities to coordinate, monitor, and deliver local services (health and education, among others), robust human capital investments, and better public health preparedness were often able to address the crisis needs more comprehensively. Internal World Bank efforts were facilitated by already having operational support to human capital, gender, disease preparedness, existing data systems and partnerships, and crisis instruments in country portfolios.

The evaluation findings point to the value of focusing on pandemic and crisis preparedness efforts in countries in the World Bank, at the regional level, and with global partners.

- » **Prioritizing support in areas to protect against human capital losses.** In the early COVID-19 response, there was an important emphasis on emergency health and social protection support. This needed to be quickly complemented with support for education, maternal and child health, and women and girls, which in some countries led to a secondary crisis of health and education loss and deepening gender inequalities. Countries needed the systems to continue to deliver and ensure the quality of these services during the crisis, for example, crisis-adapted platforms, such as for telemedicine and remote learning. Having systems in place that can ensure continued access to essential health, education, and gender-based services, in addition to emergency social protection, is important for protecting human capital, especially in vulnerable groups.
- » **Regional leadership and institutional capacities for crisis preparedness and crisis response.** Regional organizations have an important role in convening leaders and technical actors in countries for policy dialogue, technical learning, cooperation, and problem-solving. Developing the capacities of regional organizations is key to facilitate learning and actions by countries and to expand preparedness capacities and rapid actions for crisis response.
- » **Preparedness in countries.** Institutional capacities for crisis preparedness, such as functioning coordination structures, critical health service capacities, and data systems, are important for building strong preparedness.
- » **Internal preparedness of the World Bank.** Partnerships, operational readiness (tools and flexibilities), and hands-on assistance need to be in place before a crisis. Country portfolios that include crisis instruments and support for human capital allow for quick access to financing and swift support to vulnerable groups in times of crisis, while maintaining the focus on longer-term human capital development. Also important for country portfolios was drawing on repurposed projects, regional projects, ASA, grants, and trust funds to enable quick early financing.
- » **Global alignment among partners.** Global alignment and coordinated actions at the global level are important for good support to countries. In the early days of the response, the World Bank could have played a more decisive role at the global level regarding vaccines and to ensure that guidance to pro-

tect human capital was consistently part of the early global-level guidance on the COVID-19 response.

Recommendations

The findings from the evaluation inform four recommendations for ensuring stronger future preparedness.

Recommendation 1. Use the World Bank’s crisis recovery efforts to strengthen the resilience of essential health and education services to ensure that human capital is protected in a crisis.

Proposed Actions

- » In health, build on innovations developed during COVID-19 to help countries strengthen telehealth and other platforms for continuing essential health services in an emergency. Help countries improve the quality of frontline services, including the availability of data to inform decisions for quality improvements. Services could be improved to better manage supplies, deliver vaccines, support health workers to deliver effective care, and ensure infection prevention and control measures. The availability and use of feedback from beneficiaries and coverage of vulnerable groups are also important. The World Bank could also help develop new capacities to deliver services, such as in psychosocial care.
- » In education, draw on evidence and innovations of the COVID-19 response to strengthen platforms for continuous learning in a crisis. Strengthen community networks that have been established to support learning. To avoid learning losses, and facilitate knowledge building to uptake effective approaches to help children in and out of school catch up. Help countries develop approaches that increase the reach to vulnerable groups that may have been missed by remote learning. Strengthen monitoring of beneficiary feedback on the quality of learning.

Recommendation 2. Apply a gender equality lens to health and social crisis response actions across sectors.

Proposed Actions

- » Develop actions across sectors (in health, education, urban, and social protection) for protecting women and girls from shocks, which can be drawn on in a crisis response. This is especially important in countries with high needs for addressing gender equality. Examples of areas to support gender equality include psychosocial support, sexual and reproductive health, income and asset accumulation, and community engagement.

Recommendation 3. Help countries strengthen regional cooperation and crisis response capacities for public health preparedness.

Proposed Actions

- » Support regional organizations to facilitate cooperation, political leadership, and technical learning, especially in Africa. Such support could help strengthen preparedness in countries and regional mechanisms for crisis response, facilitate financing and technical partnerships, encourage innovation, and expand evidence to scale up effective approaches. Regional support could also facilitate evidence-based and data tools to help countries prioritize investments and monitor crisis response actions.
- » Help countries strengthen national and subnational platforms to coordinate and deliver crisis interventions, such as One Health platforms, with greater emphasis on critical health services and demand-side activities, such as citizen engagement. At the national level, invest in platforms that coordinate action and prepare various sectors to take on specific roles in crisis. At the subnational level, invest in platforms that can reach local government and communities for disease surveillance, risk communication, delivery of health and social services, and monitoring support.

Recommendation 4. Build on the COVID-19 experience to strengthen the World Bank's internal crisis preparedness so that it has the tools and procedures ready to respond in future emergencies.

Proposed Actions

- » Review and expand operational flexibilities for processing new projects in crises and develop guidance on the effective use of instruments at different stages of crisis response. The World Bank could also explore innovative ways to strengthen the use of crisis instruments in countries, such as through support to communities, and expand guidance on hands-on assistance for citizen engagement and gender, learning from the provision of such support in procurement.
- » Expand and strengthen the World Bank's partnerships and instruments to enable coordinated financing, advance market commitments, and technical support that will help countries strengthen crisis preparedness. The partnerships could be at the global, regional, and country levels. They could include technical partnerships to expand knowledge for quality implementation of preparedness activities, partnerships with nongovernment and the private sector to support community-based implementation, feedback on services and use of technology, and global partnership for aligning financing, plans, and guidance to support countries.
- » Strengthen tools to allow for the integrated management and frequent reporting of monitoring data on projects in World Bank portfolios.

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APPENDIXES

Independent Evaluation Group

*The World Bank's Early Support
to Addressing COVID-19:
Health and Social Response*

Appendix A. Methodology

Evaluation Questions

The overarching question that the evaluation answers is: What has been the quality of the World Bank's early COVID-19 response in countries in terms of saving lives and protecting poor and vulnerable people? Three questions underlie this query:

- » What has been the relevance of the World Bank's early COVID-19 response to addressing the needs of countries in saving lives and protecting poor and vulnerable people (that is, the diagnosis, design, and tailoring of interventions to country situations)?
- » What has facilitated or hindered implementation of the World Bank's COVID-19 responses in countries, and how is the World Bank supporting learning and adjustments?
- » How well are operational processes, instruments, and partnerships supporting the World Bank's COVID-19 responses in countries?

Evaluation Design and Framework

The evaluation is designed to support learning from the World Bank's COVID-19 response based on evidence at the country, portfolio, and corporate levels. It uses a mixed methods approach that combines quantitative and qualitative evidence. To support feedback, the design split the delivery of the evaluation into modules, whose staggered delivery enabled dialogue with World Bank management and staff on interim findings as evidence emerged.

The evaluation is underpinned by a conceptual framework of the stages and thematic areas of the health and social response and by a theory of action to guide the review of the quality of the World Bank's COVID-19 response to support countries. The conceptual framework is adapted from the World Bank Group's COVID-19 response framework (World Bank 2020b). It describes a multidimensional crisis response with interlinked health and social responses

across three stages: relief, restructuring, and recovery. The theory of action defines the dimensions to assess the quality of World Bank support in relation to its relevance to needs of countries, implementation and learning and adjustment, and operational processes in support of countries. In developing the theory of action, the evaluation team drew on principles related to the science of delivery were drawn on (Asis and Woolcock 2015).

Evaluation Components

Table A.1 lists and describes the components of the overall evaluation design. The components' methods vary to support the triangulation of findings across the three evaluation questions, drawing on data from the country, portfolio, and corporate levels.

Table A.1. Evaluation Components

Evaluation Component	Description
Case-based analysis	Case studies of eight countries reviewed their projects and analytic work, and interviewed World Bank staff, government, and civil society to review the quality of the World Bank's early COVID-19 response against the theory of action.
Review of country situations: support types, needs, and implementation status	The analysis used publicly available data on indicators in areas of the conceptual framework, portfolio data, and data on World Bank support to human capital in countries before COVID-19 to (i) apply machine learning cluster analysis to understand differences in support to COVID-19 across countries; (ii) assess the alignment of the World Bank's COVID-19 support with countries' needs; and (iii) apply decision tree analysis to understand the features of the portfolio that facilitated or hindered satisfactory project implementation in countries during the early COVID-19 response.
Rapid review of evidence	A structured literature review identified evidence on 50 interventions to support effective epidemic and crises responses using a rapid scoping method. Evidence was reviewed from systematic reviews and country studies and benchmarked against the World Bank support to countries.
Review of lessons	The review synthesized lessons from past crises in areas of the theory of action, based on 170 projects where the World Bank responded to crises in the past 20 years. The lessons were then benchmarked against successes and challenges from Implementation Status and Results Reports of projects supporting the early COVID-19 response in countries.
Learning on regional support	Four regional projects were reviewed to assess their support to the COVID-19 response in countries. Using the outcome harvesting approach, evidence on emerging results was collected from a review of project documents and interviews of country actors and World Bank staff involved in the projects, which were then verified in consultation with the project team.
Stocktaking of innovations	Innovations supporting the World Bank's COVID-19 response in countries were identified through a crowdsourcing survey of country teams, the portfolio review, and a review of innovation stories published by Global Practices.

(continued)

Evaluation Component	Description
Portfolio identification and analysis	A portfolio of 253 projects and 175 advisory services and analytics supporting the first 15 months of the COVID-19 response was identified from 107 countries using a systematic process of search, delimitation and inclusion, coding and verification, and analysis. Analysis was done against the areas of the theory of action. The portfolio analysis included a review of support the Multiphase Programmatic Approach used by Health, Nutrition, and Population (HNP).
Monitoring analysis	Based on the portfolio of 253 projects, 2,219 indicators were identified and reviewed. Analyses of indicators examined monitoring of the early COVID-19 response.
Analysis of multiphase programmatic approach of health	The analysis of the MPA draws evidence from the evaluation portfolio, case studies, and innovation stocktaking to assess the MPA projects led by the HNP Global Practice. The focus is on the first year of the MPA support between April 2020 and April 2021.
Review of internal processes and partnerships	Interviews and documents on the World Bank response were analyzed to identify lessons from the World Bank's COVID-19 corporate-level response across areas of the theory of action. Key aspects of the review looked at coordination and collaboration, past crisis experiences, financing instruments, operational processes, partnerships, knowledge support, and monitoring of the response.

Source: Independent Evaluation Group; World Bank 2022.

Ensuring Validity of Findings

The evaluation team took steps to reinforce consistent assessment of the quality of the World Bank's early COVID-19 response.

- » The components of the evaluation addressed different levels of analysis (country, portfolio, corporate) to address the evaluation questions; the design of the protocols used for the analysis followed the theory of action and conceptual framework (figure A.1).
- » Triangulation was applied at multiple levels by cross-checking evidence sources within a given evaluation component and across components. For example, in case studies, information was extracted from interviews with country implementers and World Bank staff and document review to validate findings. Further, the team triangulated findings across different evaluation components and levels of analysis by iteratively synthesizing and making sense of evidence to respond to the evaluation questions. For example, validating findings from the case studies using findings from the review of country situations, portfolio, and internal processes and partnership review.
- » Findings from the analyses were validated through discussions with World Bank counterparts, such as teams in World Bank country offices and Global Practices (GPs), to interpret and review findings from the evaluation components. Consultations were also organized with World Bank counterparts to validate the evaluation's scope and methods.
- » Advisers and peer reviewers provided feedback at the beginning, during, and at the end of the evaluation process, and the team followed Independent Evaluation Group (IEG) quality control processes.
- » The evaluation team triangulated findings across other ongoing evaluations, including the IEG evaluation of the economic response to COVID-19.

Limitations

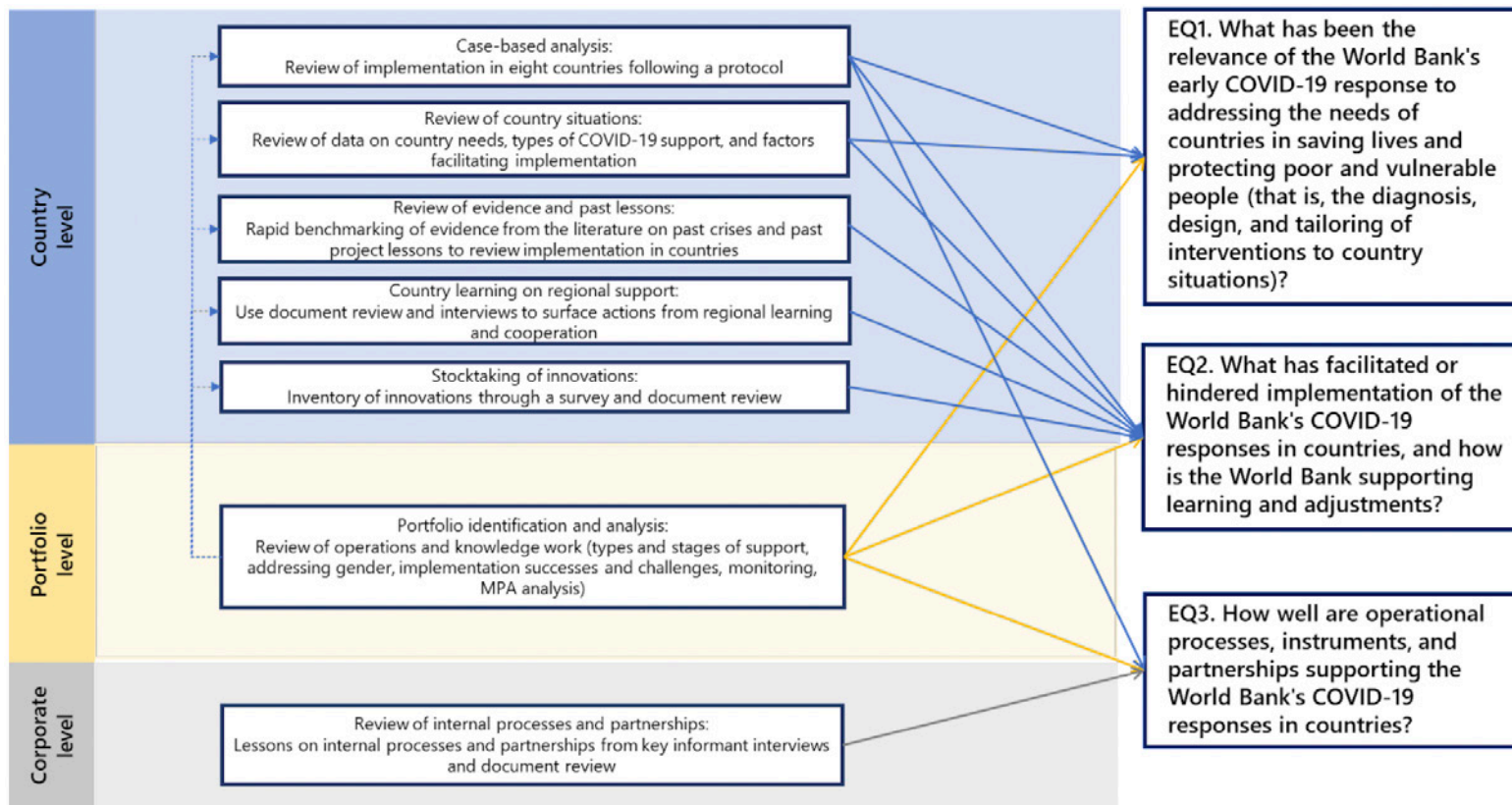
Notwithstanding these steps, the following are key limitations of the evaluation design.

- » Since this is an early-stage evaluation, outcomes are not assessed; rather, the focus is on the quality of the response based on the relevance of its design and whether implementation and learning processes and outputs are well positioned to support pathways to outcomes. This analysis offers learning to inform later stages of the response.
- » The portfolio analysis focuses on the World Bank's early COVID-19 response between February 1, 2020, and April 30, 2021, data was extracted at various dates outlined in detail below, providing an estimated snapshot of the early time period of an evolving portfolio. The portfolio is focused on countries vulnerable to human capital and development losses, and, thus, it is most representative of these countries. To consider the dynamic nature of the response, a rapid update of the portfolio was done at the end of the evaluation to understand how support is shifting. Moreover, the portfolio estimates early support and financing in the countries included in the evaluation. Countries have a range of repurposed projects supporting COVID-19 that the evaluation may not fully capture. Moreover, the portfolio focuses on the GPs included in the evaluation, while a range of GPs supported the health and social response in countries, such as Agriculture and Food, Social Sustainability and Inclusion, and Transport. Further, a detailed analysis of COVID-19 financing is beyond the scope of the evaluation.
- » Case studies included information on the response in the country, advisory services and analytics (ASA) and project document reviews and interviews with country actors and World Bank staff. The case studies were completed over about six months, between April 2021 and October 2021, due to the high number of COVID-19 cases in countries, the intensive burden of the pandemic on health sector personnel, and illness and personal losses of interviewees due to COVID-19. Interviews with subnational actors are limited to two case studies (Senegal and India). Challenges interviewing local actors in countries were mitigated by using publicly available secondary data on beneficiary feedback about the COVID-19 response.
- » The review of country situations estimates country needs before and during the COVID-19 response using publicly available data. However, data on indicators are limited to those available at the national level. Data are missing for some countries and the analysis does not include data on how other

partners may have addressed needs. Moreover, the findings of the clustering and decision tree analyses are based on analyzed features of the early response. The response may have different features in future that would need to be considered.

- » A strength of the literature review is that no interventions are ruled out *ex ante*. However, this is a rapid review limited to evidence from systematic reviews and country studies published after January 2016. It likely misses recent studies emerging from the ongoing support to COVID-19 country responses. Moreover, the review of evidence on social protection interventions is limited by the focus on epidemic and crisis situations, since these are long-term interventions in countries to protect vulnerable groups, expanded in a crisis. Similarly, evidence on remote learning may be transferable from noncrisis situations and would have been missed by the literature review.
- » The regional project review examines the support of regional projects to implementation and learning to advance country responses for COVID-19. However, broader achievements of these projects are beyond the scope of the evaluation. Moreover, while the outcome harvesting method used for this analysis provides a useful means of backward-tracing verified outcomes, selecting on outcomes may introduce biases of omission relative to which areas were and were not explored in interviews and identified in documents. To avoid this, interview questions were semistructured.
- » A key strength of the stocktaking of innovations is the capture of examples of how the World Bank innovated in the early COVID-19 response. However, the evaluation does not look at the effectiveness of these innovations. Moreover, the innovations identified were self-selected by World Bank teams or have been chosen for inclusion in documents that were reviewed by the evaluation. As a result, the analysis may have missed innovations not reported by World Bank teams. Also, what constitutes an innovation can be interpreted in different ways.
- » The main limitation of the corporate-level review of internal processes and partnerships is that interviews captured perspectives from the first 15 months of implementation, and the understanding of and thinking about the response evolved rapidly.

Figure A.1. Evaluation Design Matrix



Source: Independent Evaluation Group.

Note: EQ = evaluation question.

Overview of Evaluation Methods

Case-Based Analysis

The case studies provide in-depth analysis of the quality of the early COVID-19 response at the country level for all areas of the theory of action. The case studies focus on the evaluation time period (February 1, 2020, to April 30, 2021), and interviews were conducted between April and October 2021. The evaluation team selected eight countries (Djibouti, Honduras, India, Mozambique, the Philippines, Senegal, Tajikistan, and Uganda) for analysis to understand the support of multiple GPs and how early support is helping to protect human capital. The cases selected received health, social, and institutional strengthening support and have a Human Capital Index of 50 percent or below. The case study analysis triangulates data from project and country documents, interviews, and secondary data on the COVID-19 situation (Yin 1999). Data were captured in Excel using a consistent protocol across countries. Interviewees include actors involved in implementation of the response, including World Bank task teams and country management, government, civil society, and development partners. Evidence was gathered and synthesized using consistent protocol through remote connections due to travel restrictions. In each country, the IEG team employed national consultants to facilitate country stakeholder interviews. The case studies focus on five GPs: Education; Health, Nutrition, and Population (HNP); Macroeconomics, Trade, and Investment; Social Protection and Jobs; and Urban, Disaster Risk Management, Resilience, and Land (GPURL). Other GP projects were reviewed, and staff were interviewed, when recommended by country management to understand the cross-sector breadth of the health and social support in the countries.

Review of Country Situations: Support Types, Needs, and Implementation Status

The analysis estimates how the response has addressed needs of countries, the differing types of support to countries, and features that facilitated the satisfactory implementation of early World Bank support. The analysis uses the thematic areas of the conceptual framework—critical health services, es-

essential health services, risk communication, protecting poor people and vulnerable, child welfare and social services, and cross-cutting areas of gender and inclusion—to guide data collection on indicators to estimate country situations and needs at the onset of COVID-19. It also looks at data on potential factors of country vulnerability (urban risk and response capacities), and data on the situation during COVID-19 (disease situation, responsiveness of the countries, and estimated changes in the social situation). Publicly available indicators from secondary data sources were collected for 80 countries. For themes with multiple indicators, principal component analysis and composite measures were used to reduce the dimensionality of the data (Howe et al. 2008; Pirani 2014). The data on country situations was combined with portfolio data on the World Bank’s COVID-19 response, and data on World Bank support to human capital before COVID-19 from a forthcoming IEG analysis (World Bank, forthcoming). The data on country situations is from between February 2020 and April 2021. Data on human capital support between FY15 and FY20 before COVID-19 from a forthcoming Independent Evaluation Group (IEG) evaluation was also integrated in the Excel data set (World Bank, forthcoming). Three analyses were done using this integrated data set: (i) machine learning clustering analysis in Python was used to understand the types of World Bank support planned among countries (Caliński and Harabasz 1974; Davies and Bouldin 1979; Handl and Knowles 2007); (ii) Stata and Excel were used to develop a heat map to assess the alignment of World Bank support with country needs and previous human capital support; and (iii) decision tree analysis was conducted in Python and applied at the country level to understand the conditions facilitating and hindering satisfactory project implementation in the early COVID-19 response (Kam Ho 1995; Schapire 2013). The main classification feature in the decision tree was the proportion of projects with satisfactory implementation status ratings.

Rapid Evidence Review

The literature review synthesizes evidence on the effectiveness of health and social interventions to support epidemics and crises to better understand the relevance of the World Bank’s interventions in countries (Arksey and O’Malley 2005; Levac et al. 2010). As the COVID-19 evaluation design calls for a nimble, learning-oriented approach, a rapid scoping method was

used to identify evidence relevant for the World Bank's response. The review focuses on evidence from recent health crises, such as Ebola, and knowledge on COVID-19 published after January 2016. Covidence software and Excel were used to manage the review. Evidence sources are limited to systematic review studies and country studies in English from low- and middle-income countries. Key databases searched between November 15, 2020, and February 15, 2021, include EvidenceAid, PubMed, SCOPUS, Cochrane, Campbell, 3ie, J-PAL, World Bank Development Impact Evaluation, and World Bank Open Knowledge Repository. Minimum quality standards were assured by prioritizing peer-reviewed articles. The search for evidence was conducted in two phases: the first stage was a broad search using keywords "epidemic" "outbreak" or "pandemic;" and the second stage used keywords related to the thematic areas of the conceptual framework of the evaluation. All article titles and abstracts were manually screened, and then the full text of the remaining articles reviewed. The final search phase yielded 70 relevant articles, with evidence on 50 interventions relevant to different areas of the COVID-19 response framework. The coverage of these interventions in the World Bank's portfolio was then reviewed to assess the alignment of COVID-19 support with the existing evidence base on what works to support crisis response.

Review of Lessons

The review of lessons helps to understand areas that facilitated or hindered implementation of the early COVID-19 response in countries, and how these compare to past crises. The analysis systematically identifies and synthesizes lessons reported in projects from crises over the past 20 years (January 2000 through December 2020) and benchmarks these against successes and challenges reported in Implementation Status and Results Reports of projects supporting the COVID-19 response. The search for lessons in projects was conducted in two phases. The first stage was a broad search using keywords ("crisis" "emergency" "epidem*" "disease" AND "outbreak" "pandemic" the second stage used keywords related to the thematic areas of the conceptual framework of the evaluation. In total, 256 lessons from 170 past projects were coded in Excel against the theory of action and grouped by common areas of success or challenge. The successes and challenges reported in the

current response were then benchmarked against past lessons to assess how the World Bank improved its crisis support.

Learning on Regional Support

The review of regional support focuses on the value-added by four regional health projects (Regional Disease Surveillance Systems Enhancement project, Africa Centres for Disease Control and Prevention project, East Africa Public Health Laboratory Networking, and Organisation of Eastern Caribbean States Regional Health Project) to support country-level COVID-19 responses. These were the main regional projects identified in the portfolio and in discussion with GPs supporting COVID-19 projects. The analysis uses an outcome harvesting method (Wilson-Grau 2019), which draws on evidence from interviews with country implementers and World Bank staff involved in regional projects and project document review (such Implementation Status and Results Reports and Aide Memoires) to gather detailed information in the form of verifiable outcome statements that describe early results and process milestones achieved to support countries. These statements focus on what the milestone was, who was involved, when and where, why it was significant, and how the project provided support. The timeline of the analysis is the evaluation period (February 1, 2020, to April 30, 2021), and interviews were conducted between April and June 2021. The findings are organized by result areas to analyze the support to COVID-19 responses across regional projects. A review process with project teams verified the accuracy of the outcome statements.

Stocktaking of Innovations

The stocktaking of innovations seeks to understand the innovations undertaken by the World Bank in-country responses to COVID-19. Innovations were captured in more than 100 countries through the portfolio review, crowdsourcing, and reviewing documented innovations. The examples of innovations were collected between February and June 2021. First, innovations described in project documents and Implementation Status and Results Reports were extracted. Second, innovations were crowdsourced from World Bank task teams by inviting all Human Development Practice Group Program

Leaders to complete a brief questionnaire in SurveyMonkey to capture new approaches. Sixty-eight percent of World Bank country management units responded to the survey. Third, innovations were identified by reviewing stories shared in documents and databases on the World Bank COVID-19 intranet sites of GPs. The team included examples of innovations if they reflected a new approach or practice in the country and if the World Bank had a defined role in designing or implementing the innovation. Innovations also needed to fall within the scope of the COVID-19 health and social response to be included. Each innovation was coded by the following: thematic area; actors involved in its implementation (community groups, health structures, local government, multisectoral team, schools, private sector, and nongovernmental organizations); whether the innovation addressed digitalization, gender, or monitoring and evaluation; and if it could be applied to support the restructuring of systems. All innovations were coded and analyzed in Stata through descriptive statistics, similar types of innovations were grouped to identify common themes, and positive outliers were identified where innovations were limited and could be further expanded (World Bank 2022).

Portfolio Identification and Analysis

For the portfolio analysis a systematic document and data review focused on internal sources and was enriched by using external quantitative data. The portfolio covers the period of February 1, 2020, to April 30, 2021. The project list was first extracted on February 1, 2021, and then updated on May 12, 2021. Disbursement monthly snapshot data have been updated to June 1, 2021, and Implementation Status and Results Report data were extracted on November 5, 2021. The process is anchored in the thematic areas of the conceptual framework and dimensions of the theory of action to assess the quality of the World Bank's early COVID-19 response. The methodology for the portfolio review consists of four main stages: search, delimitation and inclusion, coding and verification, and portfolio data analysis.

- » In the search stage, operational financing projects and ASA using COVID-19 project tags and text analytics were searched.
- » In the delimitation and inclusion stage, parameters were applied to align the identified portfolio with the scope of the evaluation. This limited the cover-

age to five GPs (Education, HNP, Macroeconomics, Trade, and Investment, Social Protection and Jobs, and the Global Practice of Urban, Resilience, and Land [GPURL]), and support to pillars 1, 2, and 4 of the COVID-19 response that were active or approved by April 30, 2021. The portfolio of ASA also covered the Poverty and Equity GP. Further, the portfolio was limited to projects in countries that received fast-track financing for COVID-19 or support through regional projects ($n = 270$ parent projects; $n = 196$ ASA). The portfolio was also limited to include countries classified as having a medium, high, or very high vulnerability to their development achievements and human capital gains being offset by COVID-19.¹

- » In the coding and verification stage, the COVID-19 portfolio of projects and ASA was manually reviewed to verify the inclusion of projects and code the elements of projects related to the conceptual framework and theory of action. After coding, the final verified portfolio included 253 operational financing projects and 175 ASA in 97 countries.
- » In the portfolio data analysis stage, data were analyzed for learning on the evaluation questions. This involved adding data features to the final portfolio from the World Bank's systems on disbursement, trust funds, restructuring, procurement, and implementation status. The final data set was analyzed in Excel, Stata, and Tableau software. Python was used for text analysis of procurement data to identify types of goods.

The portfolio analysis included a review of support through the Multiphase Programmatic Approach used by HNP.

Monitoring Analysis

As part of the portfolio-level analysis IEG also reviewed 2,219 indicators from the projects (covering the portfolio period of February 1, 2020, to April 30, 2021). These indicators were coded by pillar, thematic response area, and stage of the response (relief or restructuring), and by evidence of tracking or progress.² Indicators were then analyzed in Stata and Tableau.

Analysis of Multiphase Programmatic Approach of Health

The analysis reviews the quality of early support of the MPA projects led by HNP. The analysis applies the evaluation's theory of action (support to needs, implementation and learning, and operational processes and partnerships). It then assesses overall progress of the first year of support of the MPA, toward achieving its objective. The analysis draws on evidence from the evaluation portfolio, case studies, regional project analysis, and innovation stocktaking to assess the early MPA projects. The focus is on the first year of the MPA support from when the first projects were approved in April 2020 to April 30, 2021, within the portfolio period covered by the evaluation.

Review of Internal Processes and Partnerships

This corporate-level review sought to distill lessons and findings on how the World Bank's COVID-19 coordination and collaboration, experience with past crises, financing instruments, operational processes, partnerships, knowledge support, digital tools, and monitoring of the response guided and supported the early COVID-19 response. IEG structured its data collection and analysis using the evaluation's theory of action components: relevance to countries' needs, multidimensional implementation, operational processes, partnerships, and learning. IEG reviewed key documents on the World Bank's response and conducted more than 90 individual or group semistructured interviews with World Bank staff and managers from GPs and corporate units, all regions, select board members and advisers, and partners. IEG synthesized interview and document review evidence to distill lessons and findings on: (i) factors that facilitated the response to support countries and (ii) opportunities to improve future actions. The analysis covers the 15-month evaluation period, with interviews taking place between February and September 2021.

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¹ The Inform COVID-19 Risk Index was used to categorize countries based on their vulnerability to development achievements being offset by the pandemic. The evaluation adjusted the index to consider the country's human capital index given concerns surrounding losses of human capital in countries. The countries were then separated into quartiles based on their vulnerabilities to development and human capital losses (very high vulnerability, high vulnerability, moderate vulnerability, low vulnerability). Appendix B includes a list of the countries in the portfolio by vulnerability quartile. The Inform COVID-19 Risk Index includes dimensions of social inclusion (such as gender inequality and poverty), economic vulnerability, governance and institutional capacity, health systems capacity, environment, and population risks (such as access to sanitation and population mobility and density) (Poljanšek, Vernaccini, and Marin Ferrer 2020; UN 2020; World Bank 2020a).

² Indicators were coded based on the status of monitoring, with “no monitoring” denoting no progress data reported, “evidence of tracking” denoting that the updated value showed no change or adverse change from the baseline, and “evidence of progress” denoting the data entered reflected progress toward the target.

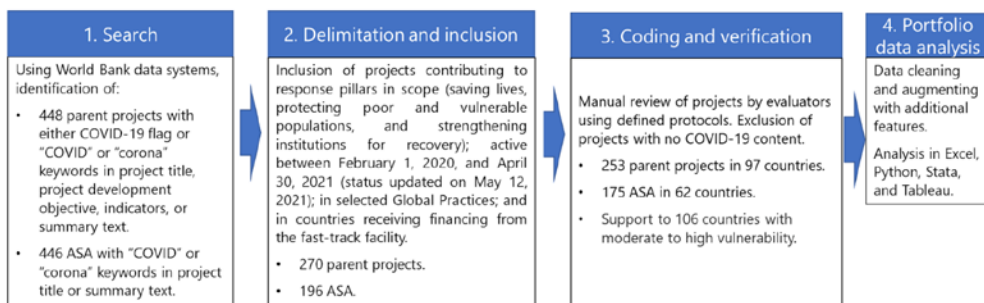
Appendix B. COVID-19 Portfolio Analysis

What is the quality of the early response to COVID-19 in countries in terms of saving lives and protecting poor and vulnerable people? To help answer this question, the Independent Evaluation Group reviewed the portfolio of operational financing projects and advisory services and analytics (ASA) that responded to COVID-19, from February 1, 2020, to April 30, 2021. The analysis looks at the relevance of support to needs of countries, implementation and learning, and operational processes to assess dimensions of quality.

Methodology

The methodology for the portfolio review consisted of four stages to estimate the early COVID-19 portfolio for countries vulnerable to human capital and development losses: search, delimitation and inclusion, coding and verification, and portfolio data analysis (figure B.1).

Figure B.1. Portfolio Identification and Analysis Process



Source: Independent Evaluation Group portfolio.

Note: In the coding and verification stage, one additional country is added (Grenada) that has low vulnerability because it is covered by a regional disease prevention-focused project. World Bank data systems include Business Intelligence, Standard Reports, and the Enterprise Data Catalogue. The project list was verified against project lists from the Global Practices and an internal Independent Evaluation Group database tracking COVID-19 projects. ASA = advisory services and analytics.

In the search stage, operational financing projects and ASA using COVID-19 project tags and text analytics were identified. This process included all projects with a COVID-19 project tag or with keywords (“COVID” or “corona”) in the text of the project title, project development objective, indicators, or summary. The ASA search focused on the keywords in the title or summary text. Additional projects and ASA were identified by reviewing COVID-19 projects tracked by Global Practices (GPs), related projects identified in project documents and Implementation Status and Results Reports,¹ and projects that activated Contingency Emergency Response Component (CERC; 448 projects and 446 ASA).² Using this combination of methods, new projects and repurposed projects responding to COVID-19 were identified.

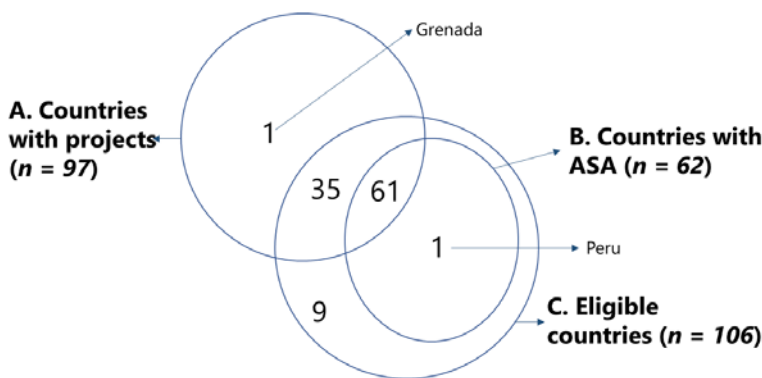
In the delimitation and inclusion stage, the portfolio was limited to include the following:

- » Projects with support in any of the three COVID-19 response pillars covered by the evaluation between February 1, 2020, and April 30, 2021—namely, saving lives, protecting poor and vulnerable populations, and strengthening institutions for recovery.
- » Projects and ASA in five GPs leading the support to the early COVID-19 health and social response: Education; Health, Nutrition, and Population; Macroeconomics, Trade, and Investment; Social Protection and Jobs; and Urban, Disaster Risk Management, Resilience, and Land. Projects in these GPs represent about 75 percent of the early health and social response portfolio.³ The portfolio of ASA also covers the Poverty and Equity GP.
- » Projects in countries that received fast-track financing for COVID-19 and or support through regional disease-focused projects. The portfolio was limited to include countries classified as having a medium, high, or very high vulnerability to human capital gains being offset by COVID-19.^{4,5} Based on these criteria, 106 countries were eligible to be included in the portfolio. The combined project and ASA portfolios covered 98 countries, of which 97 had projects, and 62 had ASA.^{6,7} Twenty-nine countries in the portfolio were in fragile and conflict-affected situations (FCS).

Applying these steps resulted in 270 projects and 196 ASA. Figure B.2 summarizes the coverage of projects and ASA in the portfolio.

In the coding and verification stage, the COVID-19 portfolio of projects and ASA was manually reviewed. Coding templates based on the evaluation framework for the health and social response and theory of action were administered through SurveyMonkey to extract information. For projects, coders reviewed Project Appraisal Documents, program documents, Implementation Status and Results Reports, restructuring papers, and aide-mémoire. The template coded and extracted information for each financing project, including on interventions in the health and social response, areas of institutional strengthening support, stages of support, implementing actors, beneficiaries, address of gender, support to vulnerable groups, geographical targeting, and innovations. For ASA, coders reviewed concept notes, planned deliverables, and available reports. All coding included training and quality checks. The template coded information on the type and content of the ASA. After coding and reviewing any additional related projects supporting COVID-19 identified in project documents to try to maximize the coverage of repurposed projects, the final verified portfolio included 253 operational financing projects and 175 ASA across 98 countries. About 60 percent of the financing projects identified were tagged as supporting the COVID-19 response, and the remaining 40 percent of projects, often repurposed projects, did not have a COVID-19 tag.

Figure B.2. Summary of Country Coverage in the Project and Advisory Services and Analytics Portfolio



Source: Independent Evaluation Group.

Note: The portfolio covers 107 countries; Peru had ASA identified in the portfolio but not financing projects. Grenada was added to the portfolio based on its coverage by the Organisation of Eastern Caribbean States Regional Health Project (P168539). ASA = advisory services and analytics.

In the portfolio analysis stage, data were analyzed for learning on the evaluation questions. This involved adding data features to the final portfolio from the World Bank's systems (on disbursement, trust funds, restructuring, procurement, and implementation status). The final data set was analyzed in Excel, Stata, and Tableau software. Text analytics of procurement data used Excel and Python.

The portfolio covers a substantial portion of the World Bank's early health and social response. In the 106 countries, this portfolio covers an estimated 73 percent of International Development Association commitments, 75 percent of International Development Association and International Bank for Reconstruction and Development commitments, and 95 percent of the tagged commitments made by the five GPs. The analysis covers about 40 percent of all World Bank commitments made between February 1, 2020, and April 30, 2021. Other financing was for the COVID-19 economic response not in scope of this evaluation and countries not covered by the evaluation.

Limitations. Based on the verification of the portfolio in case study countries, it is estimated that the portfolio covers more than 90 percent of support to the early health and social response to COVID-19 in the countries and GPs analyzed. Some repurposed projects are likely missed in the portfolio analysis that were not tagged, did not have keywords, or that were not referred to in related project documents. Moreover, the response continues to be dynamic, with additional projects being added monthly. The project list was first extracted on February 1, 2021, and then updated on May 12, 2021. Disbursement monthly snapshot data have been updated to June 1, 2021, and Implementation Status and Results Report data were extracted on November 5, 2021. Extraction dates are important to the extent the portfolio is highly dynamic, with internal tagging of COVID-19 projects continuously changing during the evaluation period.

Relevance of COVID-19 Response to Needs of Countries

Scope of the Response Portfolio

In response to the COVID-19 pandemic, the World Bank increased its portfolio in the health and social sectors, adding small and short-duration projects across countries. The portfolio covered by this evaluation is estimated at a little more than \$30 billion, including \$15 billion International Development Association and \$14 billion International Bank for Reconstruction and Development in operational financing, \$1.5 billion in trust funds, and \$60 million in ASA commitments.⁸ It is also estimated that there was \$1.84 billion in CERC commitments from other GPs allocated to the health and social response not covered by the portfolio. The estimated new and repurposed project financing allocated to the response in the portfolio countries is in figure B.3, panel a, and the total project financing, ASA, and trust funds are in figure B.3, panel b. Compared with the 15 months before the pandemic, the five GPs increased their processing of projects and doubled their overall commitments in the countries. Health, Nutrition, and Population had almost five times more projects approved (88 compared with 18), followed by Education (51 compared with 16), and then Social Protection and Jobs (37 compared with 15) and Macroeconomics, Trade, and Investment (56 compared with 34), whereas Urban, Disaster Risk Management, Resilience, and Land remained static (33 compared with 38). Other GPs—such as Transport, Water, Governance, and Energy and Extractives—processed fewer projects during the same period. The median size of projects decreased from \$100 million to \$70 million, meaning that GPs worked hard to manage more smaller and shorter-duration projects with an average length of about 2.5 years. In Health, Nutrition, and Population, the change was greatest, with the median project size decreasing from \$79 million to \$23 million. Some projects have since added additional financing for later stages of the response.

Figure B.3. Estimated Financing Commitments to Early COVID-19 Response for Vulnerable Countries in Portfolio

a. New and repurposed project financing commitments to early COVID-19 response in portfolio



b. Estimated project, trust fund, and ASA commitments to early COVID-19 response in portfolio

		Lead Global Practice, Estimated Commitments (US\$, millions)						
Fiscal Year	Financing	Health, Nutrition, and Population (projects = 111, ASA = 42)	Social Protection and Jobs (projects = 39, ASA = 45)	Macroeconomics, Trade, and Investment (projects = 26, ASA = 25)	Education (projects = 43, ASA = 23)	Urban, Disaster Risk Management, Resilience, and Land (projects = 34, ASA = 7)	Poverty and Equity (ASA = 23)	Total
FY20	Projects (n = 199)	8,146	2,891	2,619	2,914	2,565	—	19,135
	Trust Funds	617	86	6	192	29	—	930
	ASA (n = 66)	11	6	3	4	4	5	33
	Subtotal	8,774	2,984	2,628	3,110	2,598	—	20,098
FY21	Projects (n = 114)	358	4,433	2,865	1,287	975	—	9,919
	Trust Funds	43	145	100	250	4	—	543
	ASA (n = 99)	7	4	2	1	2	5	21
	Subtotal	409	4,582	2,967	1,539	981	5	10,483
Total projects		8,504	7,324	5,484	4,201	3,540	—	29,054
Total trust funds		660	231	106	442	33	—	1,473
Total PEF		0.196	—	—	—	—	—	0.196

(continued)

		Lead Global Practice, Estimated Commitments (US\$, millions)						
Fiscal Year	Financing	Health, Nutrition, and Population (projects = 111, ASA = 42)	Social Protection and Jobs (projects = 39, ASA = 45)	Macroeconomics, Trade, and Investment (projects = 26, ASA = 25)	Education (projects = 43, ASA = 23)	Urban, Disaster Risk Management, Resilience, and Land (projects = 34, ASA = 7)	Poverty and Equity (ASA = 23)	Total
		Total ASA		18	10	5	5	
Grand Total		9,182	7,566	5,596	4,648	3,579	10	30,581

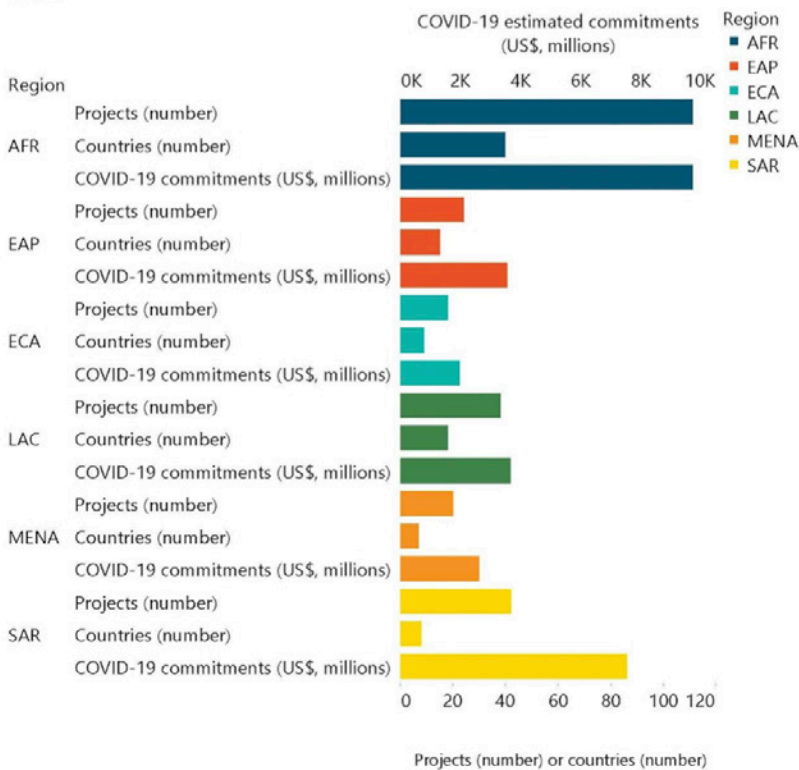
Source: Independent Evaluation Group portfolio.

Note: In panel a, the size of the boxes increases with the number of projects. In each box, the top number shows the number of projects, and the bottom numbers show the estimated commitments for the Global Practice. Total estimated commitments are defined as the full project commitment amounts for projects approved on or after February 1, 2020 (including additional financing), and as the sum of undisbursed balances and disbursements for projects approved before February 1, 2020 (project commitment data were retrieved on May 12, 2021). New projects (approved on or after February 1, 2020) are assumed to have 100 percent share of COVID-19 content. The total number of projects is 253. The total estimated commitments amount is US\$29,054 million. Panel b reports COVID-19 estimated commitments in US\$, millions, including funding by IBRD, IDA, recipient-executed trust funds, and World Bank-executed trust funds. Projects and ASA cover the evaluation period of February 2020 to April 30, 2021, and are divided by fiscal year. Table excludes 10 ASA totaling US\$3.4 million led by global thematic units and the Development Research Group. PEF amounts are based on the PEF Allocations Steering Body (World Bank 2020a). Table is based on 313 projects (253 parents and 60 additional financing), and 165 ASA. — = not applicable; ASA - advisory services and analytics; IBRD - International Bank for Reconstruction and Development; IDA - International Development Association; PEF - Pandemic Emergency Financing Facility.

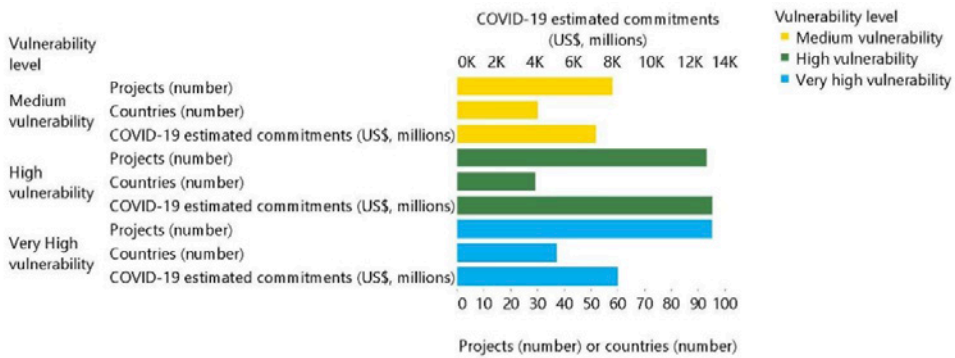
Health, Nutrition, and Population has the largest share of projects and commitments in the evaluation portfolio, followed by Social Protection and Jobs; Macroeconomics, Trade, and Investment; Education; and Urban, Disaster Risk Management, Resilience, and Land. By Region, the largest share of commitments is in Africa, followed by South Asia and East Asia and Pacific Regions (figure B.4, panel a), although individual project commitments in Africa are on average smaller than other Regions. Africa also has the largest number of countries and projects covered by the portfolio. The portfolio includes countries and projects across various levels of vulnerability (figure B.4, panel b). Regarding ASA, Social Protection and Jobs and Health, Nutrition, and Population combined account for about half of the ASA, estimated at \$10 million and \$18 million, respectively. The Poverty and Equity GP accounts for about 13 percent of ASA (about \$10 million). Other ASA was spread across GPs.

Figure B.4. Estimated Project Financing and Overview of Evaluation Portfolio

a. Projects and estimated financing by region



b. Projects and estimated financing by country vulnerability



Source: Independent Evaluation Group portfolio.

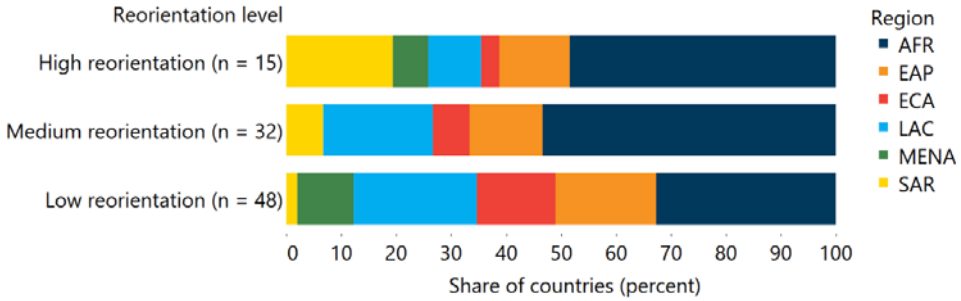
Note: In panel a, projects (number), countries (number), COVID-19 commitments (US\$, millions), and COVID-19 commitments (US\$, millions) are for each Region. Color shows details about the Region (group). Details are shown for projects (number), countries (number), and COVID-19 commitments (US\$, millions). In panel b, projects (number), countries (number), COVID-19 estimated commitments (US\$, millions), and COVID-19 estimated commitments (US\$, millions) are for each vulnerability level. Color shows details about vulnerability level (group). The view is filtered on vulnerability level, which keeps high vulnerability, medium vulnerability, and very high vulnerability. Panel b excludes one country (Grenada) that is part of two regional projects (P117871 and P168539) but that is classified as having low vulnerability. The total number of projects is 253 in 97 countries. The total estimated commitments amount is US\$29,054 million. AFR = Africa Region; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

The portfolio emphasizes new projects developed for COVID-19: 68 percent of projects are new, whereas the remaining are projects repurposed to support COVID-19. South Asia and Africa introduced the highest level of reorientation of their portfolios through new and repurposed projects and ASA. Portfolio reorientation helped identify a range of response areas quickly (figure B.5, panel a).

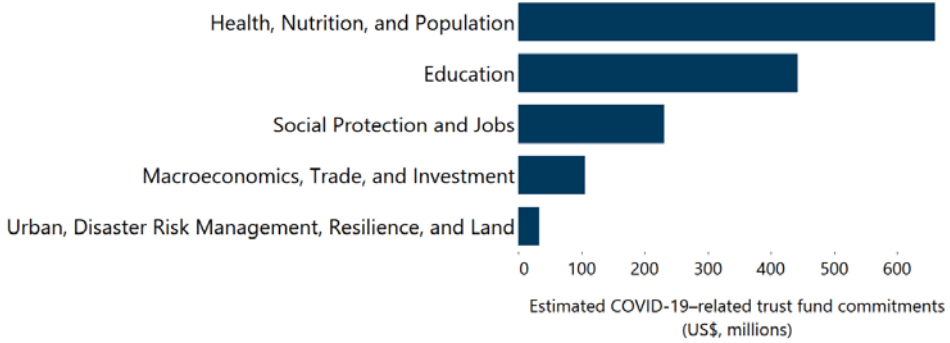
Regional project support and trust fund financing were important to supporting the early response. Regional projects supported the response, drawing on \$515 million in financing and covering 23 percent of the countries. These regional projects approved before COVID-19 were able to repurpose support across the countries to expand critical health services and institutional strengthening. Trust funds supported 74 percent of countries for critical health services (figure B.5, panel b) and to coordinate the response. The Pandemic Emergency Financing Facility accounts for about \$196 million of trust fund support. Other notable trust funds supporting the response include the Global Financing Facility, country-level pooled donor trust funds, and the Health Emergency Preparedness and Response umbrella trust fund. World Bank teams adjusted the use of previously existing trust funds to account for new needs related to COVID-19.

Figure B.5. Portfolio Reorientation in Countries for COVID-19 and Trust Funds

a. Country portfolio reorientation by Region (financing projects and ASA)



b. Estimated trust fund financing to COVID-19 by Global Practice

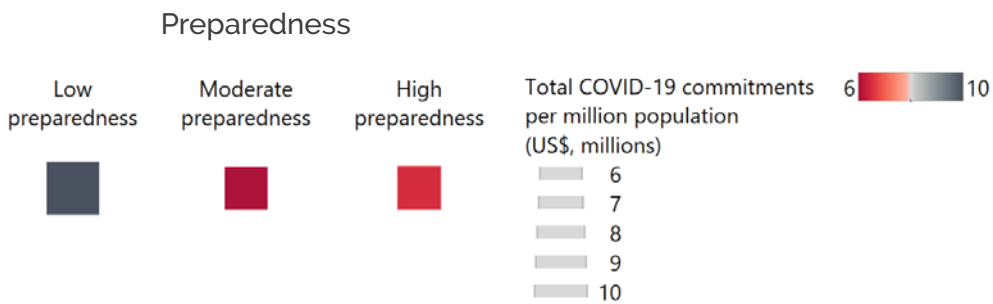


Source: Independent Evaluation Group portfolio.

Note: In panel a, reorientation is defined as the number of projects per country responding to COVID-19, including financing projects and advisory services and analytics. It has a mean value of 3.86, median of 3.0, and standard deviation of 3.13. Reorientation levels are defined as terciles. Low reorientation ≤ 3 projects, medium = 4 projects, and high ≥ 5 projects. The total number of countries is 95. In panel b, trust fund data include both World Bank-executed and recipient-executed trust funds. The total number of projects is 146. AFR = Africa Region; ASA = advisory services and analytics; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

Countries with lower levels of preparedness potentially needing more support received the highest project financing commitments per million population in the early response (figure B.6). The portfolio also emphasized support to small states and FCS. Small states received on average about \$38 million per million population in the COVID-19 response, compared with about \$7 million for other countries. FCS countries received \$9 million per million population. This points to the efforts to support countries in challenging situations.

Figure B.6. Commitments to COVID-19 Response by Country



Source: Independent Evaluation Group portfolio; preparedness indexes are from the International Health Regulations Core Capacity Index, <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/preparedness> (accessed February 1, 2021); and e-SPAR State Parties Annual Reporting, "State Parties Self-Assessment Annual Reporting on the Implementation of the International Health Regulations." <https://extranet.who.int/e-spar/#capacity-score>.

Note: Values were calculated by dividing the total COVID-19 commitments in each preparedness stratification by the total population represented in each stratification. The total number of countries is 94 and excludes regional projects.

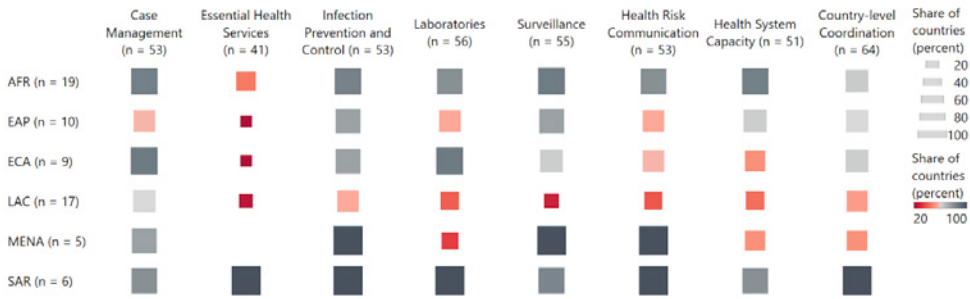
As of January 31, 2022, the World Bank’s COVID-19 portfolio continued to expand and change composition. The evaluation conducted a rapid update of the health and social response portfolio to understand how it has grown since the early the evaluation period. The COVID-19 response has expanded to include 381 projects and \$60 billion in commitments across the 106 countries and five GPs. Of the projects added to the portfolio, about 40 percent were approved after April 30, 2021. The remaining 60 percent are previously approved projects that have added a COVID-19 tag or adjusted their implementation to support COVID-19 since the early portfolio was drawn. Health, Nutrition, and Population projects represent about 25 percent of the projects in the evolving portfolio, compared with about 40 percent in the early portfolio. Agriculture and Food has expanded its coverage to be one of the five main GPs supporting the health and social response.

Design and Targeting of the Support

The World Bank supported most health emergency priorities in early COVID-19 response plans in countries (66 percent), although there was limited support to the continuity of essential services (figure B.7). The World Bank responded to the needs identified in country COVID-19 plans for surveillance, case management, and infection prevention and control,

aligning with the World Health Organization priority areas for COVID-19. Continuation of essential health services was often not prioritized in early country planning for COVID-19. Vaccination had limited support in the early response across regions, given the emphasis of early plans on prevention and control.

Figure B.7. Alignment of World Bank Support with Country COVID-19 Plans by Region



Source: Independent Evaluation Group portfolio; country COVID-19 plans; WHO COVID-19 Partners Platform. Geneva.: WHO (accessed May 1, 2021). <https://covid19partnersplatform.who.int/en>.

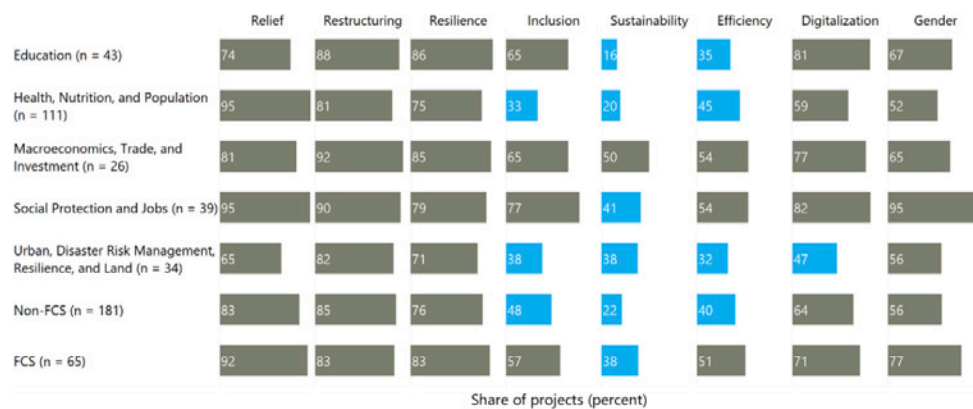
Note: The analysis shows the percent of countries by Region that had World Health Organization plans in a response area and received at least one World Bank intervention in that area. The analysis is conducted for countries with complete data on COVID-19 plans. The total number of countries is 66. AFR = Africa Region; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

The World Bank’s support across GPs covered both relief efforts and reforms to restructure systems (figure B.8). Support of Health, Nutrition, and Population and to FCS countries focused on the relief stage, although there is planned support to restructure systems, such as health human resource plans. Macroeconomics, Trade, and Investment and Social Protection and Jobs focused on restructuring systems, such as for social protection. In Education, early support focused on remote learning, with restructuring support to reopen schools with improved safety and sanitation conditions. Urban, Disaster Risk Management, Resilience, and Land focused on restructuring support, such as to improve conditions in urban slums. Interventions to support the resilience of systems have been incorporated into ongoing efforts across GPs, where people, communities, systems, and assets have been prepared for shocks that could emerge from diseases, shutdowns, and income loss. The early response did not address longer-term support for preparedness capacities after COVID-19 or consider the efficiency of resource use in countries. Likewise, sustainability in the form of planning for long-term consequences in terms of services, systems, environ-

ment, resources, or people was limited in all areas of the response except for support led by Macroeconomics, Trade, and Investment.

Support to enhance the addressing of inclusion, gender, and digitalization in projects has been strongest in the social response (figure B.8). Social Protection and Jobs projects most consistently addressed inclusion, gender, and digitalization, followed by Education and Macroeconomics, Trade, and Investment. The absence of actions to address gender is pronounced in operations financed under the first Multiphase Programmatic Approach (MPA) support. Inclusion aspects in a project supported increasing the access of vulnerable groups to services and other resources. In FCS country responses, there has been better emphasis on inclusion, gender, and digitalization than in non-FCS countries.

Figure B.8. Design Elements of Project Support to Countries by Global Practice



Source: Independent Evaluation Group.

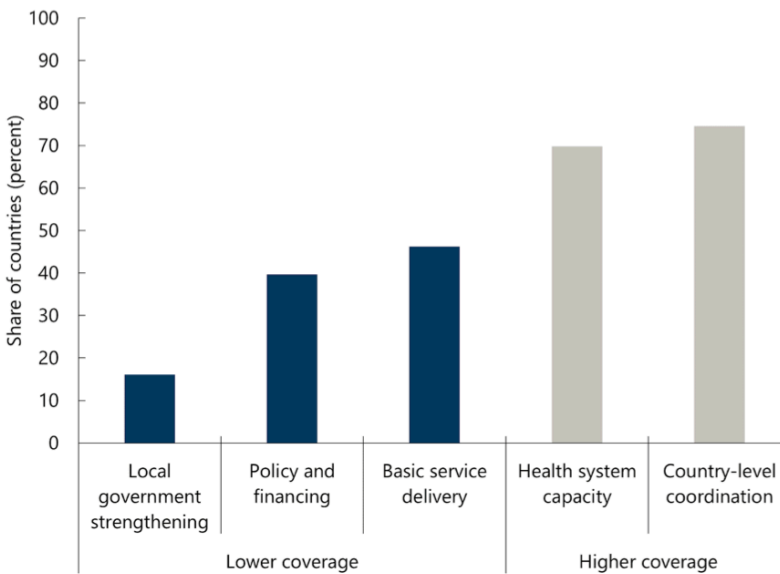
Note: Bar size represents the percent of projects within each Global Practice that support the specified stage of the response or have specified orientation of project design. Blue bars denote areas with less than 50 percent of projects. The total number of projects is 253. "Relief" refers to whether a project includes support for the emergency stage of the COVID-19 response. "Restructuring" refers to whether a project includes support for recovery. "Resilience" looked at whether a project supported preparing people, communities, systems, and assets for shocks, such as those that could emerge from diseases, shutdowns, and income loss. "Inclusion" looked at whether a project supported increasing the access of disadvantaged groups to services and other resources. "Sustainability" looked at whether project activities supported planning for long-term consequences in terms of the management of the services, systems, resources, or people to ensure continued benefit. "Efficiency" refers to considerations for cost-effective government resource use in a constrained environment. "Digitalization" and "gender" looked at whether project interventions included any interventions to address those areas. FCS = fragile and conflict-affected situation.

Institutional Strengthening

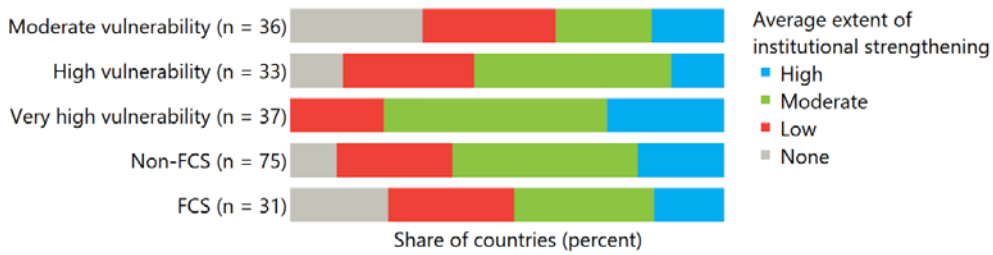
Early support to institutional strengthening focused on country-level coordination and core public health functions to respond to COVID-19 (figure B.9, panel a). Integrating institutional strengthening from the onset of the response helped support basic capacities for the immediate crisis, with the most extensive support going to FCS and higher vulnerability countries (figure B.9, panel b). Examples of support include to help governments develop COVID-19 plans and policies, strengthen laboratory and surveillance systems, and provide social protection and education services. This support will need to be deepened to support recovery. Local government received limited direct institutional strengthening support outside FCS countries, although national support to COVID-19 plans intends to channel resources to subnational levels.

Figure B.9. Institutional Strengthening in Early COVID-19 Response in Countries

a. Areas of institutional strengthening support



b. Extent of institutional strengthening in countries



Source: Independent Evaluation Group portfolio; vulnerability indexes are from the INFORM COVID-19 Risk Index (Poljanšek, Vernaccini, and Marin Ferrer 2020; World Bank 2020b; UNINFO, COVID-19 Data Portal, https://data.uninfo.org/Home/_InformRiskk [accessed February 1, 2021]).

Note: In panel a, calculations are by share of countries with at least one intervention in an institutional strengthening area. The total number of projects is 253 in 97 countries; 981 interventions focused on institutional strengthening. In panel b, the extent of institutional strengthening in a country is calculated by stratifying in terciles the average percent of institutional strengthening interventions within projects. "Low" refers to countries with less than 4 percent of possible institutional strengthening interventions, "medium" between 4 and 20 percent, and "high" 20 percent and above. Institutional strengthening is defined against the areas identified in the conceptual framework of the evaluation. COVID-19 = coronavirus; FCS = fragile and conflict-affected situation.

Support to Implementation and Learning in Countries

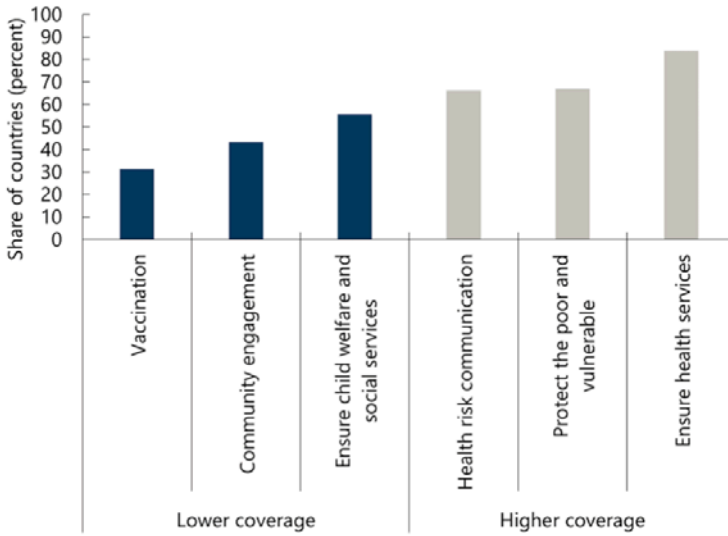
Multidimensional Implementation

The World Bank’s early operational financing focused on addressing the health emergency and social protection. More than 80 percent of countries received project support to ensure health services (figure B.10, panel a). The health support focused on critical health services for infection prevention and control, case management, surveillance, and laboratories (figure B.10, panel b). Risk communication has also received some attention, especially in FCS countries. The emphasis on critical health services reflects the alignment of early support with World Health Organization priority areas. In addition, about 67 percent of countries received support to protect poor and vulnerable persons (social protection and or informal economy support).

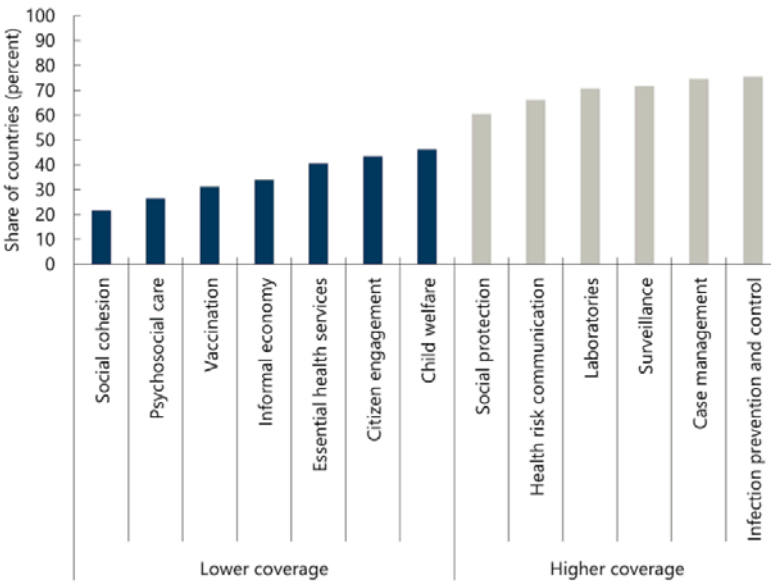
Reorientation of country portfolios to cover a range of COVID-19 response areas often drew on existing projects. The widest coverage of response areas in country portfolios is seen where existing projects were repurposed to support interventions for COVID-19. Areas not well addressed in the response are social cohesion, psychosocial care, informal economy support, and citizen engagement.

Figure B.10. Thematic Areas of COVID-19 Response in Countries

a. Thematic response areas



b. Breakdown of thematic response areas



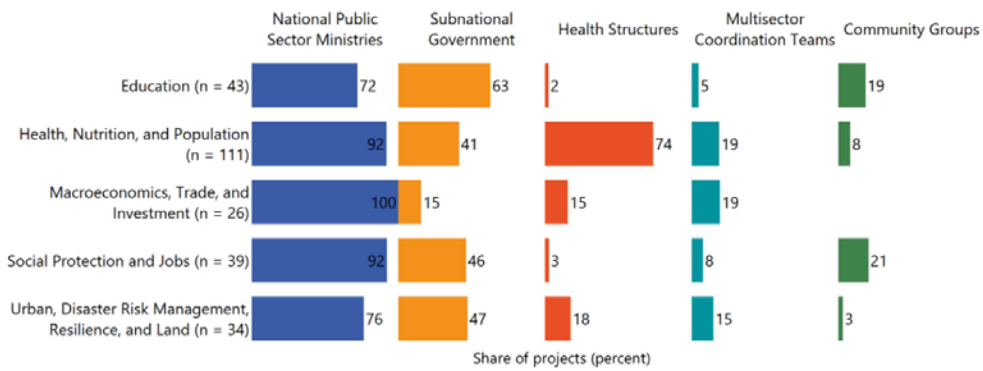
Source: Independent Evaluation Group portfolio.

Note: In panels a and b, calculations are by share of countries with at least one intervention in a thematic response or breakdown of area. The total number of projects is 253, covering 3,204 interventions coded for the evaluation. The number of countries used as the base is 106. COVID-19 = coronavirus.

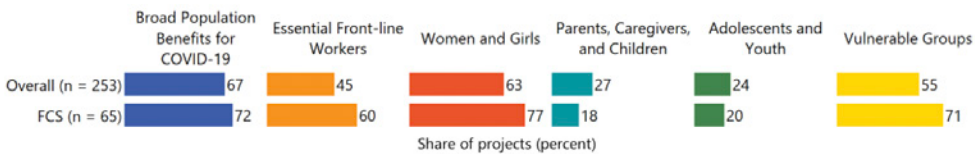
Most early support focused on engaging national ministries, with less support of subnational government and targeting of specific population groups (figure B.11). Few countries have multisectoral coordination teams or projects supporting community groups. Targeting of specific vulnerable groups was limited and more common in FCS countries and in Africa than other Regions. By GP, Education has had the most disaggregated response engaging parents and adolescents. Health, Nutrition, and Population engaged health structures and essential frontline workers through national plans. Social Protection and Jobs stands out for its focus on women and girls and vulnerable groups.

Figure B.11. Country Actors Delivering Coronavirus (COVID-19) Project Support

a. Project implementing actors



b. Project beneficiaries



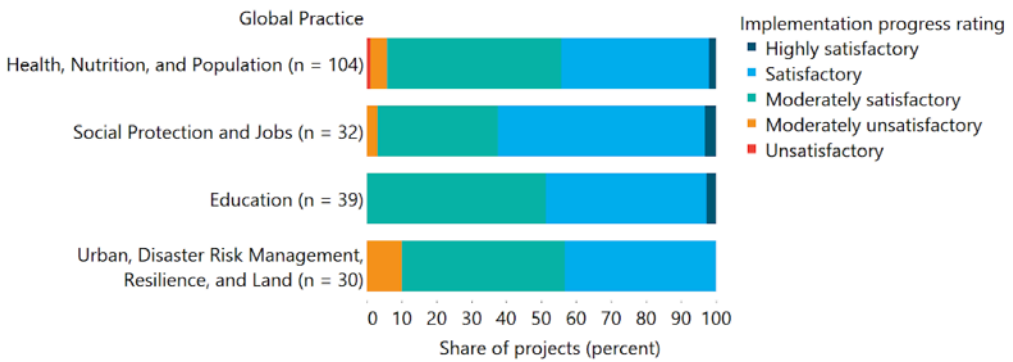
Source: Independent Evaluation Group portfolio.

Note: The bars indicate the percent of projects within each Global Practice that had at least one World Bank intervention that targeted the implementing actors or beneficiaries. Analysis covered 97 countries and 253 coded projects. FCS = fragile and conflict-affected situation.

Implementation Status of Project Support

Across GPs, about half of the projects supporting COVID-19 have satisfactory or better implementation progress ratings (figure B.12). Social Protection and Jobs shows slightly greater early implementation progress, which may relate to the extent of work done before COVID-19 to develop social protection systems and thus the readiness of this sector to respond to the crisis. Projects have lower implementation ratings in countries that had more than 40 weeks of community spread of COVID-19 per the World Health Organization classification, suggesting implementation is challenging when countries experience a peak in cases.

Figure B.12. Project Implementation Progress by Global Practice



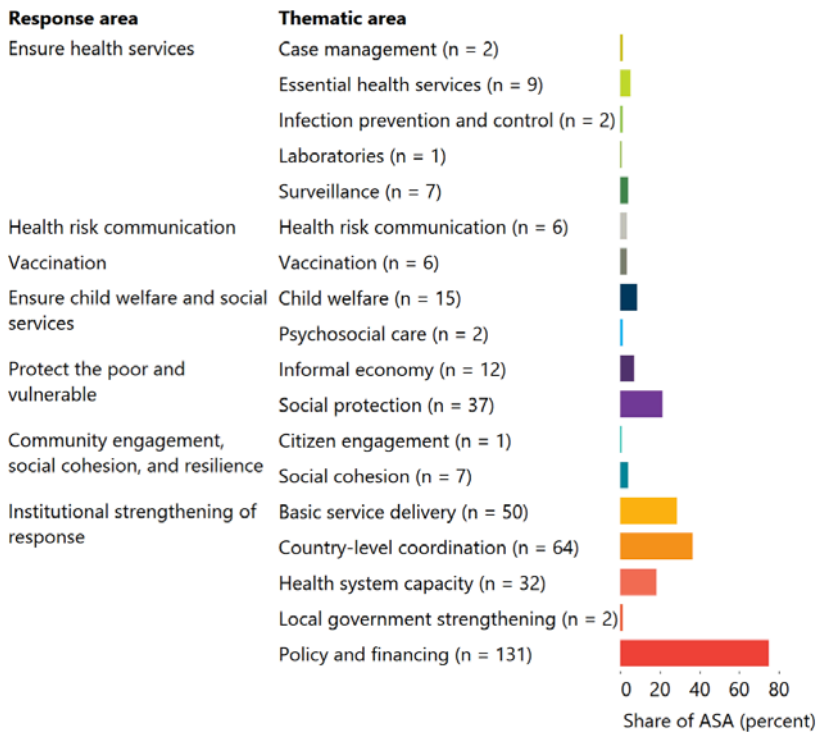
Source: Independent Evaluation Group portfolio.

Note: The figure excludes one project from the Macroeconomics, Trade, and Investment Global Practice. New projects with no implementation progress rating to date were excluded. The extraction date for Implementation Status and Results Reports is November 5, 2021. The total number is 205 projects.

Use of Advisory Services and Analytics to Guide Response

ASA support cuts across thematic areas of the COVID-19 response, with more than 90 percent focused on institutional strengthening of systems, policy, and services and 21 percent focused on social protection (figure B.13).

Figure B.13. Advisory Services and Analytics Support to COVID-19 Response by Theme

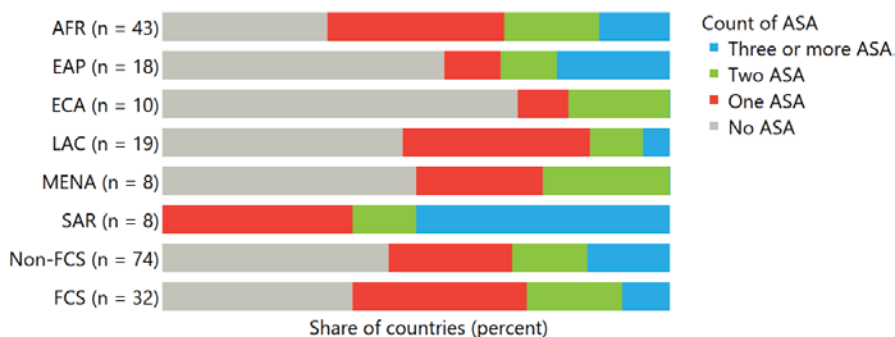


Source: Independent Evaluation Group portfolio.

Note: Because each ASA could address multiple response areas, the total percent is greater than 100; the total number is 175 in 62 countries and 13 regional units with ASA. Regional units include Africa, Andean countries, Caucasus, Central America, East Africa, Europe and Central Asia, Latin America and the Caribbean, Middle East and North Africa, multiregional, Southern Africa, Western Africa, Western Balkans, and the world. ASA = advisory services and analytics.

Globally, just under 60 percent of countries have had ASA support for COVID-19. The emphasis on ASA varies by Region (figure B.14). South Asia was the only Region where all countries undertook some form of ASA. In Africa and FCS countries, more than 60 percent of countries undertook at least one ASA (although individual commitment amounts of ASA were often small). Other Regions had lower ASA coverage.

Figure B.14. Extent of Advisory Services and Analytics Coverage in Countries by Region

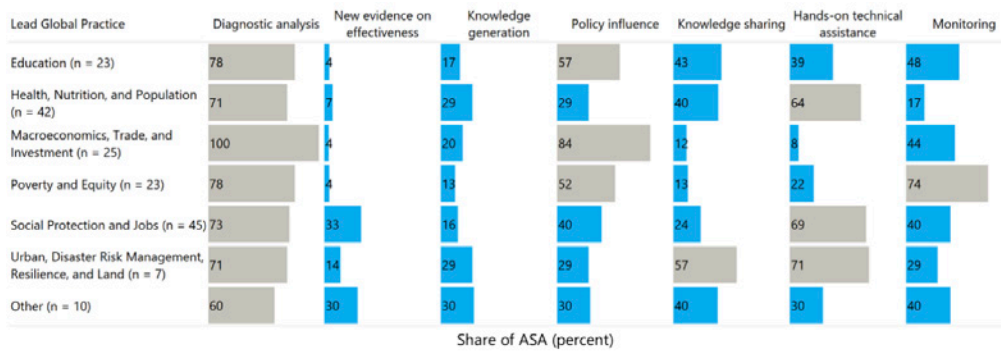


Source: Independent Evaluation Group portfolio.

Note: The analysis includes only country-level ASA and excludes regional and global ASA. Figure includes 62 countries with ASA and 44 without ASA. The total number is 106 countries. AFR = Africa Region; ASA = advisory services and analytics; EAP = East Asia and Pacific; ECA = Europe and Central Asia; FCS = fragile and conflict-affected situation; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

ASA was used most often for diagnostic analysis (more than 90 percent of ASA; figure B.15). Social Protection and Jobs undertook the highest number of ASA, followed by Health, Nutrition, and Population. After diagnostic analysis, ASA provided support through policy analysis (67 percent of ASA), monitoring the impact of COVID-19 (63 percent of ASA), and hands-on technical assistance (61 percent of ASA). Macroeconomics, Trade, and Investment supported most ASA to influence policy. Across GPs, less-covered areas of ASA were knowledge sharing (42 percent), knowledge generation to document experiences (29 percent), and operational research to identify new evidence on effectiveness (28 percent).

Figure B.15. Types of Advisory Services and Analytics Support for COVID-19



Source: Independent Evaluation Group portfolio.

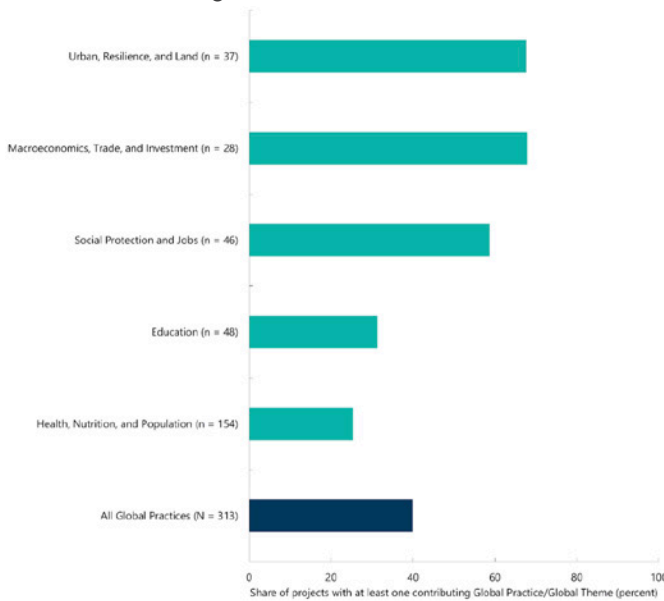
Note: Bar size represents the percent of ASA in Global Practices by the various type. Given that ASA can have multiple purposes, the amounts add up to more than 100 percent. The blue bars represent ASA types less than 50 percent. The total number is 175 in 62 countries, and 13 regional units with ASA. Regional units include Africa, Andean countries, Caucasus, Central America, East Africa, Europe and Central Asia, Latin America and the Caribbean, Middle East and North Africa, multiregional, Southern Africa, Western Africa, Western Balkans, and the world. "Other" are analytical products requested by Global Themes, country management units, and the Development Research Group. ASA = advisory services and analytics.

Operational Processes in Support of Countries

Coordination across Global Practices to Support Implementation

Development policy financing (DPF) and crisis instruments encouraged collaboration across GPs: 68 percent of DPFs and 52 percent of crisis instruments had GP collaboration, often led by Macroeconomics, Trade, and Investment and Urban, Disaster Risk Management, Resilience, and Land. By Region, South Asia and Middle East and North Africa had the greatest GP collaboration on projects (more than 70 percent of countries had GP collaboration on projects, compared with 50 percent or less in other Regions). By GP, Health, Nutrition, and Population and Education had limited collaboration on projects, compared with other GPs (figure B.16). There are opportunities for further collaboration on the MPA, with just 28 percent of projects working with another GP. Box B.1 describes examples of GP collaboration.

Figure B.16. Percent of Collaboration in Global Practice Projects for COVID-19



Source: Independent Evaluation Group portfolio.

Note: The analysis looks at collaboration in parent and additional financing projects. The total number is 253 parent projects and 60 additional financing. Urban, Resilience, and Land = Urban, Disaster Risk Management, Resilience, and Land.

Box B.1. Examples of Global Practice Collaboration in the COVID-19 Response

- » In India, Social Protection and Jobs and Health, Nutrition, and Population collaborate to provide a health insurance plan for health workers delivering care to patients with COVID-19.
- » In Madagascar, Urban, Disaster Risk Management, Resilience, and Land; Health, Nutrition, and Population; and Social Protection and Jobs collaborate to rehabilitate and equip health centers to deliver COVID-19 services; facilitate social distancing and hygiene services, including public handwashing stations and sanitation for public transport; and provide cash transfers and cash-for-work activities. Also, Education, Governance, Social Protection and Jobs, and Health, Nutrition, and Population collaborate to improve learning support in schools, governance of education in emergencies at all levels, and water, sanitation, and hygiene in schools and to provide grants to community teachers.

(continued)

Box B.1. Examples of Global Practice Collaboration in the COVID-19 Response (Cont.)

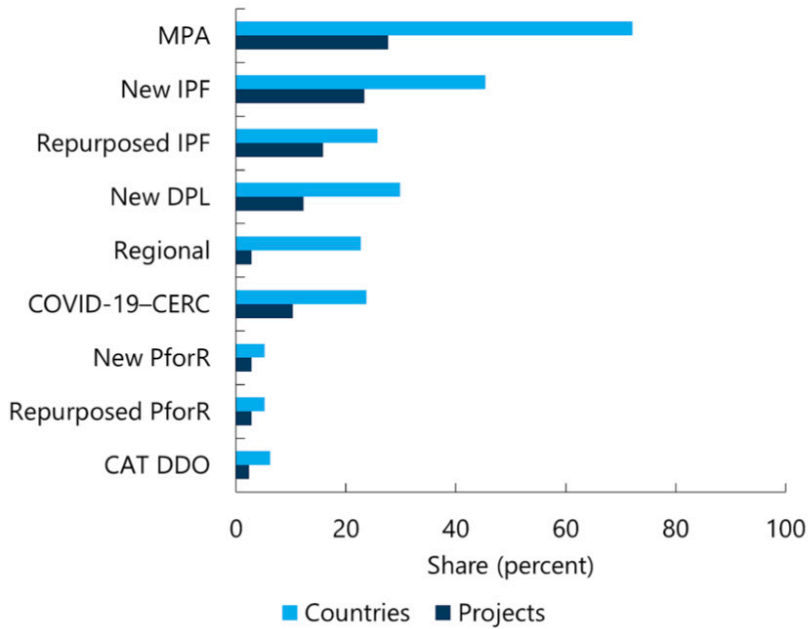
- » In West Africa, Health, Nutrition, and Population and Agriculture collaborate to train One Health community agents in community-based surveillance and response.
- » In Uzbekistan, Agriculture; Energy; Finance, Competitiveness, and Innovation; Poverty and Equity; and Macroeconomics, Trade, and Investment collaborate in a development policy loan to enhance economic inclusion and social resilience in response to COVID-19 by increasing targeted support to vulnerable households.
- » In Nepal, Urban, Disaster Risk Management, Resilience, and Land; Governance; Sustainability and Inclusion; Transport; and Water collaborated to strengthen the institutional and fiscal capacities of municipalities for continued service delivery during COVID-19, including support to labor-intensive public works for individuals from poor and vulnerable households.

Source: Independent Evaluation Group portfolio.

Mix of Instruments Supporting Implementation

A mix of instruments was used to deliver health and social support for COVID-19 (figure B.17). The MPA and regional projects led by Health, Nutrition, and Population were the main support to the early health response and to a lesser extent, CERCs and repurposed projects. Countries in Latin America and the Caribbean used more DPFs, CERCs, and repurposed projects than other Regions. This may reflect experience with crisis response. About 17 percent of projects in the portfolio were restructured to support the early health and social response. There was limited use of additional financing between March and June 2020, with about 2 percent of projects receiving additional financing. Additional financing increased after June 2020, when a waiver was available for applying the Environmental and Social Framework safeguards (increasing to about 21 percent of the early response portfolio). More than 75 percent of additional financing is associated with new projects for COVID-19. Overall, the early response had a high use of new projects. Box B.2 provides examples on the use of instruments.

Figure B.17. Use of a Mix of Instruments to Support the Response



Source: Independent Evaluation Group portfolio.

Note: The total number is 253 projects in 97 countries. CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component; DPL = development policy loan; FY = fiscal year; IPF = investment project financing; MPA = Multiphase Programmatic Approach; PforR = Program-for-Results.

Box B.2. Examples of Instrument Uses in the Response

Development policy financing: The Colombia COVID-19 crisis response development policy financing undertook prior actions that responded to the emergency while also helping to restructure systems. The prior actions included:

- » Definition of a costed basket of health services and technologies to attend to patients infected by COVID-19, which allowed the allocation of additional resources to health insurance companies and health-care providers.
- » Expansion of the main database for targeting social programs to facilitate relief response cash payments, which can be used in future emergencies.

(continued)

Box B.2. Examples of Instrument Uses in the Response (Cont.)

- » Accelerated implementation of the value-added tax refund program targeted at the poorest who are already receiving cash transfers.

Investment project financing: In Pakistan, a repurposed investment project financing in the education sector supported the emergency response by procuring personal protective equipment, sanitization, and other hygiene equipment for technical institutions in Punjab. By contrast, the Khyber Pakhtunkhwa Human Capital Investment project combined emergency and restructuring needs by developing community engagement and feedback systems, including the implementation of a communication strategy for positive healthy behaviors and lifestyle. The project was approved in June 2020 and started disbursing in September 2020.

Source: Independent Evaluation Group portfolio.

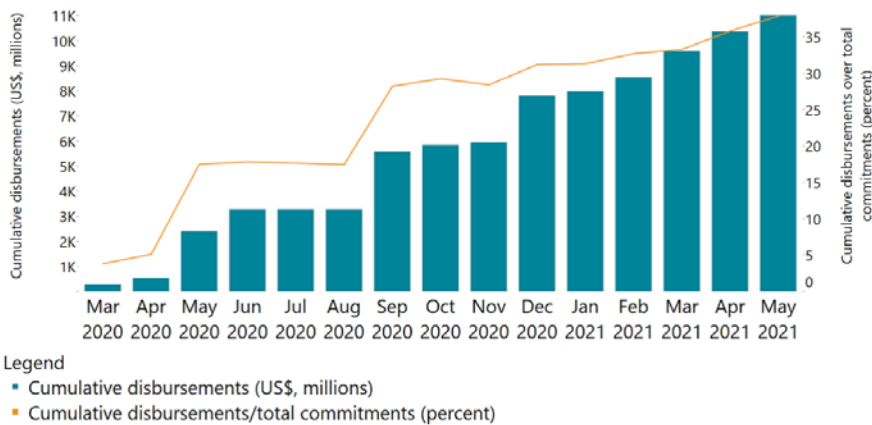
Estimated Disbursement of Financing to Support the Response

The World Bank disbursed an estimated 38 percent of COVID-19 commitments in the financing portfolio based on data up to June 1, 2021, with the first data on disbursement in March 2020, immediately when the COVID-19 crisis was declared (figure B.18). Early disbursement in the first months of the pandemic reached 69 countries and steadily increased in fiscal year (FY)21. Following the announcement of the pandemic at the end of FY20, the World Bank's COVID-19 portfolio grew quickly, disbursing just under \$3.3 billion between March and June (7 percent went to FCS countries, and 69 percent went to high and very high vulnerability countries). In FY21, the pace of disbursement slowed, increasing each quarter by an average of about \$1.5 billion and reaching 86 countries (including 25 FCS countries). Cumulative disbursement throughout the early response was about \$11 billion (11 percent went to FCS and 64 percent to high and very high vulnerability countries).

Emergency instruments and repurposed projects supported rapid early disbursement. Most MPA projects were approved by FY20. Excluding those that

have yet to disburse, the MPAs took an average of about two months to make first disbursements. New DPFs started to disburse in May 2020 and made up the largest share of disbursements. This emphasizes the value of quick-disbursing emergency instruments, such as CERC and catastrophe deferred drawdown option, for crisis response. Moreover, existing regional projects and repurposed project support disbursed quickly, pointing to the importance of having relevant investments before the crisis hit. About 50 percent of new projects disbursed within two months, about 80 percent within five months, and others lagged beyond.

Figure B.18 Cumulative Disbursement of Early Support to COVID-19

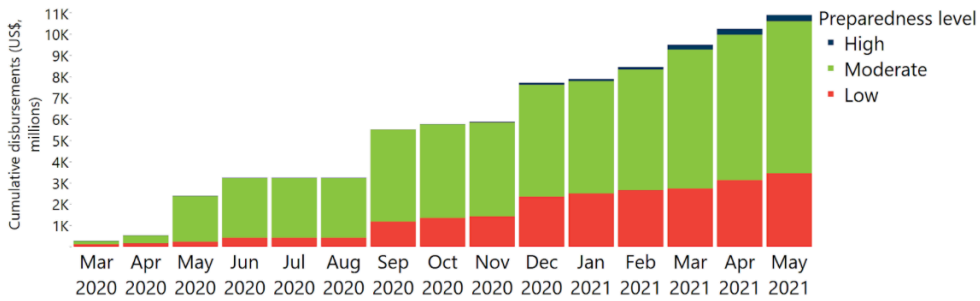


Source: Independent Evaluation Group review based on monthly Standard Reports data, extracted on June 1, 2021.

Note: There are 92 countries with available disbursement information, with 86 of them showing monthly disbursements during the period for projects in the financing portfolio, in addition to three regions with disbursement information for regional projects (Eastern Africa, Western Africa, and the Organisation of Eastern Caribbean States countries). The total number of country units is 89. Disbursements are adjusted with the share of COVID-19 response content estimated in the coding of each project by the Independent Evaluation Group. New projects (approved on or after February 1, 2020) are assumed to have 100 percent share of COVID-19 content. The numerator for the percent of monthly disbursements is the cumulative disbursements reported for projects in the evaluation portfolio up to that month. The denominator is the cumulative approved project commitments in the portfolio up to the same month. The total estimated commitments amount is \$29,054 million.

The World Bank disbursed fastest in countries with at least moderate levels of preparedness (figure B.19). By the end of May 2021, moderate preparedness countries accounted for 65 percent of country disbursements made since March 2020 in the evaluation portfolio. They were followed by low preparedness countries with about one-third of disbursements; the pace of disbursements for low preparedness countries was relatively slow until September 2020, suggesting it took about six months for the World Bank to deliver on its commitments under these circumstances.

Figure B.19 Cumulative Disbursement by Preparedness

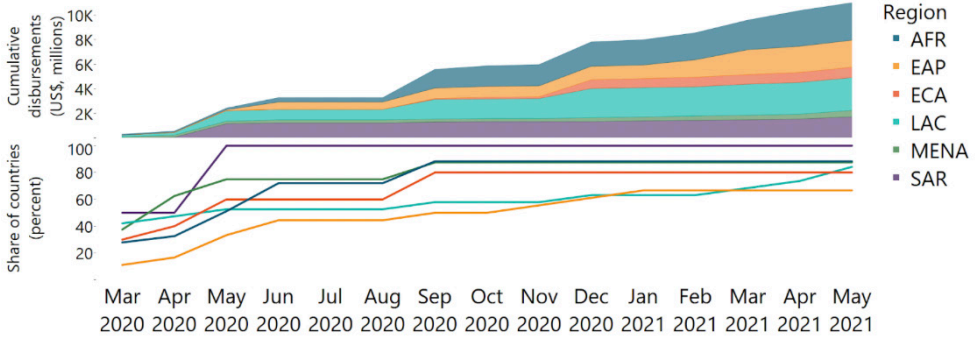


Source: Independent Evaluation Group portfolio review based on monthly Standard Reports data, extracted on June 1, 2021.

Note: There are 92 countries with available disbursement information, with 86 of them showing monthly disbursements for projects in the financing portfolio. Data on vulnerability come from the INFORM COVID-19 Risk Index, adjusted to include the Human Capital Index (Poljanšek, Vernaccini, and Marin Ferrer 2020; World Bank 2020b; UNINFO, COVID-19 Data Portal, https://data.uninfo.org/Home/_Inform-Riskk [accessed February 1, 2021]); data on preparedness are from WHO (2017, 2021a). Regional projects are excluded from the figure because preparedness data are not available for Regions. The total number of countries is 86. COVID-19 = coronavirus.

Early in the pandemic, disbursement reached countries quicker in Africa, although the overall amount was low; the key support was from Urban, Disaster Risk Management, Resilience, and Land and Health, Nutrition, and Population, with other GPs adding support by May 2020 to support the crisis (figure B.20). Between March and June 2020, disbursement of financing in Africa reached 31 countries (78 percent of countries), increasing to 38 countries in FY21. The amount of financing to Africa increased in August 2020. Early financing to Latin America and the Caribbean also reached most countries.

Figure B.20 Cumulative Disbursement of Project Support by Region



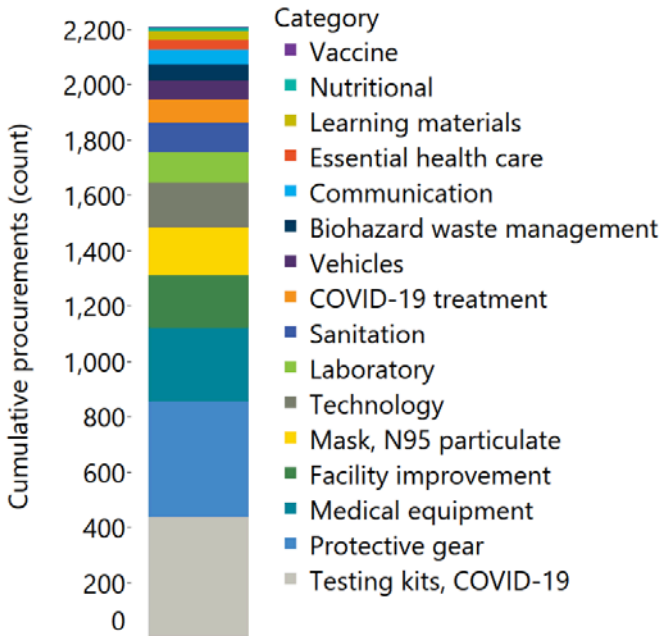
Source: Independent Evaluation Group portfolio review based on monthly Standard Reports disbursement data, extracted on June 1, 2021.

Note: The total number of country units is 89. AFR = Africa Region; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

Procurement of Goods and Services

Most of the procurement of goods (52 percent) focused on providing COVID-19 testing and laboratory equipment and protective gear, including masks (figure B.21). More limited procurement supported medical equipment (12 percent); facility improvements for quarantine, infection prevention and control, and patient care (9 percent); technology (7 percent); sanitation (5 percent); medication (4 percent); and other items such as vehicles, waste management, communication and learning materials, and nutritional products (about 11 percent combined). Vaccines account for less than 1 percent of early procurement, increasing later in the response. The types of goods procured over the period remained consistent with the focus on consumables. World Bank–facilitated procurement assisted countries with difficulty to procure medical supplies when there was a client request. In the early response, World Bank–facilitated procurement accounted for about 4 percent of all procurement of goods.

Figure B.21 Cumulative Procurement of Goods by Type



Source: Independent Evaluation Group portfolio.

Note: Data include procurement contracts signed between February 1, 2020, and April 30, 2021. Procurements were estimated through text analytics process that reviewed each line of procurement data to identify different types of goods (N = 3,977). COVID-19 = coronavirus.

Goods is the largest procurement category for the COVID-19 response, with about \$2.6 billion of support to countries across GPs. Procurement contracts rapidly increased by June 2020 and incrementally afterward; by March 2020, 3 percent of the total contracts were signed, and by June 2020, 38 percent were signed, mostly focused on health-related goods. The main instrument undertaking procurement was the MPA, with a significant contribution by CERC. The MPA, CERC, and repurposed projects account for just under 85 percent of all procurement. Direct selection was used for 59 percent of the contracts. Approximately 41 percent of countries procured services from United Nations agencies.

References

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¹ The identification of related projects identified to be supporting the response in project documents and Implementation Status and Results Reports was done as a second stage during the project coding. However, this step was important to help identify repurposed projects in the country portfolio.

² Projects with activated Contingency Emergency Response Component (CERC) in the 106 countries covered by the portfolio were identified through the portfolio identification and the Global Facility for Disaster Reduction and Recovery dashboard in May 2021 and June 2021. Twenty-six CERCs were included in projects covered by the portfolio. An additional 29 CERCs were activated in projects in other Global Practices to support the response.

³ The remaining 25 percent of projects not included in the portfolio analysis are in the Agriculture and Food, Governance, Social Sustainability and Inclusion, Water, and Transport Global Practices.

⁴ The INFORM COVID-19 Risk Index was used to categorize countries based on their vulnerability to development achievements being offset by the pandemic. The evaluation adjusted the index to consider the country's human capital index, given concerns surrounding losses of human capital in countries. The countries were then separated into quartiles based on their vulnerabilities to development and human capital losses (very high vulnerability, high vulnerability, moderate vulnerability, and low vulnerability). The INFORM COVID-19 Risk Index includes dimensions of social inclusion (such as gender inequality and poverty), economic vulnerability, governance, and institutional capacity, health systems capacity, environment, and population risks, such as access to sanitation and population mobility and density (Poljanšek, Vernaccini, and Marin Ferrer 2020; World Bank 2020b; UNINFO, COVID-19 Data Portal, https://data.uninfo.org/Home/_InformRiskk [accessed February 1, 2021]).

⁵ Very high vulnerability countries in the project portfolio are Afghanistan, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, the Central African Republic, Chad, the Comoros, the Democratic Republic of Congo, the Republic of Congo, Ethiopia, The Gambia, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, São Tomé and Príncipe, Sierra Leone, the Solomon Islands, Somalia, South Sudan, Togo, Uganda, and Zambia in Africa; Kiribati, the Marshall Islands, and Papua New Guinea in East Asia and Pacific; Haiti in Latin America and the Caribbean; and the Republic of Yemen in Middle East and North Africa (37 countries).

High vulnerability countries in the project portfolio are Angola, Cambodia, Côte d'Ivoire, Eswatini, Gabon, Ghana, Kenya, Rwanda, Senegal, and Tanzania in Africa; Indonesia, the Lao

People's Democratic Republic, Myanmar, the Philippines, Timor-Leste, Tuvalu, and Vanuatu in East Asia and Pacific; Guatemala, Honduras, and Nicaragua in Latin America and the Caribbean; Tajikistan in Europe and Central Asia; Djibouti, Iraq, and Lebanon in Middle East and North Africa; and Bangladesh, India, Maldives, Nepal, and Pakistan in South Asia (29 countries).

Moderate vulnerability countries in the project portfolio are the Seychelles in Africa; Fiji, Tonga, and Vietnam in East Asia and Pacific; Albania, Belarus, Bosnia and Herzegovina, Georgia, Moldova, Türkiye, Ukraine, and Uzbekistan in Europe and Central Asia; Belize, Bolivia, Colombia, Dominica, the Dominican Republic, Ecuador, El Salvador, Jamaica, Panama, Peru, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago in Latin America and the Caribbean; Jordan, Morocco, and Tunisia in Middle East and North Africa; and Bhutan and Sri Lanka in South Asia (31 countries).

Low vulnerability countries in the project portfolio are Grenada in Latin America and the Caribbean. Although Grenada does not meet the vulnerability criterion to be included in the list of eligible countries, it is covered by a regional disease-focused project (P168539) and thus is added to the portfolio as an exception (one country).

Countries from the eligible 106 (those with moderate vulnerability or higher) that were not covered in the portfolio of projects or advisory services and analytics are Algeria, Azerbaijan, Botswana, the Federated States of Micronesia, Namibia, Palau, Thailand, South Africa, and República Bolivariana de Venezuela.

⁶ Countries covered by advisory services and analytics are Angola, Burkina Faso, Burundi, Cameroon, the Central African Republic, Chad, the Comoros, the Democratic Republic of Congo, the Republic of Congo, Côte d'Ivoire, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Kenya, Malawi, Mali, Mauritania, Nigeria, Rwanda, São Tomé and Príncipe, Senegal, Sierra Leone, Somalia, South Sudan, Tanzania, Uganda, and Zambia in Africa; Cambodia, Fiji, Indonesia, the Lao People's Democratic Republic, Myanmar, Papua New Guinea, the Philippines, and Vietnam in East Asia and Pacific; Bolivia, Colombia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama, and Peru in Latin America and the Caribbean; Djibouti, Iraq, Morocco, and the Republic of Yemen in Middle East and North Africa; Albania, Tajikistan, and Türkiye in Europe and Central Asia; and Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka in South Asia (62 countries).

⁷ Nine countries from the eligible 106 did not have identified project or advisory services and analytics in the early response: Algeria, Azerbaijan, Botswana, the Federated States of Micronesia, Namibia, Palau, Thailand, South Africa, and República Bolivariana de Venezuela.

⁸ An in-depth analysis of coronavirus (COVID-19) commitments and financing allocations is outside the scope of the current evaluation. The evaluation provides an estimate from available data on the portfolio for the time period, countries, and Global Practices covered by the analysis.

Appendix C. Case Study Findings

This appendix presents the main findings for eight case study countries: Djibouti, Honduras, India, Mozambique, the Philippines, Senegal, Tajikistan, and Uganda.

Methodology

The evaluation team selected countries for case studies to understand the support of multiple Global Practices (GPs) and how early support to the COVID-19 response is helping to protect human capital. The selected countries have a Human Capital Index of 50 percent or below and received health, social, and institutional strengthening support for COVID-19. In addition, the countries have differing levels of vulnerability to losing their development gains due to COVID-19, and levels of preparedness for the crisis. These criteria helped the team understand how existing capacities may have enabled a country response. Other considerations for country selection included innovations to enrich learning, mix of instruments in the country portfolio, number of projects in the portfolio supporting COVID-19, coverage of fragile and conflict-affected situations, and different regions and population sizes. These criteria resulted in 41 eligible countries, which were discussed with operational counterparts to select the eight case countries.

The case studies examined at the quality of World Bank support to the early COVID-19 response. Data collection and analysis were organized using to the areas of the theory of action (needs of countries, support to implementation and learning in countries, and operational processes and partnerships) and conceptual framework to assess the quality of the response and how thematic areas and stages of support were carried out (Yin 1999). Although the analysis focused on support provided by the GPs covered by the evaluation, other GP staff were interviewed when recommended by the country management to understand the cross-sector breadth of support in the countries. Evidence sources reviewed included:

- » World Bank projects and advisory services and analytics (ASA) supporting the health and social response, identified with country teams, including project documents, Implementation Status and Results Reports, Aide Memoires, and knowledge outputs.¹
- » Interviews with actors involved in implementation of the response, including World Bank task teams and country management, government, civil society, and development partners.
- » Information on the response in the country, such as national plans and secondary data on the COVID-19 situation.

Data collection was done remotely due to travel restrictions, with all team members trained to follow the same case study protocol in Excel to ensure systematic data collection across countries. Case took place over about six months, between April 2021 and September 2021. One team member served as a coordinator working across countries to ensure consistency. In each country, the Independent Evaluation Group team relied on national consultants to provide country contextual knowledge and facilitate country stakeholder interviews.

Quality of World Bank Support

The case study countries show a medium to high implementation support across areas assessed for a quality COVID-19 response, with opportunities for improvement in some areas (table C.1). All countries have supported national COVID-19 plans and iteratively adjusted their response, often through informal meetings and exchanges. Consistent strong dialogue with government supported the response, though the extent of cross-sector collaboration and involvement of nongovernmental actors varied among countries. In terms of operational processes and partnerships, some countries deployed a wider mix of instruments and had greater GP and partner collaboration. The addressing of gender and inclusion needs attention, with countries having limited support in this area. Some countries had stronger support of monitoring systems, knowledge sharing, and ASA. Table C.3, later in this appendix, details the responses in each country.

Table C.1. Summary of Quality of Responses in Case Countries

Theory of action areas	Djibouti	Honduras	India	Moz.	Philipp.	Senegal	Tajik.	Uganda
Support to needs of countries								
Alignment with national COVID-19 plans	Dark Green	Dark Green	Dark Green	Light Green	Dark Green	Dark Green	Dark Green	Dark Green
Tailoring to needs and priorities of countries and building on capacities	Light Green	Light Green	Light Green	Dark Green	Light Green	Light Green	Light Green	Light Green
Use of knowledge work to guide needs	Light Green	Light Green	Light Green	Light Green	Light Green	Dark Green	Light Green	Light Green
Address gender inequality	Dark Green	Light Green	Light Green	Light Green	Light Green	Dark Green	Light Green	Light Green
Integration of institutional strengthening support	Light Green	Light Green	Light Green	Light Green	Light Green	Dark Green	Light Green	Light Green
Address digitalization	Light Green	Light Green	Dark Green	Dark Green	Dark Green	Dark Green	Dark Green	Light Green
Support to implementation and learning								
Dialogue with government on implementation	Dark Green	Dark Green	Dark Green	Dark Green	Dark Green	Dark Green	Dark Green	Dark Green
Knowledge sharing and promotion of innovation	Dark Green	Light Green	Light Green	Light Green	Dark Green	Dark Green	Dark Green	Light Green
Involvement of nongovernment in implementation	Light Green	Light Green	Light Green	Light Green	Dark Green	Dark Green	Dark Green	Light Green
Coordination of response	Light Green	Light Green	Light Green	Light Green	Light Green	Dark Green	Light Green	Light Green
Implementation status of interventions, and reach to beneficiaries	Dark Green	Dark Green	Light Green	Light Green	Dark Green	Light Green	Dark Green	Light Green

(continued)

Theory of action areas	Djibouti	Honduras	India	Moz.	Philipp.	Senegal	Tajik.	Uganda
Iterative adjustment of implementation	High support in the area	Medium support in the area	High support in the area	Medium support in the area	Medium support in the area	Medium support in the area	Medium support in the area	High support in the area
Operational processes and partnerships								
Internal collaboration and coordination across GPs	Medium support in the area	High support in the area	Medium support in the area	High support in the area	High support in the area	High support in the area	High support in the area	High support in the area
Partnerships to support response	High support in the area	Medium support in the area	High support in the area	Medium support in the area	High support in the area	High support in the area	High support in the area	High support in the area
Mix of instruments and streamlined processes	High support in the area	High support in the area	High support in the area	High support in the area	Medium support in the area	High support in the area	High support in the area	High support in the area
Monitoring of the response	Low support or no support identified in the area	Medium support in the area	Medium support in the area	Low support or no support identified in the area	High support in the area	High support in the area	Medium support in the area	Low support or no support identified in the area

High support in the area	Medium support in the area	Low support or no support identified in the area
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Source: Independent Evaluation Group case study analysis.

Note: The areas of support reviewed are based on the theory of action. The estimated level of support in each area is based on data collection synthesized from the case study protocol completed for each country through document review, interviews, and consultations with country teams. Validation meetings helped ensure consistency in synthesizing findings across countries.

Quality of Response: Support to Needs of Countries (Relevance)

Alignment with COVID-19 Plans

The World Bank supported response plans in different sectors based on country circumstance. In all countries the World Bank aligned with country COVID-19 plans to address health emergency needs and provide social protection to vulnerable groups. Support to address other response areas varied. Five countries also supported remote learning and reopening of schools (Djibouti, Honduras, India, Senegal, and Uganda). Djibouti, Senegal, and Uganda focused on refugee or displaced communities. Senegal had a multisector response, including to urban water and sanitation and digital strategies. In India, support aligned with national- and state-level response plans. In Mozambique, support emphasized urban water and sanitation and essential services. In the Philippines, support emphasized community engagement and social cohesion. In Uganda, support emphasized sector plans, including in water, electricity, social affairs, and agriculture.

Tailoring Early COVID-19 Support to Country Needs and Priorities

Support was limited for essential health services, risk communication, social services, and citizen engagement, and for strategies for restructuring systems for recovery. In Djibouti, support to essential health services has been limited, and project support to nutrition was diverted by the COVID-19 response. In Honduras, needs related to mental health, gender-based violence, maternal and child health services, and citizen engagement were not prominent in early support. In India, support addressed most needs in health and education, but there was limited support to strengthen systems other than in social protection. In the Philippines, health support was newly developed during COVID-19. Mozambique stands out for its focus on essential health services and preventing a secondary health crisis through diverting resources to address the urgent needs arising from COVID-19 restricting access to health services. Senegal stands out for its support in developing preparedness capacities that were applied in the response. In Tajikistan, longer-term

preparedness capacity is a challenge, and early support to essential health services and risk communication is limited. In Uganda, longer-term support is needed to strengthen systems, expand digitalization, reinforce citizen engagement, integrate public-private sector service, and enhance preparedness strategies, and to address the impact of COVID-19 on girls.

Use of Knowledge Work to Guide Needs

ASA products have been important to monitor the situation, inform needs, and collaborate with partners. Having quality ASA in place before COVID-19 helped countries support dialogue on reforms. During COVID-19, ASA supported just-in-time analyses and information to guide the response (box C.1). Access to trust fund financing and technical support were important to finance just-in-time ASA and facilitate implementation.

Box C.1. Use of ASA in Case Study Countries

- » Country assessments and monitoring informed the response. This included support to mobile surveys on the socioeconomic and gender impacts of COVID-19, poverty assessments, food security assessments, studies on refugees, assessments of health workers, and beneficiary monitoring.
- » Analyses of health systems informed thinking on how to strengthen preparedness, health information, vaccine rollout, and essential health services. In India, Honduras, and Senegal, prior analyses on disease preparedness and surveillance guided actions. In Uganda, support of the Global Financing Facility ensured resources and technical expertise to assess needs to improve health information systems and maternal and child health services.
- » Analyses of education, social protection, and crisis systems are informing immediate actions and longer-term thinking. In India, the social protection response built on knowledge work undertaken over 10 years. In the Philippines, the work previously done on community crisis instruments has been critical.

(continued)

Box C.1. Use of ASA in Case Study Countries (Cont.)

- » Just-in-time ASA helped solve implementation bottlenecks in collaboration with partners. In India, just-in-time ASA was conducted with the transport sector on the logistics of oxygen. In Mozambique, ASA sought to understand the impact of the pandemic on the private sector. In Uganda, ASA on water utilities and risk communication informed collaborative responses.

Source: Independent Evaluation Group case study analysis.

Note: ASA = advisory services and analytics

Building on Foundational Capacities

The focus on human capital before COVID-19 meant that many countries had a relevant portfolio of World Bank support to address the crisis' urgent needs. Having prior projects focusing on human capital meant in some countries, almost every project and ASA adjusted its implementation to address COVID-19, with minimum restructuring; in other countries, previous efforts on human capital helped support a focus on new projects. In Honduras, Mozambique, and Senegal, these efforts were coordinated across GPs to synergize areas of support, building on foundational capacities where there was dialogue before COVID-19.

Addressing Stages, Institutional Strengthening, and Gender Equality

The addressing of gender and inclusion has been fragmented. Health and education support was often national, with limited targeting of vulnerable groups. In all countries social protection support targeted gender and vulnerable groups, though the extent varied in each country. Djibouti tailored its support to slums and used gender assessments. In Mozambique, cash transfers were gender-sensitive, prioritizing school retention and enrollment for women and vulnerable girls. Both Mozambique's Senegal's health response emphasized women and children. Projects in Uganda include plans to address gender-based violence, and to rebuild maternal health services and engage girls.

In all countries, early COVID-19 support started a process to build more resilient systems, which demands continuation (box C.2). Sustainability will require additional support to restructure policies and systems.

Box C.2. Support to Build Resilience in COVID-19 Response

- » In health, resilience was supported through critical health services for disease prevention and control. This support included improving surveillance, laboratories, infection prevention and control (IPC), facilities, and human resource capacities. In some contexts, this support helped develop supply chains. Countries such as Djibouti have new capacities, given their limited preparedness before COVID-19. In India, the health response strengthened the network of public and private laboratories and testing systems. In Senegal, preparedness capacities established before COVID-19 are being further strengthened.
- » In education, resilience was supported by developing remote learning capacities. Infrastructure and the curriculum have been improved to engage students and parents, and teachers' capacities have been developed to support learning continuity. A few countries developed strategies to use new digital capacities to restructure systems.
- » In social protection, resilience was supported by strengthening systems. In India, prior actions helped consolidate state-level social protection systems and support migrant laborers. In the Philippines, support to expand the social protection system improved the capacity to respond to crises. In Tajikistan, early investments enabled the national rollout of the first comprehensive national social protection plan.

Source: Independent Evaluation Group case study analysis.

Note: IPC = infection prevention and control.

Addressing Digitalization

The digitalization of services was well integrated in the social response and less so in the health response. In education, countries supported television, radio, and online pedagogy resources for student learning. In Honduras,

support included a package prepared for children and parents to follow up on television and radio classes. India's support included a digital platform for teacher training. In Uganda, education support included SMS messaging to parents. In India, the Digital Infrastructure for Knowledge Sharing or DIKSHA platform engaged communities and teachers in creating and sharing relevant content for distance and remote learning. In health, there was support to health information systems, contact-tracing applications, and digital surveillance. Mozambique, the Philippines, and Tajikistan supported digital tracking systems for vaccine rollout. In Tajikistan, health sector support included information hotlines, SMS texts to citizens in remote areas, online third-party monitoring, and electronic supply chain management. In social protection, countries supported expanding digital beneficiary databases and payment systems. India and the Philippines strengthened their national identification systems, with links to digitalized payments for social benefits, social registry data on vulnerable groups, and data on migrant laborers. Djibouti supported an online platform for tracking food vouchers. Several countries used geo-enabling technology to gather monitoring data through smartphones. In Senegal, development policy financing (DPF) helped advance a strategic agenda for digital infrastructure.

Support to Implementation and Learning in Countries

Dialogue with Government on Implementation

Frequent policy dialogue supported robust responses, especially where it built on long-standing relationships in sectors. In Honduras, India, the Philippines, and Tajikistan, the social protection response built on years of policy analysis (as many as 10 years); while in Uganda, the social protection dialogue is newly evolving. In Honduras, India, and the Philippines, COVID-19 initiated new policy dialogue in the health sector. In other countries, the health sector dialogue was well-established, though experience delivering critical health services was limited. In Mozambique, the dialogue focused on ministries responsible for health, education, urban, and social protection to move forward quickly. In Uganda, dialogue similarly focused on specific ministries. In Senegal, the response built on a long-standing policy dialogue across government. COVID-19 intensified the importance of this di-

alogue for health and education. Fragmented communication and coordination across sectors were challenges in countries and at subnational levels. In Tajikistan, the health project financed an adviser to support the COVID-19 response, which was a successful strategy to facilitate communication and coordination.

Knowledge Sharing and Promotion of Innovation

In each country, innovations addressed implementation challenges. For example, in Djibouti, networks of parent groups addressed challenges of reaching communities; in India, the engagement of women's organizations addressed gaps in the availability of personal protective equipment; in Senegal, the One Health coordination mechanism helped with multisectoral engagement; and in Tajikistan, engagement with nongovernment actors to monitor the COVID-19 response helps to improve accountability. Knowledge sharing was limited in the case study countries. Djibouti stands out for using knowledge sharing to develop its response between education and social protection. Senegal had knowledge sharing through its regional project support.

Coordination of Response

High-level leadership was important to support a rapid early response. Half of the countries featured strong leadership at the prime minister or president level. In Senegal, One Health multisectoral coordinating bodies established before COVID-19 enabled rapid action with presidential participation. In Djibouti, high-level leadership ensured a swift coordinated response plan across sectors. In India, it enabled a quick response to the first COVID-19 wave, with a mix of interventions across sectors. In Honduras, despite central leadership, coordination and communication across sectors limited the response. Although Mozambique had a proactive early response, it has been difficult to maintain focus on COVID-19 given urgent simultaneous crises. The Philippines government responded quickly with an interagency task force, though the initial anchoring of the crisis as a health emergency slowed the response. The Tajikistan government was initially slow to respond, though the response accelerated with changes in ministerial leadership. In Uganda, implementation was overseen by a national task force headed by the

prime minister and sector-level committees, reaching to subnational levels. However, changes in government limited leadership on COVID-19.

Few countries had established structures to engage civil society and communities. Social protection had the widest engagement of nongovernment actors, since programs were organized to involve social agents, the informal sector, farmers, and local civil society in communities and slum areas. Education had collaboration with groups, such as parent-teacher associations. The Philippines supported community-based emergency instruments. In Tajikistan, the Global Partnership for Social Accountability supported third-party monitoring of the COVID-19 response by a civil society consortium. In Senegal and Uganda, structures established for nutrition helped with nongovernmental and community engagement. In health across countries, some support for community health workers was evident. India and Uganda had some support to private sector health services. Several countries plan to engage civil society in vaccine monitoring.

Implementation Status of Interventions and Reach of Beneficiaries

Countries frequently cited early results of World Bank support (table C.2). These results included procurement of medical supplies and equipment and the delivery of social protection benefits. Countries reported success in updating social protection systems, including expanding digitalization. A range of countries reported successes in implementing distance education tools, knowledge and skill building, and risk communication (though the extent of risk communication was often limited). Some countries also reported successes in improving health infrastructure and digitalized information systems to deliver services and coordinate the response.

Table C.2. Examples of Early Results Reported in the Case Studies

Country	Example results reported
Djibouti	Strengthened national plan; medical supplies and equipment; case management tracking, training of health workers, and guidelines; food vouchers and cash transfers; isolation facilities; digital platforms in education and network of parent associations
Honduras	Medical supplies and equipment; equipped laboratories for testing; skill building of health workers in IPC; food support for vulnerable households; virtual platform for preschool learning; early procurement of vaccines; and new partnership with health sector to support health preparedness and services
India	Medical supplies and equipment; expanded testing capacity; mobilization of community health workers for risk communication; emergency cash transfer and food support; and digitalization of learning for children
Mozambique	Medical supplies and equipment; cash transfers and system improvements; and continued support of essential health services during the crisis
Philippines	Medical supplies and equipment; digitalization of social protection payments; new implementation of community projects to support COVID-19; early procurement of vaccines; and new partnership with health sector for preparedness response
Senegal	Medical supplies and equipment; improved laboratory testing capacity; isolation facilities; cash transfers to all households in social registry; strengthened One Health approach for multisector coordination; nutrition messaging to communities; expanded country digitalization strategy; and digital infrastructure in education
Tajikistan	Medical supplies and equipment; risk communication; expansion of cash assistance payments; digital systems to track coordination of support, supply chain, and vaccines in health sector; and early support to vaccines
Uganda	Medical supplies and equipment; financing of services in health facilities; expanded laboratory capacity; water service improvements; behavior change communication; national social protection registry; expanded farm voucher; digital platforms in education and networks of parents and teachers; and nutrition messaging

Source: Independent Evaluation Group.

Note: IPC = infection prevention and control.

Country surveys show that some countries have made progress in reaching beneficiaries in areas where the World Bank works, but challenges remain. The main achievements were noted in implementing preventive measures, risk communication, and social protection. For example, in Djibouti and the Philippines, high levels of vaccine acceptance were reported. Djibouti, India,

the Philippines, Senegal, and Tajikistan identified early achievements in the coverage of social protection. Challenges still need to be addressed in all countries, the most widespread are access to essential care services, the livelihoods of informal workers, and negative social cohesion. In Djibouti, Mozambique, Tajikistan, and Uganda, surveys reported ongoing access to care issues were felt more severely by vulnerable population groups. In Senegal, disparities in awareness were reported, with women, noncity dwellers, less educated, younger, and poorer populations less informed. Negative impacts on the livelihoods of informal workers were reported in Djibouti, India, Mozambique, the Philippines, and Uganda. In Djibouti, India, and Mozambique, respondents highlighted negative mental health issues. In India and Mozambique, female respondents especially marked mental health issues. In Honduras, Mozambique, and the Philippines a significant number of children were unable to access virtual schooling or learning due to issue related to the internet, equipment, and teachers. In Senegal, Mozambique, and Uganda, distrust of government is an issue (Afrobarometer 2021a, 2021b, 2021c, and 2021d; Bau et al. 2021; Bautista, Balibrea, and Bleza 2020; Bhattacharya and Roy 2021; Grover et al. 2020; IPSOS 2020; Sumalatha 2021; Tuppal et al. 2021; WHO 2021; World Bank 2020; World Bank 2021a, 2021b, and 2021c; UNWomen 2021).

Iterative Adjustment of Implementation

Across countries, frequent meetings facilitated the review of progress, problem-solving and implementation adjustments. Frequent meetings with project and global teams pinpointed issues and identified ways to address them. In Djibouti, the package of services delivered by social agents was adapted to include COVID-19 messages. In Honduras, weekly exchanges were used to adjust project implementation plans and procurement plans. In other countries, frequent coordination meetings among project teams and virtual supervision support helped adjust implementation to address emerging needs. Uganda added COVID-19 training support for the private sector and assessed risk communication on challenges identified in the COVID-19 communication strategy.

Quality of Response: Operational Processes and Partnerships

Internal Coordination to Support Implementation

GPs collaborated on instruments. In Tajikistan, the COVID-19 Emergency Project led by the Health, Nutrition, and Population (HNP) GP, collaborated with the Social Protection and Jobs GP, and with the Social Sustainability and Inclusion (SSI) and Governance GPs for third-party monitoring of the response. In India and Mozambique, Contingency Emergency Response Components (CERC) were used to redirect resources across sectors. In the Philippines, HNP and Digital Development collaborated to digitalize systems and with SSI to support stakeholder consultations. Also, in the Philippines, the Beneficiary FIRST (Fast, Innovative, and Responsive Service Transformation) Social Protection Project led by Social Protection and Jobs collaborated with Education; Finance, Competitiveness, and Innovation; HNP; and SSI to expand digital cash grants for vulnerable families with children. In Uganda, SSI supported review of the portfolio to integrate gender and inclusion. DPFs engaged multiple GPs in policy actions, such as for child policy, health materials, informal sector engagement, and social protection. GPs collaborated on the catastrophe deferred drawdown options (CAT DDO) in Honduras. Collaboration with the Water GP has been crucial to support sanitation in slums, schools, health facilities, and public areas. Where there was no defined instrument for collaboration, GP coordination of support in countries was limited.

Partnerships to Support Response

Well-functioning partnerships active before the pandemic adapted and made important contributions to the response. Responses in all case countries used different competencies of partners through preexisting coordination mechanisms. In Djibouti, partner collaboration enabled project teams to address needs, such as psychosocial care with UNICEF and food vouchers with World Food Programme. The World Bank in Honduras collaborated with the Inter-American Development Bank in the social response, including joint missions. In Tajikistan and Honduras, procurement was undertaken with the United Nations Office for Project Services (UNOPS). In Tajikistan, frag-

mented coordination was supported by developing a web-based platform to track donor support and help improve partnership. In Uganda, a trust funded staff member in the World Bank office supports donor coordination, and ASA helped align the World Bank and partners on common strategies, such as for risk communication and water service improvements. Having the support of EdTech, the Global Financing Facility (GFF), WHO, and Gavi, the Vaccine Alliance, in a country portfolio often supported quick actions to expand support for COVID-19.

Mix of Instruments and Streamline Processes

Countries combined instruments to support a more agile response. These include crisis instruments (CERC and CAT DDO), repurposed projects, DPFs, regional projects, Program-for-Results (PforR) financing, new projects, and to some extent, additional financing, though the main use of that instrument has been to replenish project support disbursed for the crisis (box C.3).

Box C.3. Use of Instruments in Case Study Countries

- » Crisis instruments supported immediate response. In Honduras and Mozambique, emergency instruments helped leverage resources for multiple emergencies. In Mozambique, for example, the CERC of an urban sanitation project supported surveillance and infection prevention and control (IPC), and an emergency cyclone response project was repurposed for case management, IPC, risk communication, and social protection. The Philippines activated the community-based Disaster Response Operations Modality supported by a World Bank project. Across countries, challenges in using emergency support included the limited coverage of crisis instruments in the country portfolio, and the requirement for government to announce the emergency before implementation.
- » Adjusting projects to address COVID-19 needs supported a cross-sector response and helped set a course for reforms to restructure systems. The urgency of the COVID-19 response helped adjust projects to accelerate actions on key reforms, such as to expand social protection, strengthen local service delivery, and improve water and sanitation conditions in schools and slums. In India, seven education projects were repurposed to respond to COVID-19. *(continued)*

Box C.3. Use of Instruments in Case Study Countries (Cont.)

In Senegal, several projects were synergized to support social protection and food security. In Uganda, water, agriculture, and governance support was adjusted, with AF to expand support to farmers and assure the continuation of local services.

- » The MPA led by HNP helped orient health project support and procured supplies for response plans. The MPA framework provided flexible guidance to organize support in health. MPA financing supported supplies and critical health services rather than policy guidance or other aspects outlined. In most countries, the first round of MPA financing was processed quickly, with AF later for vaccination. In Uganda, the timeline of the MPA was delayed, raising questions about the efficiency of processing new project support in a crisis.
- » Regional projects supported early action to coordinate the response. In Senegal, support of the Regional Disease Surveillance Systems Enhancement (REDISSE) project and WHO has been critical for immediate actions to coordinate the response, which were later synergistic with the MPA. Having this preexisting support meant structures and capacities were in place to respond more quickly.
- » DPFs and PforR supported urgent fiscal needs. DPFs were important in India, Mozambique, Senegal, and Uganda for COVID-19 response plans, continuation of local services, informal workers, agricultural inputs, health supplies, and social protection. During the election period in Uganda, the DPF was passed by parliament in about three months. In India, PforR were used to agree on disbursement-linked indicators to orient the education and health response at the state level.
- » PEF provided small grant support to address urgent needs. The PEF was used to finance medical supplies and equipment, as many countries were concerned about borrowing more resources. In Senegal, PEF funds channeled through UNICEF and WHO provided timely support to subnational COVID-19 plans. In Uganda, the PEF provided immediate resources to the national COVID-19 plan, despite delays of parliamentary approval of the MPA. *(continued)*

Box C.3. Use of Instruments in Case Study Countries (Cont.)

- » Trust funds assured timely support. Trust fund support helped education projects in Djibouti, Honduras, India, Mozambique, Senegal, and Uganda, for remote learning and school reopening.

Source: Independent Evaluation Group case study analysis.

Note: AF = Additional Financing; CERC = Contingency Emergency Response Components; DPF = development policy financing; IPC = infection prevention and control; MPA = Multiphase Programmatic Approach; PEF = Pandemic Emergency Financing Facility; PforR = Program-for-Results Financing.

Countries had delays in early support to vaccination. Djibouti, Honduras, the Philippines, and Tajikistan coordinated with partners to prepare for early vaccine deployment, and all countries have plans to support vaccines. World Bank policy limited the ability of project teams to respond quickly to vaccine plans. For example, project teams could not procure nonapproved vaccines, which limited collaboration in task forces to support vaccine deployment. Also, the interest of government in lending rather than grant support for vaccines varied across countries.

Emergency procedures accelerated procurement and financing of activities. This included using direct contracting, e-bidding, shorter bidding periods, retroactive processes, United Nations partner procurement, and World Bank–facilitated procurement (BFP)—though guidelines were not always clear. Countries procured a large quantity of medical supplies early in the crisis, and orders took several months due to global shortages. Most governments used their own national procurement procedures. In Djibouti, the government adopted accelerated emergency guidelines for medical procurement, though this was not done in all sectors. In India and the Philippines, national procedures were assisted by close tracking by the chief procurement officer. In Mozambique and Senegal, projects collaborated to spread procurement across projects. However, in Senegal, despite dedicated efforts led by the president, cost fluctuations and limited global availability of items made procurement challenging. In Honduras, India, and Mozambique, BFP was used to procure items not easily available. However, BFP often required multiple contracts and complicated logistics. In Honduras, BFP support re-

quired coordination with the World Food Programme to purchase and deliver personal protective equipment from China, and the United Nations Office for Project Services provided logistical support. In India, the HNP and Transport GPs partnered on transportation logistics for oxygen. Another challenge in countries was the slow delivery of centrally procured items to subnational areas and audits on receipt.

Safeguards were challenging given the need to apply new guidelines amid a crisis. In most countries, the learning curve for a new project to apply the new Environmental and Social Framework was high, despite templates and extensive handholding from safeguard teams. It was a labor-intensive process for staff and government who were already overwhelmed. Moreover, structures were not well organized for required stakeholder consultations. The engagement of government experts to support the safeguards' implementation in new projects was challenging, with ministries also overwhelmed by COVID-19 and in some cases delayed project support and procurement of goods.

Monitoring of the Response

Limited communication with subnational levels and monitoring capacity of countries constrained decisions. World Bank systems require formal reporting every six months, limiting the usefulness of those reports in an emergency context. Other challenges include the limited capacity of governments to measure results and the availability of real-time data on COVID-19 cases. To address these, World Bank teams coordinated closely with partners to monitor health aspects of the response and met with the government weekly to discuss bottlenecks and review progress. Meetings were often with national counterparts since lack of mission travel limited communication with subnational actors. Some countries financed data to monitor the response. For example, Djibouti supported iterative beneficiary monitoring of education and social protection projects. In Tajikistan and Uganda, geo-enabled monitoring and supervision tools facilitated remote monitoring and project supervision of nutrition support.

Table C.3. Synthesis of COVID-19 Responses in Case Study Countries

Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Djibouti		
<p>Alignment with plans In April 2020, Djibouti launched its National Solidarity Pact framing the COVID-19 response. The government also put in place a preparedness response plan. The World Bank's support aligns with national plans and sector-specific plans, including for distance learning and refugee communities.</p> <p>Tailoring to needs and priorities Immediate support expanded quarantine and testing centers. Health capacity is low, and there was limited experience in providing critical services. Support to essential health services has been limited, and project support to nutrition was diverted by the COVID-19 response. UNICEF and WHO led vaccination response with World Bank support.</p> <p>Use of knowledge work ASA products have been adapted to help assess and monitor the COVID-19 situation and share examples of experiences from other countries. This includes surveys monitoring the socioeconomic impact, knowledge exchanges, a poverty assessment, and an analysis of health system strengthening for universal health coverage.</p>	<p>Leadership and coordination A high-level committee led by the prime minister provided guidance and led the vaccination committee, and sectors have separate COVID-19 plans. However, early in the pandemic communication was unclear, and ministries had limited experience to respond. In health, a multisectoral committee met daily to weekly, as did technical committees of health structures.</p> <p>Building on evidence and past lessons In Djibouti, support followed WHO guidance and aligned with available evidence. Greater capacity for consistent communication and coordination may have strengthened the early response, and a stronger focus on gender across sectors and the continuity of essential health services. Institutional strengthening of preparedness, particularly health systems will be important going forward.</p> <p>Policy dialogue The World Bank and government had strong dialogue on the response. Early in the crisis, dialogue focused on potential strategies for mitigation, and sharing of experiences of other countries. Then, dialogue shifted to tracking actions and assessing COVID-19 impacts.</p>	<p>Country program coordination The World Bank linked authorities to technical experts and shared global experiences. Early in the crisis, the focus was on critical sectors to cushion the economic downturn and protect vulnerable populations. The focus of the World Bank strategy on human capital before COVID-19 meant there was a relevant portfolio in health, social protection, education, urban, poverty, finance, and social development that could be adapted.</p> <p>Partnerships Though needing clarification in the initial response donor coordination with the government has been present from early in the crisis drawing on long-standing relations between UN agencies and the World Bank. For example, joint support was provided to develop and cost the national plan and good collaboration with United Nations partners, including organized support for vaccination led by UNICEF and WHO. In education, the Global Partnership for Education supported a coordination committee, and there is collaboration with UNICEF on a domestic resource mobilization strategy and to assess learning needs. World Food Programme (WFP) and the World Bank collaborated on food vouchers.</p>

(continued)

Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Djibouti		
<p>Addressing resilience, inclusion, sustainability, and gender Resilience was supported by expanding health facilities for patient care, aggressive efforts to identify cases, and support to remote learning and psychosocial care of children and teachers. World Bank support focused on refugees, displaced persons, and vulnerable populations in slum areas. In social protection, the social registry reached female-headed households. Education support helped public schools, with a focus on girls and children with special needs. Surveys on COVID-19 collected gender-relevant data.</p> <p>Addressing digitalization All sectors moved training and communication online. World Bank activities supported: (i) mobile phone survey methods; (ii) an online platform for tracking food vouchers; and (iii) television, radio, and online student learning, tablets, internet access, and online pedagogy resources. Health has less support for digitalization.</p>	<p>Iterative adjustments Most projects and ASA in the portfolio were adapted to address COVID-19. World Bank teams met weekly with the government to review progress, adapt implementation, and solve problems. For example, in social protection, the package of services was adapted to include COVID-19 messages and distribute hygiene kits. The urban project was also adapted to address COVID-19 in slum areas.</p> <p>Involvement of nongovernment The education sector developed a partnership agreement working with local authorities and nongovernmental groups, such as parent-teacher associations and local civil society groups. Social protection engaged with social agents and community actors. Response plans in health included some support to community health workers.</p>	<p>Mix of instruments The portfolio included repurposed projects, CERC, MPA, PEF, and AF. CERC provided timely financing to address the just-in-time needs of government without restructuring and heavy negotiations. The MPA framework provided flexible guidance. MPA supported financing of critical health services—other areas of the MPA framework were not possible. The PEF also supported urgent medical supplies and equipment.</p> <p>Monitoring The projects used indicators aligned with the WHO global monitoring framework for COVID-19. An ASA led by the Poverty GP is supporting iterative beneficiary monitoring of education and social protection projects to see if support is reaching beneficiaries. A challenge is the capacity of the government to measure results.</p>

(continued)

Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Djibouti		
		<p>Procurement Procurement guidelines and direct agreements accelerated processes. Retroactive procurement moved activities forward when funds were not immediately available but could later be reimbursed. Accelerated emergency guidelines for procurement by the government's medical and materials center enabled the purchase of key items, such as medical and laboratory equipment and supplies. The World Bank's response included procuring school kits, tablets, and materials for distance learning.</p> <p>Safeguards For new projects, the learning curve for applying the new Environmental and Social Framework was high.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
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Honduras

Alignment with plans
 In Honduras, the World Bank response fully aligned with the government’s plans, including strengthening surveillance; laboratory support; case management and treatment; IPC; vaccine procurement and deployment; emergency cash transfers; and remote learning.
Tailoring to needs and priorities
 World Bank support was well tailored to the needs and priorities articulated by the government. However, mental health, GBV, maternal and child health services, and citizen engagement support were not prominent in early support.
Use of knowledge work
 ASA products before and during COVID-19 have been critical to inform the response and provide longer-term direction for restructuring systems. They include ASAs on emergency preparedness; adaptive safety nets; education service delivery; early childhood development; and public expenditure reviews covering health, education, and social protection. Though the response missed opportunities to establish just-in-time ASA.

Leadership and coordination
 The government up to the level of the president adopted a national response plan for COVID-19 in February 2020. The response was facilitated by prior ASA and project support to improve preparedness. The national plan defines the responsibilities, procedures, and multisectoral and subnational coordination mechanisms for the response. Nevertheless, coordination and communication have been challenging.
Building on evidence and past lessons
 The COVID-19 support built on crisis response experience especially in social sectors. The response focused on interventions proven to work and were anchored in policy dialogue, with ASA playing a key role in informing projects. Strengthening support to communication and coordination, essential services, and citizen and community engagement could benefit future crises.

Country program coordination
 The World Bank repurposed its existing country portfolio and prepared new operations to swiftly support the government response. These adjustments facilitated a rapid, holistic, people-centered response involving all GPs. National actors appreciated the technical soundness and speed of the support. To adjust the support, meetings were held frequently with the operations manager, program leaders, task teams, and government implementers.
Mix of instruments
 The adjusted country portfolio drew on CERCs, which were repurposed to tackle the impact of hurricanes in addition to COVID-19. Health developed an emergency MPA, which was quickly approved in April 2020. The project was complemented by AF to purchase and deploy vaccines. A CAT DDO was also approved in April 2020, facilitating multisectoral coordination across GPs. PEF funds, channeled through PAHO, supported just-in-time infrastructure improvement, medical and lab equipment and supplies, and telehealth support

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Honduras		
<p>Addressing resilience, inclusion, sustainability, and gender</p> <p>Although investments aimed to secure equipment, supplies, and vaccines, Honduras focused on improving surveillance, laboratories, and social protection systems to increase resilience. The response is bringing new ways to deliver education, health services, and social assistance, improving sustainability and inclusion. The nutrition program engaged rural communities in inclusive and efficient ways, and cash transfers support women. However, the addressing of gender and inclusion in health has been limited.</p> <p>Addressing digitalization</p> <p>Digitalization has been supported particularly in the social sector, where the World Bank helped Honduras establish a more transparent and effective payment mechanism. Health and education digitalization represented only a small part of the support aimed to improve digital infrastructure.</p>	<p>Policy dialogue</p> <p>This social response was built on a long-standing policy dialogue with the government, which deepened through daily exchanges. ASA informed this dialogue and the World Bank's CAT DDO was critical to policy reform. In health services, COVID-19 helped renew policy dialogue for the first time in years. The support established a trust with government counterparts. Policy dialogue evolved from emergency measures to a dialogue aimed at assuring better health systems. In education, the dialogue supported quick project adjustments.</p> <p>Partnerships</p> <p>Coordination and collaboration in between the World Bank and Inter-American Development Bank in the social sector has been good, with regular meetings and joint missions and feedback. However, in health, collaboration was more limited. Support to government was through separate lines although there is a platform for high-level cooperation in health that includes the Pan American Health Organization (PAHO), UN-AIDS, UNICEF, Food and Agriculture Organization (FAO), WFP, United States Agency for International Development (USAID), European Union and the Inter-American Development Bank.</p>	<p>Monitoring</p> <p>The government prepared plans, progress reports, and evaluations. World Bank staff in health and other sector teams met weekly with the government to address bottlenecks. Monitoring was often done informally, given the limited capacity to monitor the response in real time.</p> <p>Procurement</p> <p>Meetings helped proactively track procurement support of projects and World Bank-facilitated procurement (BFP), which was used to procure PPE and medical equipment. The World Bank contracted UNOPS and WFP to provide logistical support in the transportation, storage, and distribution of PPE. BFP processes and logistics became more complex than expected.</p> <p>Safeguards</p> <p>The emergency MPA project followed the new safeguards framework, which was labor-intensive for the staff, particularly since November 2020 when they had to manage the impact of hurricanes and COVID-19.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
India		
<p>Alignment with plans All areas of the health and social response align with national plans and policies. Support was also provided at the state level through ongoing peer learning. The health response funded the national COVID-19 containment plan by supporting testing, tracing, tracking, and establishment of intensive care units and isolation centers. The World Bank's support was flexible enough to adapt and was highly appreciated by the Ministry of Health and Family Welfare (MOHFW). The DPFs aligned with government plans to provide social support. The World Bank also supported micro, small, and medium enterprise liquidity to help maintain workforce human capital.</p> <p>Tailoring to needs and priorities The World Bank's health response met emergency needs and supported evolving priorities, building on previous good client relations. The MOHFW reported being satisfied with the emergency loan and flexibilities introduced. Crisis response and restructuring needs were met through the social protection support. The health support focused on the crisis but also contributed to restructuring. The main challenges in the health response related to risk communication, gender targeting, essential health services, and community health workers. In state projects, services for treatment for other diseases, such as cancer, declined as services focused on COVID-19. A clear strategy to address learning losses from the school closures has yet to emerge.</p>	<p>Leadership and coordination The Indian government responded quickly to blunt the first COVID-19 wave, undertaking interventions in the social protection, education, and health sectors. Under the leadership of the prime minister, the country undertook the world's largest national lockdown and announced a relief package of about 10 percent of gross domestic product. The country put in place a national response plan focused on cluster containment, testing, tracking, tracing, and social distancing. A group of ministers under the minister of health served as the apex body for policy decisions, providing direction to the states. Several coordination committees were formed at the state and national level. Health messaging was a challenge, as contradictory messaging emanated from different national agencies, while several religious festivals and political campaigns hindered needed social distancing.</p> <p>Building on evidence and past lessons Social protection used accumulated knowledge over a 10-year period to define the response. The health sector drew on their experience of implementing tuberculosis and HIV testing and tracking systems and an analysis of health system challenges in India. Education drew on lessons and experience generated by extensive prior engagement in education and shared GP-level knowledge where required to provide technical assistance.</p>	<p>Country program coordination The country response was coordinated through the targeted design of three projects in health, social protection, and micro, small, and medium enterprises. Two CERC activations by Urban, Disaster Risk, Resilience, and Land (GPURL) projects provided emergency health support. State-level health responses benefited from the national COVID-19 program. A shared ASA between health and transport focused on logistics for oxygen. The education response undertook adaptations with limited input from other GPs. The support provided for staff members was praised across GPs as quick and supportive of staff requirements working across the entire World Bank Group. Country and headquarters GPs had good coordination, but the inability to travel restricted coordination with communities.</p> <p>Mix of instruments The country deployed a range of instruments for crisis support and restructuring needs. To avoid hitting the single borrower limit and free funds, the World Bank team canceled and restructured commitments. Seven education projects were repurposed to respond to COVID-19. Education introduced new PforR. The health response was driven through the MPA and incorporated two new investment project financing (IPF), with state-level projects adapted to respond. The social protection response was implemented through a DPF. CERCs were activated in GPURL.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
India		
<p>Use of knowledge work</p> <p>ASA and knowledge work were important in the response. The SPJ response was built on knowledge work undertaken over 10 years. Since implementation of prior actions, they have used monitoring information from the Centre for Monitoring the Indian Economy to track and communicate changes in social protection coverage. HNP undertook knowledge work during the pandemic at state and national levels. Some prior HNP work at the state level supported the health response, and surveillance and testing of tuberculosis and HIV informed the response. The education response did not target individual ASA, using GP-level knowledge and existing dialogue to provide inputs on lessons. No ASA were identified on risk communication or assuring health services. The Transport GP undertook an ASA related to the logistics of oxygen to help resolve bottlenecks.</p>	<p>Policy dialogue</p> <p>The influence of policy dialogue during the pandemic was found to be responsive where there were strong prior relationships with the government. The country office has a close working relationship with the Department of Economic Affairs within the Ministry of Finance and good relationships in social protection. In the health sector, previous dialogue had focused on the state level and was limited to work on tuberculosis and HIV/AIDS at the national level. The Department of Economic Affairs helped open the space for dialogue and lending by helping to coordinate with the MOHFW. Consequently, as engagement restarted, technical support was provided to respond to COVID-19. In states where there was a good prior relationship, the World Bank's advice was taken up faster, for example, in defining cost structure for government health insurance for COVID-19, and in Maharashtra and Kerala, especially on the oxygen supply.</p>	<p>Monitoring</p> <p>Monitoring of the response is continuous and is being used within the World Bank and in engaging with partners. The Poverty GP and SPJ work with Centre for Monitoring the Indian Economy, who undertake frequent surveys to track COVID-19 effects. The World Bank corporate-level monitoring efforts have been less useful for informing adaptations. The project monitoring for the MPA was initially too complicated and restructured about 10 months into the project. Most indicators for the social and health responses show achievement above target.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
India		
<p>Addressing resilience, inclusion, sustainability, and gender</p> <p>India's response contributed to developing the resilience of the health system, with limited support to inclusion, sustainability, and gender. Resilience has been supported by developing a network of public and private laboratories and testing systems, developing intensive care units capacities, and supporting new labs for genomic sequencing. Prior work with women's self-help groups and small and medium enterprises better enabled their mobilization to support large-scale procurements of COVID-19 PPEs and other critical support. Education support helped project beneficiaries better enter the labor market or retrain. Prior actions in the social protection DPF helped consolidate state-level systems and reach migrant laborers. The social protection response did include prior actions directed at environmental sustainability in climate-resilient public works. Gender considerations were not included in the health response. In social protection, women were targeted to receive benefits.</p>	<p>Partnerships</p> <p>The World Bank worked well with development partners. Asian Development Bank (ADB) lent an additional \$500 million to the health response and supported the government's social protection package using prior action, such as the World Bank's. ADB also replicated the STARS education project. Asian Infrastructure Investment Bank provided support to the World Bank's health project. There was ongoing coordination with UNICEF and WHO at the country level.</p> <p>Involvement of nongovernment</p> <p>Innovations resulted from support to the private sector and limited involvement of civil society organizations in the health and social protection response. In implementing the MPA, extensive consultations were not held. The education sector has had ongoing engagement of civil society. For example, in the Nagaland, the client used existing relationships with community structures to deepen understanding and buy-in. The World Bank used public-private partnerships to catalyze innovation in the health sector and the biopharma arena, which supported the development of the first COVID-19 DNA vaccine.</p>	<p>Procurement</p> <p>Tensions arose with procurement processes within the World Bank and with the client. To implement the MPA quickly it was agreed that India could use national procurement mechanisms and the World Bank provided ongoing support to the government through consultants and local procurement specialists. Tensions arose with the client in the MPA over the use of a "Make in India" clause and of eligible expenditures; these were resolved with Country Management Unit guidance. BFP proved useful for oxygen, where quick turnaround periods were required. The client reported that no other multilateral development bank was able to provide this support. It was suggested that a PforR or DPF would have been better options for the emergency response to avoid the procurement tensions.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
India		
<p>Addressing digitalization</p> <p>Increased levels of digitalization were embraced across the health and social responses. The social protection response supported the increased use of digitalized social registries. In education, the response supported the shift to online teaching and an online platform that offers teacher training. Few provisions for the privacy of data and measures to strengthen cybersecurity were identified in any World Bank project reviewed. The government is drafting legislation for data privacy and cybersecurity, but concerns were voiced on whether citizens are informed and protected.</p>	<p>Iterative adjustments</p> <p>All areas of the COVID-19 response made implementation adjustments. The MPA was restructured in April 2021 to increase allocation to the crisis response, while investment project financing projects repurposed uncommitted funds to COVID-19. The education response restructured and reallocated funding to adjust to the digital learning environment. Social protection undertook one DPF program and is starting a second program. Beyond these formal adjustments, the World Bank regularly met with other partners and the client to identify areas to adapt. It was reported that uncertainty about requirements and waivers delayed some implementation. CERC components are now routinely written into projects for future adjustments.</p>	<p>Safeguards</p> <p>TTLs reported that implementing safeguards were cumbersome and suggested that it could be simplified for the MPA. Stakeholder engagement was reported to have targeted messaging on the project, rather than genuine consultation. Civil society engagement was reported to not have occurred in the MPA. The MPA used the government's redress mechanisms, but evidence from existing projects shows that grievance redress mechanisms (GRMs) do not always function well at the state level. The review of GRM for the health project found there was no reporting of cases, suggesting the need for improvements in accountability and GRM.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Mozambique		
<p>Alignment with plans World Bank support fully aligned with government plans in the national strategy response to COVID-19. Support aimed at strengthening the capacity of the health and social response systems. A notable challenge was providing sufficient resources, such as cash transfers and support for small enterprises, to allow the population to comply with social distancing requirements while also maintaining economic activity to sustain society.</p> <p>Tailoring to needs and priorities A significant concern for the country was avoiding a secondary health crisis linked to diverted attention and resources to COVID-19. The country had significant health needs and deepened development concerns about areas such as malaria, HIV/AIDS, malnutrition, and maternal and child health. To mitigate this, the World Bank used its Primary Health Care Strengthening Program, including AF, and the COVID-19 Strategic Preparedness and Response Project to focus on ensuring continuity of essential health services. Nevertheless, there was a sense that support to COVID-19 negatively affected essential services.</p>	<p>Leadership and coordination Although the government took the initiative and responded early, it has been difficult to maintain focus as the country has faced multiple urgent crises. The national COVID-19 response plan was launched in March 2020, though there was limited support in place to coordinate its implementation. Donors, rather than government, have the coordination and implementation of the response. However, the health, social affairs, education, and finance sectors have plans for COVID-19 support.</p> <p>Building on evidence and past lessons The early response built on lessons learned from responding to the cyclones, which occurred two years earlier and presented a similar acute crisis. The response included most health support recommended by WHO. The vaccine rollout will build on global lessons, such as the use of digital technologies to increase demand, reduce vaccine hesitancy, and engage communities in the monitoring of the vaccine rollout. Coordination helped ensure that pressing priorities for essential health care received continue prioritization. However, COVID-19 received disproportionate attention and resources compared with other urgent priorities.</p>	<p>Country program coordination A portfolio of projects designed for emergency response existed and was adapted to address COVID-19. Weekly management meetings held with program leaders coordinated the World Bank support. Engaging all country team members helped with coordination across GPs. CERCs required coordination between the task teams of the source project and of HNP to program funds. Good collaboration also existed between the Education and Water GPs to deliver WASH interventions for schools.</p> <p>Mix of instruments CERC components across the country portfolio, mainstreamed in many World Bank projects, were rapidly activated. For example, reallocation of funds from the cyclone response and recovery project provided early financing for health and social protection. The implementation of other ongoing projects was accelerated to meet needs. The COVID-19 Response DPF was used to meet fiscal needs. The \$2 million PEF funds played a minor role in supporting the health response. The MPA facilitated the response, and the second phase of the MPA provided an adaptable framework for the vaccine purchasing and deployment project. The instrument mix provided a robust World Bank response, and given familiarity with CERC, no major challenges occurred.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Mozambique		
<p>Use of knowledge work The country response did not significantly draw on ASA in designing and supporting its pandemic response. A just-in-time knowledge work was initiated to assess the pandemic's impacts on the private sector and the effectiveness of government measures to respond to those impacts.</p> <p>Addressing resilience, inclusion, sustainability, and gender The social response sought to address gender needs with cash transfers prioritizing women and WASH (water, sanitation, and hygiene) interventions targeting vulnerable girls, especially the rural poor, to increase their school retention and enrollment. It also strengthened social protection systems to reach vulnerable beneficiaries. The health response prioritized maintaining maternal and child health services. The challenge was in terms of scale rather than focus, as needs are vast beyond available resources.</p> <p>Addressing digitalization Digitalization has been supported across the main areas of the response: in health through support for digital surveillance and digitalization of vaccine rollout; in social protection through digitalization of money transfers; and in education through strengthening digitalized distance learning.</p>	<p>Policy dialogue In the absence of a centrally organized government response, the World Bank led sector-specific responses in consultation with relevant ministries and other development partners. Support focused on health, education, urban, and social protection sectors. The response built on existing sector relationships and accelerated the pace and direction of measures that were already undertaken before the pandemic.</p> <p>Partnerships Coordination among development partners used existing platforms, which support a crisis response group of donors (African Development Bank, IMF, World Bank, Canada, United Kingdom, Ireland, United States, European Union, and the Netherlands) that meet monthly with the government on cyclone recovery. The International Community COVID-19 task force led by the British High Commissioner was also established. Sector working groups enabled a division of labor among donors. The coordination and collaboration have been successful; however, the effectiveness is constrained by the government's response limitations.</p>	<p>Monitoring There is no overall monitoring of the COVID-19 response, while projects report on specific activities. The government's monitoring is concentrated in the health response, where the World Bank supports efforts to strengthen the country's health management information system to monitor case management of COVID-19 patients and adverse reactions to vaccination.</p> <p>Procurement Mozambique relied on BFP to purchase about \$9 million of respiratory equipment, diagnostic equipment, and PPE. Delivery of centrally procured items to the provinces was often slow and complicated. Implementation was hampered by the global supply crisis, though World Bank procurement proved faster than other government or United Nations agency efforts.</p> <p>Safeguards The implementation of safeguards in ongoing projects had unintended results. For example, the Urban Transformation Project required resettlement of some residents to new locations.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Mozambique		

Involvement of nongovernment
 Civil society supports vaccines by monitoring deployment and tracking vaccine delivery. Nongovernment groups will support the implementation of communication campaigns and behavior change interventions. The greater engagement of community groups is key to providing accountability for government resources. Health support involved CHWs.

Iterative adjustments
 Frequent coordination meetings among World Bank teams and virtual supervision support enabled learning and adaptation. Ongoing implementation faces two challenges: the low capacity of sub-national areas to monitor and plan the response and inadequate data to learn from and adapt the economic response.

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Philippines		
<p>Alignment with plans World Bank support aligned with the national response plan, particularly pillars 1 and 2, which includes support for health and social protection. The plan was designed in collaboration with the health sector. The World Bank did not support other sectors, such as education, as this was not an explicit priority. Efforts aimed to fill needs where government support was insufficient in the COVID-19 plan, and provide guidance, structural, and financial support to expansion of the government's response.</p> <p>Tailoring to needs and priorities The World Bank launched its first project in health since 2013 to support government needs. On the social response, the government largely relies on its own resources. The World Bank's social protection support informed the design of the government's ambitious expansion of cash transfers. Support to local government through the World Bank's disaster response instrument was flexible to allow implementation of their own priorities—the capacity of local government officials to apply the instrument was important. World Bank policy limited responsiveness to the plan for vaccination, given restrictions on purchasing vaccines that were not approved by the World Bank. The client did not request the World Bank's support in education.</p>	<p>Leadership and coordination The government responded quickly with ambitious plans to control COVID-19 and provide social protection to large segments of the population. An interagency task force led the response and constituted 34 government agencies. Originally, the crisis was considered a health emergency with the health sector overseeing the task forces and plans. However, it was quickly seen that to mobilize a response with robust actions across multiple sectors, central government leadership was needed and moved to the Department of Finance. The pandemic support accelerated and deepened interagency coordination.</p> <p>Building on evidence and past lessons The World Bank drew on lessons learned and structures developed in the wake of natural disasters, most notably Typhoon Haiyan in 2013. The early tranche of World Bank financing for health was built on the DROM introduced into World Bank lending operations. Moreover, the strong emphasis on community response aligns with global evidence. The social protection response projects also built on knowledge products to design support most effectively. These helped in the design of the government's social protection response and provided a platform for identifying beneficiaries for the expanded program. Developing procurement pathways with expedited processes for emergencies may facilitate a more efficient response in the future</p>	<p>Country program coordination There was good collaboration within and across World Bank sectors. For example, the Digital Development and Poverty GP collaborated in the study of COVID-19 impacts, and the SSI GP supported the health sector in conducting its first stakeholder consultations. The Beneficiary FIRST (Fast, Innovative, and Responsive Service Transformation) project, led by SPJ, collaborated with SSI, HNP, and Finance, Competitiveness, and Innovation for the payment systems and digital agenda and health and with education on cash transfers.</p> <p>Mix of instruments In social protection, a portfolio of relevant projects was adapted and accelerated to support the government's cash transfer program. A key early support was the community-based DROM activated in the KALAH! project to support critical health services, cash transfers to casual laborers who lost their jobs, and community engagement. The support built on the World Bank's community-driven development activities to mobilize community engagement, social cohesion, and local government emergency response planning. DROM is a process adjustment for emergencies that expedites approval, processing, and release of project funds to support local subprojects. The second phase of the MPA project was critical for financing vaccine procurement. Lack of clear communication and complex processes led to a slower and suboptimal response.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Philippines		
<p>Use of knowledge work The World Bank drew on knowledge work done previously to inform its social protection and community development activities. This included impact evaluations and guidance notes on technical topics. Recent and ongoing ASA supporting the response include a poverty and inequality assessment and a survey monitoring the impact of COVID-19 on households. The health project also supported a vaccine readiness assessment.</p> <p>Addressing resilience, inclusion, sustainability, and gender Support for laboratories, isolation facilities, and equipment, along with strengthening digitalization and support to the national identification system, is expected to improve service delivery capacity for health and social protection, and hence increase resilience and build sustainability. Social protection expansion to vulnerable households and migrant workers addresses inclusion, as does the explicit targeting of women, who make up more than 85 percent of cash recipients.</p>	<p>Policy dialogue The long-standing policy dialogue in the social protection sector facilitated a robust and rapid response, but the lack of policy and financing engagement in the health sector for more than 10 years required the reestablishment of dialogue and engagement strategy. Close dialogue with the Department of Health has been reestablished through regular meetings. A key challenge is the devolved and fragmented nature of government in health and social protection.</p> <p>Partnerships Regular partner coordination processes in the health sector are in place to ensure the complementarity of support. Though the initial focus on health slowed cross-sector coordination. The social protection sector has multiple partners providing support, including ADB, Australia's Department of Foreign Affairs and Trade and UNICEF. The devolved nature of the government with fragmentation of implementing agencies sometimes made dialogue and decision-making slow and complicated. The World Bank is leading the social response partner coordination. Coordination was smooth, but finding avenues for collaboration or joint action is often challenging with many partners providing support in similar areas.</p>	<p>Monitoring The MPA included support to track indicators for vaccination rollout online. Household surveys fed into the Beneficiary FIRST project to provide real-time information on the impact of COVID-19 on households in the poorest areas.</p> <p>Procurement Initially, the familiarity of the health sector with World Bank procurement processes slowed the response. Tracking procurement by the chief procurement officer addressed this challenge. Later, vaccine procurement was much improved, with the World Bank fast-tracking the first vaccine procurement contract and the chief procurement office conducting market engagement to orient vaccine manufacturers. Other challenges were communication across partners to coordinate procurement of items, such as COVID-19 testing machines and kits. BFP was undertaken to procure PPE and ventilators.</p> <p>Safeguards In health, the guidelines were too labor-intensive and not well adapted for the crisis setting, leading to procurement delays.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Philippines		
<p>Addressing digitalization</p> <p>The pandemic response facilitates the implementation of the government's digital transformation agenda in social protection by supporting: (i) the national identification system; (ii) digital payment tools, such as mobile money, and the use of digital identification and verification systems for cash transfers; and (iii) fast-tracking long-standing reforms of the business sector on digitalization. In health, the World Bank will support digital tracking and monitoring of vaccine delivery.</p>	<p>Involvement of nongovernment</p> <p>Civil society organizations have been engaged in the implementation of project support for COVID-19, especially in the implementation of community-based DROM in communities. Community leadership developed in response to the typhoon was crucial in ensuring community engagement for risk mitigation and maintaining social cohesion during the pandemic.</p> <p>Iterative adjustments</p> <p>Weekly meetings between the government and World Bank task team helped identify issues and devise necessary actions to facilitate project implementation. Useful adjustments to World Bank projects have been made by fast-tracking activities and adjusting the scope of projects.</p>	
Senegal		
<p>Alignment with plans</p> <p>The World Bank's response fully aligned with the government's plans, for surveillance; labs, testing, and treatment; IPC; risk communication; safety net cash transfers; school reopening; urban and peri-urban water and sanitation; and displaced persons. The main challenge was early support to finance vaccines.</p>	<p>Leadership and coordination</p> <p>The government took the initiative in implementing a COVID-19 response plan from early 2020, which was multisectoral, included all the strategic interventions recommended by WHO, and coordinated by an established One Health Council and multisectoral coordinating bodies and committees, extending to the district level. The response was facilitated by the active involvement of the president in the One Health Council, and prior ASAs and project support to improve emergency preparedness.</p>	<p>Country program coordination</p> <p>The Country Partnership Framework facilitated a rapid, holistic, people-centered, multisectoral response, which involved all GPs in the portfolio. National actors appreciated the technical soundness and speed of the support. Frequent meetings with country staff helped adjust project and ASA support and encouraged cross-project learning. Though, the overwhelming workload took its toll on staff.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Senegal		
<p>Tailoring to needs and priorities The World Bank support was well tailored to needs and priorities articulated by the government. However, more guidance and experience on communication and behavior change strategy effectiveness was needed, and psychosocial support was not prominent in the response.</p> <p>Use of knowledge work ASA before and during COVID-19 informed the World Bank's response, including project restructuring and longer-term directions. This included ASA on emergency preparedness; water and sanitation; adaptive safety nets; essential health services; food security assessment and monitoring in COVID-19; education service delivery indicators; youth employment and informal sector; digital development; COVID-19 impact monitoring; and public expenditure reviews. ASA for behavior change communication would have helped.</p>	<p>Building on evidence and past lessons Support built on experience with the Ebola outbreak, with greater emphasis on consistent communication of policy to subnational levels, risk communication, psychosocial care, and community engagement.</p> <p>Policy dialogue Senegal's response built on a long-standing policy dialogue with the government, which deepened through daily exchanges to advise on COVID-19 priorities. Dialogue and policy reform were supported through ASAs and the World Bank's DPF. In health, the dialogue intensified the sector's embrace of a multisectoral approach. In education, dialogue supported plans for immediate actions and strengthened sectoral coordination and institutional capacity.</p>	<p>Mix of instruments A portfolio of relevant projects and ASAs already existed, which was adapted to address COVID-19, and projects drew on CERC. Projects synergized support to interventions. The Health GP developed an emergency MPA, the COVID-19 Response Project, in two weeks, complementing the existing health project, the REDISSE project, and support of the GFF. The DPF facilitated multisectoral coordination across GPs to support the COVID-19 national plan and address its financing gap. PEF funds of \$15 million, channeled through UNICEF and WHO, covered subnational plans</p> <p>Monitoring The COVID-19 model of rapid preparation and multiple adjustments during implementation led to creative working. The response focused on participatory monitoring and evaluation (M&E) and joint learning and used the MPA results framework. The government proactively prepared plans, progress reports, and evaluations. On project approval, World Bank staff set up an implementation task force that met weekly to address bottlenecks.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Senegal		
<p>Addressing resilience, inclusion, sustainability, and gender Senegal's response is characterized by a strong focus on prevention by improving surveillance, risk communication, laboratory and social protection systems, and resilience for future crises. Moreover, the response is generating new capacities to deliver education, health services, social assistance, and health insurance. The response focused on women and children's vulnerability, women's empowerment, and maternal and child health services. The leveraging of the nutrition program has been an efficient way to engage communities.</p> <p>Addressing digitalization The World Bank was well prepared to support the strengthening and scale-up of digitalization due to ASAs undertaken before the crisis. Digitalization has been supported in health, social protection, and education, and was the focus of the DPF, including digital infrastructure, e-governance, and digital banking. A stand-alone operation focused on digitalization is being prepared.</p>	<p>Partnerships There was good coordination and joint learning between the World Bank and partners to plan and track national and decentralized COVID-19 plans. The policy reform matrix for the DPF offered a strong example of partner collaboration. Partners provided technical and financial support in line with their comparative advantages. Though challenges arose in the cross-sectoral response where the delineation of roles, responsibilities, and mandates was unclear.</p> <p>Involvement of nongovernment The nutrition program engaged the nongovernmental sector in the response. Civil society groups and nongovernmental actors provided care for suspected cases outside hospitals; sensitized populations about social distancing; communicated health and nutrition messages; targeted and distributed food assistance; and strengthened community leaders' capacities.</p> <p>Iterative adjustments Health and other sector teams met weekly with ministries and key implementers of projects, which created an iterative process for resolving challenges and supported ongoing learning. Examples of problem-solving included the decision to recruit contractual staff to surge resources for patient care and the provision of computing and video equipment to communicate between health offices.</p>	<p>Procurement Regular meetings helped track procurement and accelerated procedures. A large portion of medical supplies were procured in the first month of implementation; and more supplies were procured for a later wave of the pandemic. Procurement of masks was spread across projects. The government used its own procurement procedures for the medical supplies; their suppliers did not have fast delivery times. The government opted out of using World Bank-facilitated procurement, which the World Bank assessed, in retrospect, as the more cost-effective option.</p> <p>Safeguards The MPA emergency project followed the new safeguards framework, which was labor-intensive for staff. Qualified consultants trained on the new framework accelerated the government's preparation of documentation. The existing safeguard specialists in government were not trained.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Tajikistan		
<p>Alignment with plans The World Bank's support aligned with the national COVID-19 response, which divided needs among donors. In health, plans called for support to critical health services and a national task force for risk communication. The government and partners coordinated on a vaccination plan. Social protection support aligned with sector development plans.</p> <p>Tailoring to needs and priorities The early health response addressed critical health services, while longer-term preparedness capacity is a challenge. There was limited early support to ensure continuity of essential health services and vaccine communication. It may be important to assess emerging needs in education, such as for psychosocial support, which were not part of requested support.</p> <p>Use of knowledge work ASA was used to diagnose and monitor the situation and to inform coordination on response strategies. For example, the vaccine readiness assessment framework tool was applied through a coordinated effort of government and partners.</p>	<p>Leadership and coordination Initially the government was slow to respond, though it accelerated with changes in ministerial leadership. Tajikistan declared itself COVID-19 free in January 2021, which curtailed COVID-19 response efforts, though health strengthening continues. Coordination with donors to address government needs was fragmented, but improved when the health ministry was supported to develop a web-based platform to track donor support.</p> <p>Building on evidence and past lessons The support aligns with WHO guidelines. Global Partnership for Social Accountability (GPSA) support could be important to engage communities in monitoring the response.</p> <p>Policy dialogue The response built on long-standing dialogue in health, social protection, and finance. In the first phase of the response, the World Bank provided daily guidance to help develop the national response plan. The MPA project financed an adviser to support coordination of the response. In social protection, early dialogue supported expansion of cash transfers and adoption of a national social assistance plan. Ongoing dialogue is supporting expansion of performance-based financing support to strengthen health service delivery.</p>	<p>Country program coordination Initial World Bank support focused on health and social protection, including donor coordination and dialogue to advise the government. Funding support for the response was almost entirely through the MPA project. The country program focused on a small range of interventions in a few sectors, with coordination led by the country office. The HNP focal point was important in coordinating health-related interventions and support.</p> <p>Mix of instruments Tajikistan was one of the first countries to develop MPA emergency financing in health, and AF for vaccines. It also repurposed social protection project support and ASAs. The PEF was not used, as the deadline was before the government's official announcement of the pandemic. The corporate framework for the global MPA delayed approval of the first MPA and AF.</p> <p>Monitoring World Bank staff and the government frequently checked in to review the COVID-19 situation. For social protection, the management information system setup under the social protection project enabled electronic monitoring of cash transfer receipt. Geo-enabled monitoring and supervision tools were useful for remote monitoring. An ASA on mobile engagement introduced an innovative system for SMS communications nationwide, which has been used for risk behavior and vaccine messaging.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Tajikistan		
<p>Addressing resilience, inclusion, sustainability, and gender The early investments of the World Bank helped improve health facilities and enabled the national rollout of Tajikistan's first comprehensive national social protection plan, including a social registry for decision-making on payment eligibility and a comprehensive management information system. Social protection specifically targeted female-headed households with children, though gender was not strongly addressed in other aspects of the response.</p> <p>Addressing digitalization Health support addressed information hotlines and SMS text messaging. There was support for using digital methods for information gathering and monitoring. The country developed an electronic aggregation system for vaccination data at the district level and electronic system to manage health supply chains.</p>	<p>Partnerships An existing coordination committee, chaired by the World Bank, and the COVID-19 Response Group coordinated donors. Government leadership of donors weaker than needed strengthening, resulting in imperfect information on who was doing what and where there are limitations and overlaps. A World Bank partnership with Gavi, the Vaccine Alliance helped share information for early actions on vaccines.</p> <p>Involvement of nongovernment There is limited involvement of nongovernment in project support, though there are plans to include training of community volunteers for vaccine messaging. GPSA supported capacity development and execution of third-party monitoring of the response by a consortium of civil society organizations</p> <p>Iterative adjustments Based on learning during the pandemic, the AF of the Tajikistan Health Services Improvement Project will expand performance-based financing and capacity building for primary health-care services. Moreover, the World Bank will continue to build on social protection reforms.</p>	<p>Procurement The first MPA was largely used to procure medical equipment and supplies. The use of BFP was considered, but a single contract was signed with UNOPS for almost all procurement needs, and limited procurement of medical supplies was done locally. The country manager enlisted the support of the president and Ministry of Finance to provide oversight in the initial phases of the response.</p> <p>Safeguards Waivers of safeguards requirements helped approve new projects, though all requirements needed to be completed to start. Safeguard advisers provided needed handholding. A central quality review team reviewed document.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Uganda		
<p>Alignment with plans The World Bank supported all pillars of the COVID-19 national response plan and financed coordination at national and subnational levels. The response reinforced the Uganda National Social Protection Policy and aligned with sector response plans.</p> <p>Tailoring to needs and priorities The response supported relief needs in health, though risk communication, essential health services, and vaccine support were not strong in the early response. In the social response, support addressed public schools. Community engagement support focused on health volunteers, nutrition, parent groups, and farmers. Institutional strengthening support was provided, there has been support to local governments. Challenges are longer-term capacity building of surveillance, citizen engagement, public-private sector service integration, education and health systems, and preparedness coordination.</p>	<p>Leadership and coordination Uganda developed a comprehensive national COVID-19 response plan overseen by a multi-sectoral task force headed by the prime minister and sector-level committees. A similar multisector structure was established reflected at the regional and district levels, with varied success. Overall leadership of the response has been strong in sectors, building on experience with Ebola, though national election activities delayed new projects. Building on evidence and past lessons The support aligns with WHO guidance for the national response plan in health. Key areas to be strengthened are surveillance, community activities, essential services, and risk communication.</p> <p>Policy dialogue In education, health, water, and social development, frequent and close dialogue with the government on the CERC and MPA has enabled adjustments to previous World Bank projects to support COVID-19, ensured continued support for local government services, and encouraged reforms.</p>	<p>Country program coordination The country office coordinated the World Bank's response, which engaged most sectors. Projects were adjusted across GPs, which was easier to do where there were long-standing relationships with the government. The DPO was the most collaborative instrument. The social development team supported all teams to address social inclusion and gender equality.</p> <p>Mix of instruments Activation of CERC in health was immediate based on experience of Ebola, but this was the only CERC in the portfolio. Other early support was from adjustments to projects, AF, GPE, PEF, DPO, and ASA. The DPO offered multisector support to ensure basic utilities and expand social registration, support agriculture inputs, and procure medical supplies. Decoupling of the PEF grant from the MPA avoided delays of parliamentary approval of credit. Trust funds allowed for immediate actions. Parliament passed the DPF in about three months, signifying the urgency attached to this financing.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Uganda		
<p>Use of knowledge work ASA informed discussions with the government and collaboration with partners and identified strategies for COVID-19. The World Bank supported a range of ASA on water utilities; economic updates; COVID-19 impacts; results-based financing in the health sector; health information systems; risk communication, and essential services supported by GFF; a vaccine readiness assessment; and the impact on refugees.</p> <p>Addressing resilience, inclusion, sustainability, and gender The World Bank supported access to essential health services by women and children. Support to laboratories built systems capacity for disease testing. The redesign of the COVID-19 communication strategy should help better reach vulnerable groups, especially youth. Agriculture support is improving access to nutritious food and quality inputs. Support helped strengthen local government services. Support to refugee and host communities targeted vulnerable households and women. The DPF helped improve systems for social protection and resilience of the private sector. In education, support helped distance learning and school reopening, with a focus on children with special needs.</p>	<p>Partnerships The World Bank participated in the donor coordination group since before COVID-19. Having a trust funded staff in the World Bank office to facilitate donor coordination has been critical. The sector groups from before COVID-19 facilitated coordination and collaboration. Moreover, the World Bank participates in most of the committees for the response strategy and provides technical guidance. For example, the World Bank supported ASA for the risk communication strategy in collaboration with USAID. Collaboration with UNICEF in WASH has been key to delivering rapid support for education. Overall collaboration with health and other sectors and partners could be strengthened to improve multisectoral support. EdTech provided collaboration for the remote learning response, and GFF for health services and risk communication</p> <p>Involvement of nongovernment The World Bank supported training of private health service providers in COVID-19 case management, which was a challenge in the early response.</p>	<p>Monitoring Frequent check-ins with project implementers enabled an exchange on successes and ways to address bottlenecks, while few indicators were formally tracked on COVID-19 support. Lockdowns minimized physical monitoring of projects unless electronic systems were already in place. Geo-enabled monitoring has been useful in agriculture for remote project supervision. Studies have served as a means for monitoring the impact of the pandemic. A persistent challenge has been the availability of real-time data on COVID-19 cases.</p> <p>Procurement The CERC and PEF have largely been used to procure medical equipment and supplies. Projects used their existing procurement arrangements, adopting emergency guidelines to allow for flexible and accelerated procedures, including the use of e-bidding, direct contracting, shorter bidding periods, retroactive financing, and increased advanced payment. Close support of procurement specialists was important.</p> <p>Safeguards With ministries overwhelmed by COVID-19, engaging an expert to apply the new safeguards framework was impossible. Applying a new framework was labor-intensive given the many emergency demands.</p>

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Support to needs of countries	Support to implementation and learning	Operational processes and partnerships
Uganda		
<p>Addressing digitalization</p> <p>Support included building the capacity of the statistics agency to conduct phone surveys, health information systems support, and geo-enabling technology to gather monitoring data. Radio and television disseminated more information. Remote learning in education has been critical. The DPF supported local governments with internet and data.</p>	<p>Iterative adjustments</p> <p>Most projects adopted new standard operating procedures to ensure safe implementation of activities. For example, training and community mobilization activities were adjusted to limit social contact. Weekly check-in on project implementation resulted in adjustments. For example, COVID-19 training support was added to include the private sector, and the assessment of risk communication was done based on challenges identified in the communication strategy.</p>	

Source: Independent Evaluation Group case study analysis.

Note: The response details on each country are based on data collection synthesized from the case study protocol completed for each country through document review, interviews, and consultations with country teams. Internal validation meetings were also held to help ensure consistency in synthesizing findings across countries. ADB = Asian Development Bank; AF = additional financing; AfDB = African Development Bank; ASA = advisory services and analytics; BMGF = Bill and Melinda Gates Foundation; CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Components; CHW = community health worker; DPF = development policy financing; DPO = development policy operation; DROM = Disaster Response Operations Modality; FIRST = Fast, Innovative, and Responsive Service Transformation; GFF = Global Financing Facility; GP = Global Practice; GPE = Global Program for Education; GPSA = Global Partnership for Social Accountability; GPURL = Global Practice of Urban, Resilience, and Land; GRM = grievance redress mechanisms; HNP = Health, Nutrition, and Population; IMF = International Monetary Fund; IPC = infection prevention and control; IPF = investment project financing; JICA = Japan International Cooperation Agency; MOHFW = Ministry of Health and Family Welfare; PAHO = Pan American Health Organization; PEF = Pandemic Emergency Financing Facility; PforR = Program-for-Results Financing; PPE = personal protective equipment; SPJ = Social Protection and Jobs; SSI = Social Sustainability and Inclusion; TTL = task team leader; UN = United Nations; UNICEF = United Nations Children's Fund; UNOPS = United Nations Office for Project Services; WFP = World Food Programme.

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Honduras projects reviewed: Disaster Risk Management Project CERC (P131094); Corridor Second Food Security Project (P148737); Social Protection Integration (P152057); First Fiscal Sustainability DPF (P155920); Integrating Innovation for Rural Competitiveness in Honduras IRM (P158086); Transparency Accountability and Results in Honduras (P161696); Integrating Innovation for Rural Competitiveness in Honduras II CERC (P168385); AF Social Protection Integration (P175718); Early Childhood Education Improvement Project (P169161); DRM Development Policy Credit with a CAT DDO (P172567); COVID-19 Emergency Response Project (P173861); AF for Honduras COVID-19 Emergency Response Project (P176015); Improving Access and Governance in Health (P176532). **ASA reviewed:** Central America Early Childhood Development (P169033); ECD and MCH (P169202); Adaptive Social Protection: Strengthening Cash Transfers for Post Disaster Response (P1704337); Better Knowledge and Analytics to Support Governments' Response to COVID-19 in LAC (P174597); Public Expenditure Review (P175145); Pandemic Preparedness and Response (P175274); Public Health Preparedness Assessment (P175552); CA-SPL Systems for a more Inclusive and Resilient Recovery in the Aftermath of COVID-19 (P175631); Exploratory Grant: Honduras Health (GFF support).

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Andhra Pradesh Health Systems Strengthening Project (P167581); Meghalaya Health Systems Strengthening Project (P173589); Tamil Nadu Health System Reform Program (P166373). **ASA reviewed:** India PMJAY & Universal Health Coverage (P171432); India Technical Assistance for Health, Social Protection and Economic Response to COVID-19 (P174418); India 21st Century Health System – Health Financing Service Delivery and Public Health (P175882); Accelerating Direct Benefit Transfers in Low Income States (P158289); Strengthening Capability of Social Protection Delivery Chains (P167256); Knowledge sharing on innovative social protection systems (P166658); India Social Registry and Socioeconomic Caste Census (P161831); Combating Poverty: Role of Safety Nets (P149391).

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Philippines projects reviewed: KALAHI-CIDSS National CDD-Additional Financing and COVID-19 Response (P161833); Promoting Competitiveness and Enhancing Resilience to Natural Disasters Sub-Programs 2 DPF (P170914); COVID-19 Emergency Response Project (P173877); COVID-19 Emergency Response Project AF (P175953); Beneficiary FIRST (Fast, Innovative, and Responsive Service Transformation) Social Protection Project (P174066); Emergency COVID-19 Response DPF (P174120). **ASA reviewed:** Philippines: The Future of Jobs (P173234); Strengthening Support for the Pantawid Program and Philippines Social Protection Systems (P173380); Real Time Monitoring of COVID-19 Impacts in the Philippines (P174356); Poverty & Inequality in the Philippines: Past, Present & Perspectives for the Future (P174861); Strengthening Local Health Systems for UHC (P175650).

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Recovery (P172723); Saint-Louis Emergency Recovery and Resilience (P166538); Saint-Louis Emergency Recovery and Resilience AF (P170954); Municipal Solid Waste Management Project (P161477); Rural Water Supply and Sanitation (P164262); West Africa Agricultural Production Program (P153419); Sahel Irrigation Initiative Support (P154482); WAAPP Support to Groundnut Value Chain (P158265); Agriculture Livestock and Competitiveness (P164967). **ASA reviewed:** Poverty Monitoring (P164474); UHC and Pandemic Preparedness (P164017); Public Expenditure Review (P170349); Digital Development (P171740); Adaptive Social Protection (P174074); Poverty Assessment (P173204); Strengthening Data and Knowledge on Poverty in Sub-Saharan Africa (P172791); Water Security in Senegal (P172233); Education Service Delivery Indicators; and analytic work supported by the Global Financing Facility to assess basic services quality and continuity; Agriculture Sector: food security assessment in COVID context.

Tajikistan projects reviewed: Social Safety Net Program (P122039); Health Systems Improvement (P126130) Emergency COVID-19 (P173765). **ASA reviewed:** Listening to Tajikistan (P171950); Strengthening Tajikistan's Health System for Women, Children and Adolescents (P172002); KTF: Mobile Engage (P173327); Agri-food sector and Public Expenditure Review (P174499); Third Party Monitoring of Tajikistan Emergency COVID-19 Project (P175904).

Uganda projects reviewed: Uganda Reproductive, Maternal and Child Health Services Improvement Project CERC and AF (P155186, P174163); COVID-19 Economic Crisis and Recovery DPF (P173906); COVID-19 Emergency Education Response Project (P174033); Secondary Education Expansion Project (P166570); COVID-19 Response and Emergency Preparedness Project (P174041); Laboratory Networking Project (P111556); Building Resilient Communities (P173818); Third Northern Uganda Social Action Fund (P149965); Multisector Food Security and Nutrition and AF (P149286, P176878); Skills Development Project (P145309); Intergovernmental Fiscal Transfers Program and AF (P160250, P172868); Integrated Water Management and Development Project (P163782); Irrigation for Climate Resilience Project (P163836); Development Response to Displacement Impacts Project (P152822); Agriculture Cluster Development Project (P145037). **ASA reviewed:** Strengthening Social Protection Systems in Uganda (P175018); Continuity of Essential Health Services (GFF); Uganda Umbrella Authorities (Global Water Security Program of Water GP Trust Fund); Monitoring COVID-19 Impacts (P175978); Uganda Economic Update (P174884); COVID-19 health service disruptions (P176692).

Appendix D. Review of Country Situations: Analysis of Country Support Types, Needs, and Implementation Status

This appendix analyzes the World Bank's early health and social response in countries on its, support to COVID-19 needs and satisfactory implementation.

Data and Methodology

The analysis combined publicly available data on indicators with the evaluation's portfolio data to estimate how well COVID-19 responses aligned with the health and social needs of countries, and to examine features of the portfolio that facilitated or hindered satisfactory implementation. Publicly available data on indicators related to country situations were used to estimate the needs for each area of the health and social response framework for COVID-19 (table D.1). Indicators were identified to estimate the needs of countries before the COVID-19 response and during the early response, and categorized in quartiles by reviewing the spread of data across countries, with the best situation the fourth quartile and the worst situation the first quartile.¹ For areas with multiple indicators, principal component analysis and composite measures were constructed for each area (Howe et al. 2008; Pirani 2014).² The portfolio data included information on support in health, social protection, child welfare and social services, community engagement, institutional strengthening, operational instruments, implementing actors, and project implementation status from between February 2020 and April 2021. Data on human capital support between FY15 and FY20 before COVID-19 from a forthcoming Independent Evaluation Group (IEG) evaluation was also integrated in the Excel data set (World Bank, forthcoming).

Table D.1. Indicators Related to Country Situations

Area	Country-level indicators	
Situation before COVID-19		
Preparedness capacities to deliver critical health services for epidemics	Laboratory capacity—laboratories set up to identify infectious agents and hazards	IHR 2017
	Human resources capacity—trained persons in place for public health emergencies, including nurses, midwives, physicians, epidemiologists, laboratory specialists, and communication specialists, among other expertise.	IHR 2017
	Surveillance capacity—systems for rapid detection and response to public health risks	IHR 2017
Health services capacity	Access to health care score—captures health expenditures, vaccinations, health personnel per population, and maternal mortality	Inform 2020
Risk communication	Risk communication capacity—systems to communicate risks and promote community resilience to cope with a public health emergency	IHR 2017
Protect poor and vulnerable	Socioeconomic vulnerability score—captures Human Capital Index, Multidimensional Poverty Index, Gender Inequality Index, income inequality, development assistance, and remittances	Inform 2020
	Vulnerable groups score—captures refugees, displaced persons, women and girls subjected to violence, and persons with HIV, malaria, tuberculosis, neglected tropical diseases, and undernourishment and dietary adequacy	Inform 2020
Child welfare and social services	Population in multidimensional poverty, age 0 to 9—captures acute deprivations in health, education, and living standards	Oxford 2010–18
	Birth registration—coverage of birth registration	UNSD 2001–19
Gender equality	Inequity score—considering Gender Inequality Index and income inequality	Inform 2020
Community vulnerability	COVID-19 vulnerability score—composite measure based on 10 indicators: air transport, tourism, IHR capacity, points of entry, access to cities, road density, literacy, mobile cellular subscriptions, internet use, and trust in government	Inform 2020
Digitalization	Inform awareness score—captures literacy, mobile cellular subscriptions, and internet use	Inform 2020
Urban health risk	COVID-19 hazard and exposure score—composite measure based on eight indicators: population density, urban population, household size and type, access to sanitation and drinking water, and open defecation	Inform 2020

(continued)

Area	Country-level indicators	
Situation before COVID-19		
Health epidemic response capacity	Health capacity specific to epidemic response—average of 13 IHR core capacity score and operational readiness index ³	Inform 2020
Situation during early COVID-19 response		
Government responsiveness	Average stringency of prevention measures—composite measure based on four indicators of prevention: gathering restrictions, testing policy, contact tracing, facial coverings, averaged between February 2020 and April 2021	Oxford 2020–21
Disease situation	Average community transmission—transmission classification of the spread of COVID-19, averaged between February 2020 and April 2021	WHO 2020–21
Social situation	COVID-19 poverty increase projection—regional estimate of increase in poverty (less than \$1.90 per day per capita) in 2021 from baseline projections before the pandemic	World Bank 2020
	Average economic support—measure of income support services and debt relief	Oxford 2020–21
	Total school closures—total weeks of full or partial school closures between February 2020 and April 2021	UNESCO 2020–21

Source: Lakner et al. 2020; Thomas et al. 2021; Poljanšek, Vernaccini, and Marin Ferrer 2020; UNESCO 2021; UNSD 2021; WHO 2021.

Note: Inform = Inform COVID-19 Risk Index; IHR = International Health Regulation; Oxford = Oxford COVID-19 Government Response Tracker; UNESCO = United Nations Educational, Scientific and Cultural Organization; UNSD = United Nations Statistics Division; WHO = World Health Organization.

Having constructed an integrated country-level data set, the following analyses were conducted using Python, Stata, and Excel, with visualizations in Tableau:

- » Machine learning clustering analysis to understand the types of World Bank support planned among countries (Caliński and Harabasz 1974; Davies and Bouldin 1979; Handl and Knowles 2007). The algorithm reviewed the portfolio data and clustered countries that showed similar patterns of support in addressing country situations.⁴ Principal component analysis was applied across the clusters, reducing the variables to produce meaningful groupings of data for interpretation. The assessment tested three clustering models.⁵ The final analysis used a hierarchical clustering algorithm that was compared with other tested algorithms.⁶

- » Heat map of the alignment of World Bank support with country needs and previous human capital support (table D.3). The heat map shows the level to which the World Bank responded to country needs before COVID-19, and the extent that having previous human capital support aided in addressing of country needs during COVID-19. The analysis looked at countries with indicators in the bottom two quartiles, in terms of having a defined need before COVID-19, and the proportion of these needs that were addressed by the support of World Bank projects in the country portfolio.
- » Decision tree analysis at the country level to understand portfolio features that facilitated or hindered satisfactory project implementation in the early COVID-19 response (Kam Ho 1995; Schapire 2013). The outcome variable used to construct the decision tree analysis was the proportion of projects focused on COVID-19 in a country portfolio with satisfactory (satisfactory or highly satisfactory) implementation progress ratings. The decision tree was constructed using AdaBoost, which identifies a series of trees after testing several models and uses a tenfold cross-validation.⁷ The final features in the model were selected using the backward feature selection, a step-by-step approach. Finally, a set of eight features that produced the best score were selected to identify those that were important to satisfactory project implementation in countries.

Types of Support Planned by the World Bank in Countries

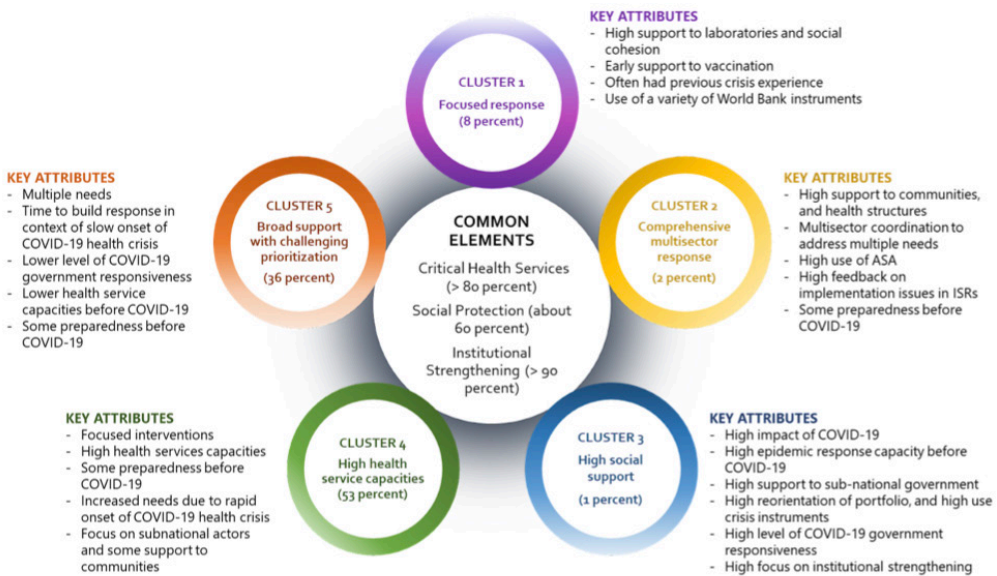
The machine learning clustering analysis suggests that prioritizing World Bank support to needs was more challenging in some countries. The analysis identified five clusters of countries (figure D.1) that can be grouped into three types based on the level to which World Bank support prioritized country needs. All countries had core World Bank support to expand critical health services and social protection. Better prioritization of World Bank support to address needs is seen in countries with higher average epidemic response capacities before COVID-19 and capacities to deliver essential health services, and early government responsiveness to put in place prevention measures, which is also supported by findings from case studies con-

ducted for the evaluation. Case studies suggest a progressive prioritization of the response in some countries to better address needs and reach vulnerable groups. World Bank support was challenging to prioritize in countries with lower health services capacities, slower average early government responsiveness, and extensive needs to address the health and social threats of COVID-19.

- » About 11 percent of countries fall into clusters that had high government responsiveness or previous preparedness to coordinate and deliver critical health services, and focused World Bank support to prioritize needs. About 8 percent of countries (cluster 1) undertook a focused response with a higher intensity of interventions on laboratories, vaccination, and social cohesion, drawing on government leadership and previous crisis experience. Two percent of countries (cluster 2) developed a multisectoral response with increased intensity of engagement across levels of government and reach to the community to address a range of needs. These countries also undertook more advisory services and analytics relative to other countries to inform needs, and had some preparedness to deliver critical health services before COVID-19. One percent of countries (cluster 3) had a high focus on the social response with a high degree of reorientation of the country portfolio to address needs across sectors, while responding to the high impacts of the COVID-19 crisis. In all three clusters, governments had medium to high average responsiveness to act on COVID-19 measures, and medium to high average capacity to deliver essential and critical health services before COVID-19.
- » About 53 percent of countries (cluster 4) had high average capacities to deliver health services before COVID-19, and focused World Bank support on priorities in a few areas to address needs. These countries often had fewer pre-COVID-19 needs. However, they also often faced a higher early impact of the COVID-19 crisis and may face increasing needs in the future.
- » About 36 percent of countries (cluster 5) had extensive needs and limited capacities to deliver health services, making prioritizing support to address needs challenging. These countries often had low levels of human capital and extensive health and social development needs before COVID-19. The key in these countries was protecting against development losses, and early government responsiveness to meet prevention needs was often low. Case studies

from the evaluation suggest opportunities to progressively prioritize support to better focus on needs and vulnerable groups. Even with pre-COVID-19 preparedness there were often vast needs across sectors, and limited capacities to deliver health services. Regional project support and multisectoral coordination may help countries to strengthen their response capacities (as seen in Senegal), though reinforcing health systems to deliver essential health services may be an important part of preparedness in these countries.

Figure D.1. Types of World Bank COVID-19 Support to Countries



Source: Independent Evaluation Group.

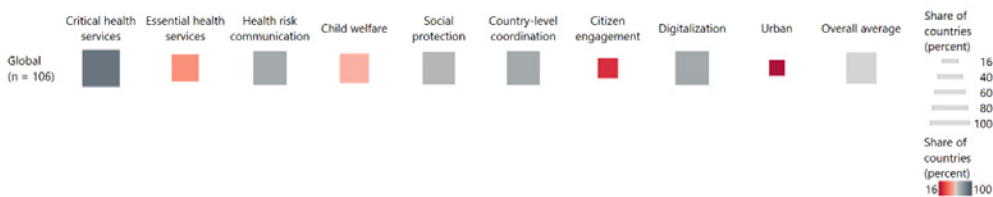
Note: **Cluster 1 (purple)** = focused response. A cluster of seven countries: Republic of Congo, Djibouti, Ghana, Honduras, Kenya, Sierra Leone, and Togo. **Cluster 2 (gold)** = comprehensive multisector response. A cluster of two countries: Senegal and Pakistan. **Cluster 3 (blue)** = high social support, institutional strengthening, and responsiveness of government. India is the sole country in this cluster. **Cluster 4 (green)** = high-capacity countries. Large cluster of 48 countries: Albania, Bangladesh, Belarus, Bhutan, Bolivia, Bosnia and Herzegovina, Cabo Verde, Cambodia, Colombia, Comoros, Dominica, Ecuador, El Salvador, Eswatini, Fiji, Gabon, Georgia, Guatemala, Haiti, Indonesia, Iraq, Jordan, Kiribati, Lao People's Democratic Republic, Lebanon, Maldives, the Marshall Islands, Moldova, Morocco, Myanmar, Nepal, Nicaragua, Panama, Philippines, São Tomé and Príncipe, the Solomon Islands, Sri Lanka, St. Lucia, Suriname, Tajikistan, Trinidad and Tobago, Tunisia, Türkiye, Tuvalu, Ukraine, Uzbekistan, and Vietnam. **Cluster 5 (orange)** = broad support with high needs. Main cluster of 32 countries: Afghanistan, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, and Chad. Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, The Gambia, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Papua New Guinea, Rwanda, Somalia, South Sudan, Tanzania, Timor-Leste, Uganda, Vanuatu, Republic of Yemen, and Zambia. Boldface indicates that the country is a case study in the evaluation. N = 90 countries. ASA = advisory services and analytics; ISR = Implementation Status and Results Report.

Findings of Country Needs Analysis

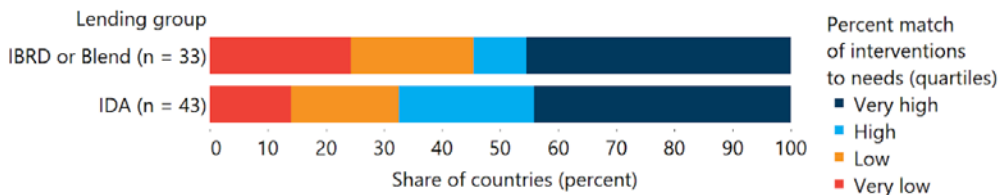
The World Bank’s support for COVID-19 addressed most emergency needs related to critical health services, coordination, social protection, and digitalization, with challenges in other areas (figure D.2a). Challenges arose in addressing needs related to essential health services, community engagement, and urban public health support. About 45 percent of countries addressed needs to a high level (figure D.2b).

Figure D.2. Alignment of Project Support with Needs of Countries

a. Alignment of World Bank country support to needs by response area



b. Extent of alignment of World Bank country support to needs



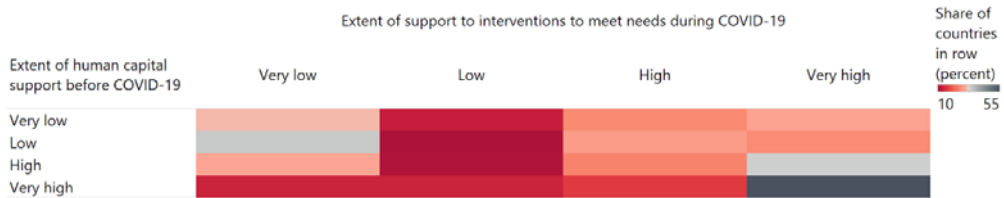
Source: Independent Evaluation Group portfolio.

Note: Figure a shows the percent of countries with needs in the bottom two quartiles that received at least one World Bank intervention in that area. Interventions are based on the analysis of 203 projects coded for the evaluation in 89 countries that had data on needs and World Bank support. Red shading indicates that needs were addressed in less than 50 percent of countries. Gray shading indicates that needs were addressed in 50 percent or more of countries. Figure b shows the overall alignment of country support by quartile. Very high = more than 80 percent alignment between World Bank interventions in the portfolio and needs; high = 66.6 to 80 percent alignment; low = 33.3 to 66.6 percent alignment; very low = 0 to 33.3 percent alignment.

Analysis of Previous Support to Human Capital

Countries that previously had high levels of support to human capital more consistently addressed health and social needs during the early response. About 79 percent of countries in the portfolio had high or very high levels of World Bank support to human capital in health, social protection, or education before COVID-19. About 52 percent of these countries had early COVID-19 responses that addressed health and social needs at high or very high levels, compared with 46 percent of these countries that had low or very low previous support to human capital (figure D.3). Having developed this support before COVID-19 helped prepare the countries to flexibly respond to needs related to the crisis.

Figure D.3. Address of COVID-19 Response Needs Based on Prior Human Capital Support



Source: Independent Evaluation Group needs analysis. The human capital data were coded as part of World Bank forthcoming IEG assessment.

Note: The extent of human capital support before COVID-19 is based on interventions in projects before COVID-19, before February 1, 2020, in the Health, Nutrition, and Population; Social Protection and Jobs; and Education Global Practices.⁸ Interventions during COVID-19 are defined as the quantity of interventions per country in an area in the highest two quartiles of their distribution across countries. A country need is defined as the baseline indicator of an area in each country falling in the bottom two quartiles of the indicator's distribution across countries. *Extent of support to interventions to address needs during COVID-19:* Very low: 0 percent – 33 percent, Low: 33 percent – 67 percent, High: 67 percent – 80 percent, Very high: More than 80 percent. *Extent of human capital support before COVID-19:* Very low: 0 projects – 1 projects, Low: 2 projects – 3 projects, High: 4 projects – 7 projects, Very high: 8 projects – 20 projects. N = 78 countries.

Support to Satisfactory Implementation at a Country Level

The decision tree analysis identifies a mix of country portfolios features that appear important to satisfactory implementation progress (satisfactory or highly satisfactory). The importance of each feature in the decision tree is proportional to the average decrease in impurity, or the explanatory value-added by the variable to correctly predict the classification of the imple-

mentation status of a project. Features on higher nodes in the decision tree have more explanatory value. All features are independently important, but together they make it more likely for projects to have a satisfactory implementation progress. The key features important to satisfactory implementation progress are shown in table D.2 in the order of their explanatory value as predictors in the model. The coverage of these features in country portfolios points to opportunities for improving future World Bank crisis responses, especially in terms of better support to monitoring, citizen engagement, essential health services, gender, and urban health, which were less frequent in countries. The findings also point to the value of investing in preparedness in countries with greater needs and lower capacities such that they can better equip for crisis response. Figure D.4 shows that only about 40 percent of countries had high or very high coverage of most of these features in their support to the COVID-19 response.

Table D.2. Country Portfolio Features Facilitating Satisfactory Implementation of Early COVID-19 Health and Social Response in Countries

Feature of country support	Findings of decision tree
Monitoring and evidence of early progress (Country coverage: 74 percent had indicators monitored, and 64 percent had indicators that showed early evidence of progress)	Countries with a higher frequency of World Bank support to monitoring of the COVID-19 response (in the top two quartiles) and early evidence of progress were more likely to have projects with satisfactory implementation progress: 30 percent of explanatory value, with an additional 10 percent if there was early evidence of progress. In early evidence, the key was having indicators that could provide routine information on project implementation. Notably, this support was important for all countries.
Support to citizen engagement, essential health services, and laboratories (Country coverage: 43 percent, 41 percent, and 71 percent)	Countries with World Bank support to COVID-19 in citizen engagement, essential health services, and laboratories were more likely to have projects with satisfactory implementation progress: each intervention added an explanatory value of 12 percent. Notably, this support was important for all countries irrespective of their needs or situation before COVID-19. This finding is consistent with the case studies and evidence from the literature, which point to the importance of having health service capacity in place during a crisis, and demand-side engagement of communities. Moreover, the importance of access to laboratory testing is seen in past lessons and the regional project analysis.

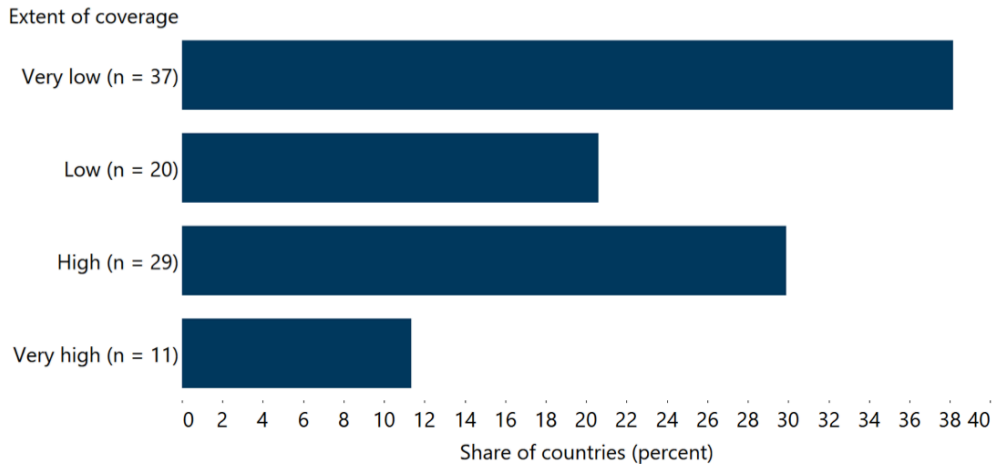
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Feature of country support	Findings of decision tree
Address gender equality (Country coverage: 64 percent had support to address gender equality needs in the early COVID-19 response)	This finding suggests that World Bank support to gender in the early COVID-19 response was important for all countries, but especially in countries with greater needs related to gender equality. Better addressing of gender equality needs in the country portfolio (top quartile) made it more likely to have projects with satisfactory implementation progress: 10 percent explanatory value was added.
Address urban health risks (Country coverage: 24 percent had urban support in the early COVID-19 response)	The findings suggest that in countries with higher urban health risks targeted support in this area was important in the COVID-19 response. Better addressing urban health risks for the spread of COVID-19 in a country (top two quartiles) made it more likely to have projects with satisfactory implementation progress during the early COVID-19 response: 8 percent explanatory value was added.
Preparedness capacities to deliver critical health services (Country coverage: 49 percent had better preparedness to delivery critical health services (top two quartiles); 91 percent of countries with lower preparedness to delivery critical health services (bottom two quartiles) received support in the early COVID-19 response to address this need)	The findings suggest that supporting critical health services was important among countries with lower preparedness. Countries better prepared to deliver critical health services before COVID-19 (top quartiles) were more likely to have projects with satisfactory implementation status: 6 percent explanatory value was added by having preparedness capacities in critical health services before COVID-19.

Source: Independent Evaluation Group decision tree analysis.

Note: Percentages reported for critical health services, gender inequality, and urban health risk measure the extent to which World Bank support in the respective area was aligned with a country's needs in that area. A need is defined as the underlying needs variable in an area falling in the bottom 50 percent of its distribution across countries. IHR - International Health Regulations.

Figure D.4. Coverage of Features Supporting Satisfactory Implementation in Countries



Source: Independent Evaluation Group portfolio.

Note: The levels relate to quartiles of the share of features supporting satisfactory implementation in countries. Very low = 0 to 37.5 percent; low = 37.5 to 50 percent; high = 50 to 75 percent; very high = more than 75 percent. N = 97 countries.

Table D.3. Abridged Heat Map of Pre-COVID-19 Needs and COVID-19 Response in Countries

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
East Africa regional average:					High	High	High	-
Angola	worst (1st quartile)	better (3rd quartile)	worse (2nd quartile)	worst (1st quartile)	Very high	Very low	High	Yes
Burundi	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	Low	Low	Low	Yes
Comoros	worse (2nd quartile)	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	Low	High	Low	Yes
Congo, Democratic Republic of	worst (1st quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	High	Very high	Yes
Ethiopia	worst (1st quartile)	best (4th quartile)	worst (1st quartile)	worst (1st quartile)	Very high	Very high	High	Yes
Kenya	worst (1st quartile)	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	Very high	Very high	Very high	Yes
Lesotho	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	Low	Very low	Very high	Yes
Madagascar	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	Low	High	Very high	Yes
Malawi	better (3rd quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	Very low	Very low	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Mozambique	better (3rd quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	High	Very high	Yes
Rwanda	worse (2nd quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	High	Very high	Yes
São Tomé and Príncipe	worse (2nd quartile)	worst (1st quartile)	better (3rd quartile)	better (3rd quartile)	Very low	High	Low	No
Somalia	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)		Very low	Low	High	No
South Sudan	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	Very low	Low	Very low	No
Tanzania	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	High	Very low	Yes
Uganda	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	worst (1st quartile)	High	Very high	Very high	Yes
Zambia	worse (2nd quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	Very low	High	Very high	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
West Africa regional average:					High	High	High	-
Benin	worst (1st quartile)	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	High	Low	Very high	Yes
Burkina Faso	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	High	Very high	Yes
Cabo Verde	better (3rd quartile)	better (3rd quartile)	better (3rd quartile)	worse (2nd quartile)	Low	Very low	Low	No
Cameroon	worst (1st quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	High	High	Low	Yes
Central African Republic	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	Very low	High	Very high	Yes
Chad	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	High	Low	Low	Yes
Congo, Republic of	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worse (2nd quartile)	Low	High	Low	Yes
Côte d'Ivoire	worst (1st quartile)	best (4th quartile)	worst (1st quartile)	worst (1st quartile)	Very high	High	High	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Gabon	worse (2nd quartile)	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	Low	Very low	Very low	No
Gambia, The	worst (1st quartile)	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	High	High	Low	Yes
Ghana	worse (2nd quartile)	worse (2nd quartile)	worse (2nd quartile)	worse (2nd quartile)	Very high	High	Very high	Yes
Guinea	worst (1st quartile)	best (4th quartile)	worst (1st quartile)	worst (1st quartile)	High	High	High	Yes
Liberia	worst (1st quartile)	best (4th quartile)	worst (1st quartile)	worst (1st quartile)	Very high	Low	Very high	Yes
Mali	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	worst (1st quartile)	High	Low	Low	Yes
Mauritania	worst (1st quartile)	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	Very low	High	Very high	Yes
Niger	worst (1st quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	High	Low	High	Yes
Nigeria	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	worst (1st quartile)	Very high	High	High	Yes
Senegal	worse (2nd quartile)	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	Very high	Very high	Very high	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Sierra Leone	worst (1st quartile)	better (3rd quartile)	worst (1st quartile)	worse (2nd quartile)	Very high	Very high	High	Yes
Togo	worse (2nd quartile)	better (3rd quartile)	worse (2nd quartile)	worse (2nd quartile)	Low	Low	High	Yes
East Asia and Pacific regional average:					Low	High	Low	-
Cambodia	worse (2nd quartile)	best (4th quartile)	worse (2nd quartile)	worse (2nd quartile)	Very high	High	Very low	Yes
Indonesia	worse (2nd quartile)	best (4th quartile)	better (3rd quartile)	worse (2nd quartile)	High	Very high	Very low	Yes
Lao People's Democratic Republic	worse (2nd quartile)	best (4th quartile)	better (3rd quartile)	worse (2nd quartile)	High	High	Very low	No
Marshall Islands, The	worst (1st quartile)	best (4th quartile)	worst (1st quartile)	worse (2nd quartile)	Very low	Very low	Low	No
Myanmar	worse (2nd quartile)	worse (2nd quartile)	worse (2nd quartile)	worse (2nd quartile)	Low	High	Low	Yes
Papua New Guinea	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	worst (1st quartile)	Very low	Low	Very low	No

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Philippines	worse (2nd quartile)	better (3rd quartile)	better (3rd quartile)	better (3rd quartile)	Low	Very high	Very high	Yes
Tonga	worse (2nd quartile)	best (4th quartile)	worse (2nd quartile)	better (3rd quartile)	Very low	Very low	Very low	Yes
Vietnam	better (3rd quartile)	best (4th quartile)	best (4th quartile)	better (3rd quartile)	High	Very high	Very high	Yes
Europe and Central Asia regional average:					Low	Low	High	-
Albania	better (3rd quartile)	worst (1st quartile)	best (4th quartile)	best (4th quartile)	Low	Very low	Very high	Yes
Belarus	best (4th quartile)	better (3rd quartile)	best (4th quartile)	best (4th quartile)	Very low	Very low	Very high	Yes
Bosnia and Herzegovina	better (3rd quartile)	worst (1st quartile)	best (4th quartile)	better (3rd quartile)	High	Very low	Low	No
Georgia	best (4th quartile)	worse (2nd quartile)	worse (2nd quartile)	best (4th quartile)	High	Very low	Very high	Yes
Moldova	best (4th quartile)	worse (2nd quartile)	best (4th quartile)	best (4th quartile)	Very low	Low	Low	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
	Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs
Tajikistan	better (3rd quartile)	best (4th quartile)	worse (2nd quartile)	better (3rd quartile)	High	High	Very high	Yes
Türkiye	best (4th quartile)	better (3rd quartile)	better (3rd quartile)	best (4th quartile)	Very low	High	Very high	Yes
Uzbekistan	best (4th quartile)	best (4th quartile)	better (3rd quartile)	best (4th quartile)	Very high	Low	No needs	Yes
Latin America and the Caribbean regional average:					Low	High	High	-
Bolivia	worse (2nd quartile)	better (3rd quartile)	better (3rd quartile)	worse (2nd quartile)	Very low	Low	Very low	Yes
Colombia	better (3rd quartile)	better (3rd quartile)	worse (2nd quartile)	best (4th quartile)	Low	Very high	Low	Yes
Dominican Republic	better (3rd quartile)	worse (2nd quartile)	better (3rd quartile)	better (3rd quartile)	Low	Very low	Very low	No
Ecuador	better (3rd quartile)	worse (2nd quartile)	better (3rd quartile)	better (3rd quartile)	Low	High	Very high	Yes
El Salvador	better (3rd quartile)	best (4th quartile)	best (4th quartile)	better (3rd quartile)	Very low	Very low	Very high	Yes
Guatemala	worse (2nd quartile)	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	Very low	High	Very high	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Haiti	worst (1st quartile)	worse (2nd quartile)	worst (1st quartile)	worse (2nd quartile)	High	Very high	Very high	Yes
Honduras	better (3rd quartile)	worse (2nd quartile)	worse (2nd quartile)	better (3rd quartile)	High	Very high	Very high	Yes
Nicaragua	better (3rd quartile)	best (4th quartile)	better (3rd quartile)	worse (2nd quartile)	Low	Low	High	Yes
Panama	best (4th quartile)	best (4th quartile)	better (3rd quartile)	better (3rd quartile)	Very low	High	Very low	Yes
St. Lucia	worse (2nd quartile)	better (3rd quartile)	better (3rd quartile)	better (3rd quartile)	Very low	Low	High	Yes
Middle East and North Africa regional average:					High	Low	High	-
Djibouti	worst (1st quartile)	worst (1st quartile)	worse (2nd quartile)	better (3rd quartile)	Very high	Very high	Very high	Yes
Iraq	worse (2nd quartile)	better (3rd quartile)	worst (1st quartile)	better (3rd quartile)	Low	Low	Very low	No
Jordan	better (3rd quartile)	better (3rd quartile)	worse (2nd quartile)	best (4th quartile)	High	Low	Very high	Yes
Lebanon	better (3rd quartile)	worse (2nd quartile)	worst (1st quartile)	better (3rd quartile)	High	Very low	Very high	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Morocco	better (3rd quartile)	best (4th quartile)	better (3rd quartile)	worse (2nd quartile)	Low	High	Very high	Yes
Tunisia	better (3rd quartile)	worst (1st quartile)	best (4th quartile)	best (4th quartile)	Very low	Low	Low	Yes
Yemen, Republic of	worst (1st quartile)	better (3rd quartile)	worst (1st quartile)	worst (1st quartile)	Very high	Low	High	No
South Asia regional average:					High	High	High	-
Bangladesh	worse (2nd quartile)	best (4th quartile)	worse (2nd quartile)	worse (2nd quartile)	Very high	Very high	High	Yes
India	worse (2nd quartile)	better (3rd quartile)	worse (2nd quartile)	worse (2nd quartile)	Very high	Very high	Very high	Yes
Maldives	best (4th quartile)	better (3rd quartile)	best (4th quartile)	best (4th quartile)	Very low	High	No needs	Yes
Nepal	worse (2nd quartile)	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	Very high	High	Very high	Yes

(continued)

Country and region	Baseline needs				Human capital support before COVID	Reorientation for COVID	COVID support	Innovations for COVID
Country	Essential health services	Critical health services	Protect the vulnerable	Assure child welfare and social services	Human capital support before COVID-19	Extent of portfolio adjustment	Alignment with needs	Reported innovations
Pakistan	worst (1st quartile)	worse (2nd quartile)	worse (2nd quartile)	worst (1st quartile)	Very high	Very high	Very high	Yes
Sri Lanka	better (3rd quartile)	better (3rd quartile)	better (3rd quartile)	best (4th quartile)	High	High	Very low	Yes

Source: Independent Evaluation Group.

Note: The heat map uses information from evaluation portfolio and from human capital support before COVID-19 to World Bank projects in Health, Nutrition, and Population; Social Protection and Jobs; and Education Global Practice (before February 1, 2020) (World Bank, forthcoming). A country need is defined as the baseline indicator of an area in a country falling in the bottom two quartiles of the distribution across countries. Interventions are considered aligned with a country's needs if the country has at least one intervention addressing an area where the baseline indicators fall in the bottom two quartiles. Reorientation is defined as the number of World Bank projects and advisory services and analytics per country responding to COVID-19. Innovations were identified through the COVID-19 evaluation. The overall alignment of needs considers areas of critical health services, essential health services, protect poor people and vulnerable, and assure child welfare and social services, gender, digitalization, and community engagement. N = 78 countries.

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¹ The quartiles are based on the distribution of data in the countries for the latest available years.

² Where at least 50 percent of a country's indicator data were available, missing values were replaced with the regional average for the indicator. About 85 percent of countries had complete information since data sources were selected to consider the completeness of the data across countries in the portfolio. The data on access to health care (about 60 percent) and the social situation (about 70 percent) were less complete. In total, the analysis included 89 countries; 8 countries in the portfolio were filtered out for having incomplete data: Belize, Central African Republic, Dominican Republic, Grenada, Guinea-Bissau, the Seychelles, Saint Vincent and the Grenadines, and Tonga.

³ The 13 IHR capacities are legislation and financing, zoonotic events and the human–animal interface, food safety, laboratory, surveillance, human resources, national health emergency framework, health service provision, risk communication, points of entry, chemical events, and radiation emergencies.

⁴ The analysis focused on thematic areas supported by projects, needs in the country before COVID-19, the COVID-19 situation during the early response, and the types of operational instruments in the portfolio. All numerical features were standardized using group-wise min-max scaling.

⁵ The analysis compared k-means, spectral, and density-based spatial clustering of applications with noise.

⁶ The performance scores of the cluster analysis are Silhouette Coefficients 0.38, Caliński-Harabasz score 3.57, and Davies-Bouldin Index –0.95. These scores point to distinct differences between clusters. The clustering analysis points to features that average low or high in the group of countries compared with other countries, to draw attention to differentiating features of the World Bank's support. Differentiating features across country clusters are identified by reviewing the distance of the average values in a cluster from the mean of other clusters: one standard deviation above the mean, the value in the cluster is high; near the mean is medium; and one standard deviation below the mean is low.

⁷ A tenfold cross-validation means splitting the data into 10 pieces, using 9 of them as training data and the remaining as test data to produce a score. Then, to avoid dependence on a small subset of the data, the exercise is repeated nine more times, shifting the piece used for testing each time. Finally, the 10 resulting scores are averaged to get a final performance met-

ric. Adaptive Boost (AdaBoost) is an ensemble method that fits a predefined number of small decision trees, the first one on the original data set and subsequent ones on bootstrapped copies. The final decision is based on a weighted average of the decision of each decision tree. The AdaBoost analysis built 50 decision trees to identify the most important features to include in the model. A stop criterion was set to identify the top features, with a maximum of ten. A stepwise grid search was used to set the hyper-parameters of the model, and the final features were selected using backward feature selection. The performance of the decision tree using AdaBoost is compared with a simple decision tree, a random forest decision tree, and a random model below:

Performance measures
Random model baseline
Decision tree
*Adaptive
(final model)
Random forest
Features in model
Threshold
ROC-AUC
F1
Precision
Recall
Accuracy
-
50%
47%
52%
54%
49%
47%
5
7%
78%
75%
61%
98%
64%
8
47%
83%
72%
58%
100%
58%
8
49%
72%
69%
59%
87%
56%

Source: Independent Evaluation Group.

Note: The receiver characteristic of the area under the curve (ROC-AUC) is a performance score that considers the true and false positive rate to assess the classification performance, and it is the main metric used to maximize performance.

⁸ The human capital data on investment before COVID-19 was coded as part of a forthcoming IEG analysis. The human capital data covers Health, Nutrition, and Population; Social Protection and Jobs; and Education Global Practice projects between July 3, 2014 and January 15, 2020 (World Bank, forthcoming). Interventions to support human capital in countries before COVID-19 were reviewed in six areas: (i) essential health services (child survival and maternal mortality, improved equitable health access); (ii) critical health services (improved pandemic preparation capacity); (iii) protecting the vulnerable (connecting workers to jobs, expanded social program coverage, improved job skill readiness, improved targeting of lowest quintile, increased birth and social registration, integrated social protection systems); (iv) assure child welfare and social services (inclusive education, learning outcomes, quality of teaching, school environment, early childhood development, stunted growth of children); (v) gender (fertility and adolescent pregnancy, gender-based violence, female higher education and science, technology, engineering, and mathematics (STEM) enrollment, female labor participation); and (vi) digitalization (information and communication technology [ICT] policies, ICT for better targeting, ICT for quality service, digital skills). The total number of areas supported in a country before COVID-19 was used to identify countries with different levels of human capital support by quartiles (1 very low, 2 low, 3 high, 4+ very high). The analysis includes N=80 countries in the evaluation portfolio with available data on human capital support before COVID-19.

Appendix E. Rapid Review of Evidence on What Works in a Crisis and Alignment with the COVID-19 Response

This rapid review synthesizes recent evidence on the effectiveness of health and social interventions to support epidemics and crises. Its purpose is to answer the question, what is the relevance of the interventions implemented in the World Bank response to COVID-19? The findings highlight effective interventions and the extent to which they were a part of the COVID-19 response.

Methodology

The review was limited to studies with evidence of interventions supporting outputs and outcomes of the COVID-19 response. As COVID-19 called for a learning-oriented approach, a rapid scoping method was used (Arksey and O'Malley 2005; Levac et al. 2010), and evidence sources were limited to systematic reviews and country studies in English from low- and middle-income countries.¹ Minimum quality standards were assured by prioritizing peer-reviewed articles. The focus was on evidence from recent epidemics, such as Ebola, published after January 2016. Vaccination was not included in the search.

The search was conducted in two phases. The first phase was a broad search using the keywords “epidemic,” “outbreak,” or “pandemic.” The second phase was a *targeted search* using the keywords “crisis” or “emergenc*” and keywords related to the outputs and outcomes of the COVID-19 response.² Databases searched between November 15, 2020, and February 15, 2021, included EvidenceAid, PubMed, SCOPUS, Cochrane, Campbell, 3ie, J-PAL, World Bank Development Impact Evaluation, and World Bank Open Knowledge Repository. All article titles and abstracts were manually screened, then the full text of the remaining articles was reviewed.³ All searches were managed and

reviewed by two persons using the Covidence software. The final database was then created in Excel for analysis in Tableau. The final search phase yielded 70 relevant articles from PubMed (39 percent), SCOPUS (60 percent), and EvidenceAid (1 percent), with evidence on 50 interventions relevant to the COVID-19 response.

Evidence was synthesized to summarize what is known to work for crisis interventions and reviewed against World Bank support of the COVID-19 response. After extracting the relevant parameters from each article,⁴ the team synthesized the evidence by the relevant COVID-19 response area and categorized it as positive, negative, no effect, inconsistent, or no evidence, and tabulated it across articles.⁵ These interventions were then compared with the COVID-19 portfolio to assess alignment with World Bank support to countries.

The synthesis of evidence has some limitations:

- » Systematic reviews analyze multiple studies from different countries, making it challenging to exclude research conducted in high-income countries.
- » The use of systematic reviews examines evidence from past crises, but likely misses emerging new areas of evidence documented in primary studies. This includes new evidence released during COVID-19.
- » Evidence from past crises may not always be transferable to the COVID-19 response.
- » The review of evidence on social protection and education interventions is limited by a focus on epidemic and crisis situations, since there may be relevant studies from noncrisis periods that could provide evidence to inform the use of these interventions in a crisis.
- » There is a risk of double counting studies since systematic reviews may draw on the same studies.
- » The alignment of evidence with the portfolio is an estimate from the coded portfolio.

Alignment of Evidence with World Bank Support for COVID-19

The synthesized evidence identifies intervention areas that could be used to respond to COVID-19 and other crises and points to areas for further learning. The evidence for each intervention area is described in the following sections. The strongest positive evidence is for essential health services, infection prevention and control, health risk communication, and community engagement. However, the selection of interventions should be weighed against needs in the country context.

The World Bank's financing support to COVID-19 in countries is in areas where there is some positive evidence from past crises (figure E.1). The portfolio overall supports areas with some positive evidence: surveillance, case management, infection prevention and control, laboratories, social protection, and country-level coordination. However, the areas of essential health services, risk communication, psychosocial support, and community engagement account for only about 15 percent of the portfolio, despite the consistent positive evidence in these areas. Other key areas of support in the portfolio, such as remote learning, have limited published evidence on the use of interventions in crises and among vulnerable populations, and there is a need for further systematic learning.

Innovations and advisory services and analytics supported some areas where gaps in evidence exist or there is limited or inconsistent evidence, such as on expanding social protection, child learning, surveillance, country coordination in a crisis. However, more learning is needed regarding the effectiveness of interventions used for crises as evidence for interventions is often limited.

Figure E.1. Alignment of Evidence with World Bank Financing, ASA, and Innovation Support to the World Bank COVID-19 Response



Source: Independent Evaluation Group.

Note: Evidence data are from the rapid review of the literature, and data on World Bank support is from the COVID-19 portfolio is synthesized by area. The circle size denotes how many studies were identified in each response area; the circle color represents the average level of evidence on interventions within each response area. Response areas where no interventions occurred are excluded from this analysis. Ninety percent of the innovations identified in the portfolio mapped to areas for inclusion in the alignment exercise. ASA = advisory services and analytics; PPE = personal protective equipment; SRH = sexual and reproductive health.

Synthesis of Evidence on What Works

Assuring Health Support (See Table E.1)

Protecting health workers with personal protective equipment, especially face coverings, is effective (11 systematic reviews, 1 country study). The systematic reviews show consistent evidence for the effectiveness of surgical masks, N95 masks, and powered air-purifying respirators (Offeddu et al. 2017; Smith et al. 2016; Licina et al. 2020; Long et al. 2020; MacIntyre and Chughtai 2020).

Effective interventions to continue essential health services during an outbreak include telehealth and supporting community health workers to deliver services (6 systematic reviews and 2 country studies). Telehealth and telemedicine⁶ limit the exposure of health workers and their patients during outbreaks (Wang et al. 2020; Monaghesh and Hajizadeh 2020). Video consultations via mobile phone or internet are an accessible, acceptable, and cost-effective method of service delivery, and can help increase health service access (Sutherland et al. 2020). The risks include excluding communities who do not have access to phones or internet service and ensuring confidentiality (Sutherland et al. 2020). There is also consistent evidence on engaging community health workers and on the importance of delivering sexual and reproductive health services during emergencies, while evidence related to the provision of services by mobile clinics during crisis is inconsistent (Bhaumik et al. 2020; McGowan et al. 2020; Singh et al. 2018).

Case detection through active surveillance interventions has different findings for different models, such as universal screening, health facility-based case finding, and digital and automated contact tracing (5 systematic reviews, 2 country studies). A country study on health facility-based active case finding during an Ebola outbreak in Democratic Republic of Congo reported positive results in identifying cases (Kunkel et al. 2019). In China, COVID-19 active case surveillance was effective when combined with rapid case diagnosis and management and strict follow-up and quarantine of persons in close contact with infected persons (Xu et al. 2020). This finding is consistent with a **systematic review** of influenza response, which finds that contact tracing, when combined with other measures, such as isolation and quarantine, can reduce respiratory disease transmission and impact (Xiao et al. 2020). Active contact tracing, however, requires significant resources, and the use of digital tools might be a more efficient but requires study (Anglemyer 2020). The effectiveness of universal screening is uncertain, and an SR on the use of automated and semiautomated contact-tracing systems finds insufficient research to support the review (Viswanathan et al. 2020; Braithwaite et al. 2020).

Table E.1. Evidence for Interventions in Assuring Health Support

Specific intervention	Agent	Evidence
Protecting health workers and delivery of services		
Health worker use of masks, respirators, and other face coverings	Health structure	Positive (3+ studies) (5 SRs)
Health worker use of other PPE (gloves, gowns, and eyewear)	Health structure	Inconsistent (1 SR)
Health worker training (infection prevention and control, disease epidemiology, risk management)	Health structure	Positive (3+ studies) (1 SR and 1 CS)
Surging capacity of human resources	Health structure	Positive (3+ studies) (1 SRs and 1 CS)
Telehealth and telemedicine	Health structure	Positive (3+ studies) (4 SRs and 1 CS)
Community health worker training	Health structure	Positive (3+ studies) (1 SR)
Mobile clinics	Health structure	Inconsistent (1 SR)
Sexual and reproductive health services in emergencies	Health structure	Positive (3+ studies) (1 SRs)
Case management and surveillance		
Active case surveillance and contact tracing	Multisector coordination teams	Positive (3+ studies) (2 SRs and 1 CS)
Adapting palliative and hospice care	Health structure	Positive (3+ studies) (3 SRs)
Digital or automated contact tracing	Multisector coordination teams	Inconsistent (2 SR)
Rapid diagnosis and case management	Health structure	Positive (<3 studies) (1 CS)
Universal screening	Multisector coordination teams	Inconsistent (1 SR)
Facility-based active case finding	Health structure	Inconsistent (1 CS)
Quarantine measures (facility)	Health structure	Positive (3+ studies) (3 SRs and 1 CS)
Household quarantine	Community (citizens)	Inconsistent (1 SR)
Health information system	Health structure	Positive (3+ studies) (1 SR)
Artificial intelligence	Health structure	No evidence (1 LR)

Source: Independent Evaluation Group.

Note: CS = country study; PPE = personal protective equipment; SR = systematic review.

Effective models for case management during epidemics include health worker training, surge capacity to expand human resources and adapting health facilities, quarantine measures, and data collection and information systems (7 systematic reviews, 2 country studies).

- » **Health worker training:** A country study on Ebola in West Africa finds that the training of health workers increased knowledge and reduced fear (Ferranti et al. 2016).
- » **Surging capacity of human resources and facilities:** An effective method of improving surge capacity is to use shift workers, request temporary transfer of workforces from other facilities, volunteer, and retired employees (Sheikhbardsiri et al. 2017). A systematic review finds that adapting existing hospices to manage palliative patient cases helped increase facilities for case management (Etkind et al. 2020).
- » **Quarantine measures:** Quarantine and isolation of infected persons is effective in reducing respiratory disease transmission, especially when done in a health facility, though community-level quarantine has inconsistent evidence (Pasquini-Descomps et al. 2017; Xu et al. 2020; Nussbaumer-Streit et al. 2020).
- » **Information systems:** Two systematic reviews address improving case management using technology for collecting patient data and automating care in emergencies (Freeman et al. 2019; Tayarani-N 2020). Information systems can be effective tools, although they may not be inclusive since they are not readily available in low-resource settings.

Risk Communication and Community Engagement (See Table E.2)

In communities, prevention measures that combine face coverings, hand hygiene, and physical distancing are most effective (17 systematic reviews, 1 country studies).

- » **Community use of masks and other face coverings:** There is consistent evidence for the effectiveness of nonwoven facemasks, standard triple-layered medical masks, or surgical masks in reducing transmission of respiratory viruses (Abdullahi et al. 2020; Aggarwal et al. 2020; Camargo et al. 2020; Chu et al. 2020; Liang et al. 2020; Barasheed et al. 2016; Pawinee et al. 2020).

- » **Hand hygiene:** Frequent hand washing is associated with reducing the risk of infection during an outbreak (Pawinee et al. 2020). The effectiveness of face coverings and hand hygiene increases when preventive measures are combined (MacIntyre and Chughtai 2020; Pawinee et al. 2020; Kivuti-Bitok et al. 2020; Saunders-Hastings et al. 2016).
- » **Physical distancing measures:** Physical distancing, including social distancing mandates, has a modest impact on reducing transmission of influenza-like viral illnesses, unless combined with other prevention measures (Abdullahi et al. 2020; Chu et al. 2020; Nussbaumer-Streit et al. 2020; Pawinee et al. 2020; Xiao et al. 2020).

Table E.2. Evidence for Interventions in Risk Communication and Community Engagement

Specific intervention	Agent	Evidence
Community-level combined hygiene and protective measures	National government	Positive (3+ studies) (3 SR)
Community engagement for risk communication and infection control	Local government and health structure	Positive (3+ studies) (2 SRs and 1 CS)
Engaging pre-existing community organizations	Local government	Positive (3+ studies) (1 SR)
Community-level hand hygiene	Community (citizens)	Positive (<3 studies) (2 SRs and 1 CS)
Community use of masks, respirators, and other face coverings	Community (citizens)	Positive (3+ studies) (6 SRs and 1 CS)
Multimedia messaging	Multisector coordination teams	Positive (3+ studies) (1 SRs and 1 CS)
Physical or social distancing	Community (citizens)	Positive (3+ studies) (2 SRs and 1 CS)
Social media	Multisector coordination teams	Inconsistent (2 SRs)
Social marketing approaches	Multisector coordination teams	Positive (<3 studies) (2 SRs)
Use of psychosocial theory approaches that tailor risk communication strategies to different populations based on their characteristics	Multisector coordination teams	Positive (<3 studies) (1 SR)

Source: Independent Evaluation Group.

Note: CS = country study; PPE = personal protective equipment; SR = systematic review.

Risk communication using community-based messaging is effective for promoting protective behavior (5 systematic reviews). Effective models identified for risk communication employ a multipronged approach, including all-of-society involvement, and multimedia, combined with community-based messaging and sanitation and hygiene measures (De Buck 2017; Walker and Adukwu 2020; Xu et al. 2020). Targeted interventions for at-risk and vulnerable groups are also effective in increasing knowledge and changing attitudes and practices (Walker and Adukwu 2020). Community-based messaging is more effective than social marketing interventions targeting segments of the population (De Buck 2017; Jackson et al. 2017). One systematic review on community health workers reported that, in previous pandemics, community health workers were effective in promoting prevention practices (Bhaumik et al. 2020).

The effectiveness of social media for risk communication is not well studied (2 systematic reviews). Two systematic reviews on the emerging use of social media did not find sufficient evidence of effectiveness; however, they highlighted important trends, such as the use of social media by governments to communicate with the public (Tang et al. 2018; Muniz-Rodriguez 2020). Social media is also used for assessing community response and needs, including studying knowledge, perceptions, and psychosocial impact (Muniz-Rodriguez 2020). There is no evidence on how to manage the risk of misinformation in social media.

Strategic community engagement is an efficient, inclusive, and sustainable means of maintaining social cohesion during an emergency. Evidence (1 systematic review) shows this includes engaging pre-existing community organizational structures and pre-emergency leaders (Jackson et al. 2017).

Assuring Child Welfare and Social Services (See Table E.3)

School closures have mixed effectiveness in delaying transmission and are unsustainable (4 systematic reviews). One systematic review finds school closures to be highly effective in delaying transmission peaks in influenza epidemics (Bin Nafisah 2018). Another systematic review finds that school closures during the Severe Acute Respiratory Syndrome (SARS) outbreak in

Asian countries had no impact on transmission (Viner et al. 2020). Another systematic review reports inconclusive findings with a tendency toward effectiveness in slowing transmission (Xiao et al. 2020). School closures are unsustainable as a disease outbreak response measure and were detrimental to children, especially vulnerable children (Cen et al. 2020).

Mental health programs are effective interventions to protect the mental health of essential workers, vulnerable populations, and the public during emergencies (8 systematic reviews). Telehealth and web-based interventions are cost-effective alternatives for delivering mental health care (Yue et al. 2020). Telehealth can also help ensure mental health service delivery to vulnerable populations and in low-resource settings (Ashfaq et al. 2020; Augusterfer et al. 2020). Psychosocial programs—group-based cognitive behavioral therapy, psychological first aid, community-based psychosocial arts programs, interventions delivered through telemedicine and online mental health services, and community mental health services—are effective in alleviating symptoms of stress and managing mental health conditions in crises contexts (Bangpan et al. 2019; Cénat et al. 2020; Lipinski et al. 2016; Papola et al. 2020; 2018; Wang et al. 2020; Yue et al. 2020).

Table E.3. Evidence for Interventions in Assuring Child Welfare and Social Services

Specific intervention	Agent	Evidence
Online education	Schools	No evidence (1 SR)
Psychosocial programs	Health structure	Positive (3+ studies) (6 SRs and 1 CS)
School closures	National government	Positive (3+ studies) (4 SRs)
School reopening	Schools	No evidence (1 SR)
Workplace mental health services	Health structure	Inconsistent (1 SR)
Telehealth and telemedicine	Health structure	Positive (<3 studies) (2 SRs, 1 CS)

Source: Independent Evaluation Group.

Note: CS = country study; SR = systematic review.

Social Protection of Vulnerable (See Table E.4)

Limited evidence exists on social protection during epidemics and crises (1 systematic review). One SR finds strong evidence for the efficiency and effectiveness of unconditional cash transfers and vouchers provided to vulnerable families during an emergency (Doocy and Tappis 2017). Conditional transfers require more complex infrastructure to monitor compliance.

The protection of girls through financial and social support is effective (1 systematic review). One systematic review finds that financial support, such as cash transfers and finding of livelihood skills, and social support, such as mentorship and provision of safe spaces, show promising results in protection of girls in a crisis (Noble et al. 2019).

Table E.4. Evidence for Interventions in Social Protection and Households

Specific intervention	Agent	Evidence
Financial and social support for protection of vulnerable girls in humanitarian settings	Local government	Positive (3+ studies) (1 SR)
Unconditional cash transfers	National government	Positive (3+ studies) (1 SR)

Source: Independent Evaluation Group.

Note: CS = country study; SR = systematic review.

Strengthening of Country and Regional Coordination (See Table E.5)

Regional coordination can enhance the ability of a country to respond to health emergencies (1 systematic review, 1 multicountry study). One systematic review finds that regional initiatives in the Caribbean have been effective in ensuring unity of response in public health emergencies (Chattu and Chami 2020). A multicountry study of the cooperation between Benin, Nigeria, and Togo to manage Lassa Fever outbreaks shows that enhanced communication and information sharing to rapidly identify and respond to cross-border transmission is an effective intervention (Kakaï 2020).

Prompt and consistent policies affect the performance of the response (1 systematic review, 1 country study). A study of China's early response to COVID-19 finds that the prompt formation of high-level policy is effective in activating management of the response at all government levels (Xu et al. 2020). Inconsistent policy guidance during an epidemic can lead to uneven policy implementation (Chughtai and Khan 2019). Workplace closures can also be an effective policy, depending on the epidemic severity and their social and economic costs (Ahmed et al. 2018).

More real-world evidence is needed regarding the effectiveness of points of entry, international travel, and transport interventions in responding to epidemics (3 systematic reviews). One SR finds some positive impact of travel bans specific to Severe Acute Respiratory Syndrome (SARS) and Ebola based on modeling studies, but not on studies based on real-world events (Errett et al. 2020). Limited evidence is available on the effectiveness of entry screening, although it is more effective when combined with quarantine, observation, and testing measures (Burns et al. 2020). Entry screening does not directly prevent the spread of disease but can provide an opportunity for awareness, education, and communication (Mouchtouri et al. 2019).

Surveillance systems enable detection of diseases efficiently and effectively, though they need to ensure standardization of surveillance indicators and methodology (3 systematic reviews, 1 country study, 1 multicountry study). Evidence from systematic reviews and country studies supports the building of country-level and multicountry surveillance systems as an efficient and

cost-effective way to build resilience against disease outbreaks (Craig et al. 2018; Pasquini-Descomps et al. 2017; Roshania 2016). A review of community-based surveillance systems finds that they were potentially an effective, inclusive, and sustainable means of rapidly identifying outbreaks and reducing the burden on health facility staff. However, the study recommends further learning to standardize protocols (Guerra et al. 2019). Geographic information systems are useful for detecting many diseases for early response (Sulistyawati and Fatmawati 2020). One systematic review finds computer models and algorithms effective in assisting planners to better understand population needs during the emergency phase of a crisis, and in strengthening resilience to future emergencies (Freeman et al. 2019).

Improved medical and laboratory supply capacities, such as stockpiling, rationing, point-of-care diagnostics, and collaborative aid networks are effective in managing supplies, though more evidence is required on effective logistics in emergencies (4 systematic reviews). One systematic review finds that stockpiling medicines and laboratory supplies and antivirals during the H1N1 influenza was cost-effective (Pasquini-Descomps et al. 2017). Another systematic review finds the rationing of medical supplies is an effective intervention, though the long-term sustainability of this approach is questionable (Sheikhbardsiri et al. 2017). One systematic review examines collaborative aid networks across organizations for emergency response, which compare favorably with deploying individual nongovernmental organizations for emergency logistics, as they can support longer-term strengthening of partnerships and systems (Bealt and Mansouri 2018). In terms of laboratory technology, point-of-care diagnostics—which provide devices for prompt and accurate diagnosis in the clinic without requiring complex laboratory procedures—can be an effective and sustainable solution for improving capabilities in low-resource settings (Semret et al. 2018). There is a dearth of published literature on different models for sourcing, delivery, and distribution of health-care commodities for emergencies (Babatunde et al. 2020).

Table E.5. Evidence for Interventions in Strengthening Country-Level Coordination

Specific intervention	Agent	Evidence
Coordination and policy		
Regional coordination	National government	Positive (3+ studies) (1 SR & 1 CS)
Prompt and consistent policies	National government	Positive (<3 studies) (1 SR & 1 CS)
Travel control	National government	Positive (3+ studies) (4 SR)
Work closure and restrictions	National government	Positive (3+ studies) (1 SR)
Surveillance systems		
Computer models and algorithms	National government	Positive (3+ studies) (1 SR)
Community-based surveillance	Multisector coordination teams	Inconsistent (1 SR)
Country-level surveillance systems	National government	Positive (3+ studies) (1 SR & 1 CS)
Geographic information systems	National government	Positive (3+ studies) (1 SR)
Multicountry clinical surveillance and data collection system	National government	Positive (<3 studies) (1 CS)
Medical and laboratory supply capacities		
Emergency medical supplies and logistics models in humanitarian settings	National government	No evidence (1 SR)
Collaborative aid networks	Local government	Positive (3+ studies) (1 SR)
Point-of-care diagnostics	Health structure	Positive (3+ studies) (1 SR)
Rationing of medical supplies	Health structures	Positive (3+ studies) (1 SR)
Stockpiling of antivirals	National government	Positive (<3 studies) (1 SR)

Source: Independent Evaluation Group.

Note: CS = country study; SR = systematic review.

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¹ The underlying research for SRs had to include at least one study conducted in a low- and middle-income country.

² Keywords for the first search phase were “epidemic” “disease outbreaks” “outbreak” “pandemic” “infect*disease” and “infectious disease outbreak.” In the second search phase, the keywords “crisis” and “emergency” were combined with keywords relating to output and outcome areas of the COVID-19 response: assure health services (“health servic*” “health system” “essential servic*” “human resourc*” “case management” “laborator*”); assure child welfare and social services (“child welfare” “social welfare” “educat*” “school*” “learn*” “mental health” “psychosocial*” “gender-based violence” “women empowerment” “girl*” “parent*” “caregiver*” “youth” “adolescent”); risk communication and community engagement (“communit*” “engag*” “social participation” “engagement” “mobilization” “behavior” “citizen*” “cohesion” “sanitation” “hygiene” “safety”); social protection of vulnerable persons and households (“social protection” “vulnerab*” “poverty” “risk group*” “at-risk” “safety net” “asset*” “livelihood*” “food security*” “informal”); strengthened national and subnational preparedness (“prepared*” “read*” “public policy” “public” “policy” “coordination” “strengthening” “institut*” “capacity” “public good*” “supply chain” “food supply” “water supply” “local government”).

³ The first phase of searching identified 5,524 articles, and the second phase identified 11,237 articles, which were reduced after removing duplicates and abstract and full text screening. Out of a concern for lack of generalizability, the review excluded studies focused on malaria, HIV and AIDS, tuberculosis, and nonemergency settings. In addition, the review excluded studies on the efficacy of drugs, vaccines, and medical treatment interventions, and on nutrition, which is addressed by another Independent Evaluation Group (IEG) evaluation (World Bank 2021).

⁴ A data charting form extracted parameters from articles: the study objective(s); interventions targeted; outcomes measured; the effect of each intervention; the beneficiary and agents delivering the intervention; and whether the intervention addressed factors related to resilience, inclusion, sustainability, and efficiency, as guided by the RISE Framework (World Bank 2020).

⁵ Intervention study results scale levels are negative, positive, no effect, inconsistent, and no evidence. Negative – articles reviewed find a negative effect of the intervention on the intended outcome; positive – articles reviewed find a positive effect on the intended outcome; no effect – articles reviewed find no significant effect on the intended outcome; inconsistent –

articles reviewed find mixed evidence on the intervention (positive, negative, or no effect); no evidence – articles reviewed did not find studies on the intervention. The final categorization of an intervention is based on the summation of all studies in that intervention category.

⁶ Telemedicine is the remote provision of clinical services, and telehealth, which includes telemedicine, is the broader provision of clinical and nonclinical services using electronic communication and information technology (WHO 2006).

Appendix F. Review of World Bank Successes and Challenges from Past Crises to Inform the COVID-19 Response

What have we learned from past crises to facilitate effective response? The Independent Evaluation Group (IEG) conducted a review of World Bank operations that supported health and social emergencies in the years 2000–20. The lessons were then used to identify findings on common successes or challenges that facilitated or hindered implementation of crisis responses, which could be benchmarked to understand the implementation successes of the World Bank’s early COVID-19 response.

Methodology

The review identified lessons from past crisis, synthesized these lessons, and used the findings to benchmark implementation successes and challenges of the COVID-19 response. The past crises covered by these projects include disease responses, such as avian influenza, Ebola, and cholera, and natural disasters, such as drought, flooding, and hurricanes.

- » **Identification of lessons from past crisis.** A search of the World Bank’s operations database between January 2000 through December 2020 identified 308 closed projects evaluated by IEG. The project development objectives and titles were searched for keywords (“crisis” “emergency” “epidem*” “disease” AND “outbreak” ”pandemic”). Then, a targeted search of the summary, component descriptions, and indicators used keywords related to the COVID-19 health and social response.¹ This identified 170 projects from which 436 lessons were extracted from Implementation Completion and Results Report Reviews and Project Performance Assessment Reports. Most of the lessons were from the Health, Nutrition, and Population (182), Urban (139), Agriculture (47), and Social Protection and Jobs (29) Global Practices, with the remaining spread across the other GPs (39).

- » **Synthesis of lessons from past crises.** Lessons were coded in Excel to understand the successes and challenges of projects that hindered or facilitated implementation in countries. This was done by grouping lessons to identify similar successes and challenges of projects related to areas of the theory of action of the evaluation: addressing needs of countries; supporting implementation and learning during crisis; and internal processes and partnerships to support implementation). In total, 256 lessons on successes and challenges were identified and coded—about 60 percent of the original 436 crisis-related lessons. These lessons were coded by three evaluators for quality assurance.²
- » **Benchmarking of findings against COVID-19 response.** The COVID-19 portfolio review extracted 566 successes and challenges from Implementation Status and Results Report of active projects and coded them against the same areas used for coding past lessons. This enabled the analysis to compare reported successes and challenges in the COVID-19 response to findings on past crises and combine the COVID-19 portfolio data with past projects' data for analysis in Stata. Findings were then visualized in Tableau.

Factors that Facilitated Effective Crisis Response

The synthesis of past lessons highlights common factors that can facilitate implementation of a crisis response (box F.1). The factors are organized according to the evaluation's theory of action and relate to internal operational support of World Bank task teams and country and client activities to supply services and support demand-side activities in communities. The findings suggest that projects with successes in these areas may be more likely at completion to have satisfactory project outcome ratings in Implementation Completion and Results Report Reviews, compared with projects encountering challenges.³

Box F.1. Factors that Can Facilitate Effective Crisis Response Implementation

Addressing Needs of Countries

Ongoing responsiveness to needs during a crisis is supported by frequent dialogue to help navigate immediate realities on-the-ground, while maintaining a longer-term focus on development priorities and objectives. Lessons included:

- » Engage in continuous dialogue with the government sectors during planning and throughout implementation to address evolving needs for immediate support and longer-term reforms.
- » Use diagnostics to tailor project support to address emerging needs.
- » Draw on existing capacities and activities to quickly shift implementation in needs areas.
- » Prioritize early support to ministries with the highest potential impact on the crisis.
- » Target support to high-risk or vulnerable groups most likely to be affected by the crisis.
- » Focus projects on a few emergency activities that address key needs for the response, including demand- and supply-side activities to delivery services and engage communities.

Coordinating roles and areas of support throughout implementation with government and partners to address emerging priorities in a country's response. Lessons included:

- » Coordinate with all levels of government and with development partners to align actions and resources during planning and throughout implementation.
- » Coordinate the support of different projects and sectors to provide immediate support and plan actions to address long-term needs for recovery.

Supporting Implementation and Learning in Countries

Multisector coordination and coordination at national and subnational levels helped ensure an effective response that reached local actors. Lessons included:

(continued)

Box F.1. Factors that Can Facilitate Effective Crisis Response Implementation (Cont.)

- » Support existing government structures and networks to coordinate actions to build capacity for managing crises.
- » Support multisectoral groups to coordinate implementation across ministries and agencies.
- » Promote dialogue between national and subnational actors to help articulate strategies at various levels and share information.

Continuous engagement with government helped support corrective actions based on learning and shifting situations. Lessons included:

- » Provide continuous supervision to help the government address shifting priorities.
- » Strengthen monitoring and evaluation (M&E) arrangements and communication regarding data to promote learning.
- » Ensure candor in implementation and timely decisions on course correction and adjustments.
- » Provide technical support in challenge areas to help advance implementation.

Engaging government in ongoing monitoring of priorities and reach of beneficiaries in key areas of response. Lessons included:

- » Draw clients into a learning-by-doing approach, reviewing M&E and country demands.
- » Engage all relevant collaborators in a dialogue to plan and implement tailored interventions.
- » Support community-level interventions that are based on local priorities.
- » Provide user-friendly technical tools and guidance to support implementation.
- » Establish a quality assurance system for local services.
- » Support community-based systems for surveillance, health education, and service delivery.

(continued)

Box F.1. Factors that Can Facilitate Effective Crisis Response Implementation (Cont.)

- » Engage local government and communities to facilitate the monitoring of the response.

Monitoring of behavior change was important for effective communication approaches. Lessons included:

- » Support consistent communication messaging to improve the awareness of all stakeholders.
- » Use surveys and other assessments to track changes in beneficiary behaviors and barriers.
- » Assess gender barriers to case management in an epidemic and to continued access of health and social services.
- » Develop culturally and gender-sensitive interventions by involving community and local providers.

Operational Policies and Partnerships (Corporate Level)

Partnership and collaboration enabled projects to develop synergies to rapidly implement emergency actions. Lessons included:

- » Establish partnerships with experienced agencies to support new approaches, technical learning, and deliver interventions that reach communities.
- » Facilitate information sharing across partners on the response.
- » Conduct joint diagnostic work to help build consensus on response strategies among actors.

Flexibility in operational procedures helped clients to rapidly access resources for a timely response while maintaining the requirements to manage fiduciary risk. Lessons included:

- » Draw on emergency contingency resources in the portfolio to support immediate actions.
- » Reallocate financing from existing active projects in the portfolio. *(continued)*

Box F.1. Factors that Can Facilitate Effective Crisis Response Implementation (Cont.)

- » Allow for additional financing to support rapid disbursement over developing a new project.
- » Allow for retroactive financing to support rapid implementation early in the crisis.
- » Design new projects with flexible procedures that allow for rapid processing.
- » Use performance-based financing to provide results-oriented financing for ministries.

Streamlining implementation support to projects allowed for the rapid implementation of crisis measures. Lessons included:

- » Prepare terms of references and technical specifications in advance of project implementation and share examples.
- » Apply global templates to simplify new project design.
- » Facilitate procurement of international supplies to help countries with limited access to goods.
- » Phase implementation of project activities for smoother processes.
- » Spread procurement needs across projects to reduce centralized delays.
- » Use data and indicators from existing systems and stakeholder efforts to simplify M&E.
- » Engage closely with safeguard and procurement specialists to support urgent processes.

Source: Independent Evaluation Group review of lessons.

Note: M&E = monitoring and evaluation.

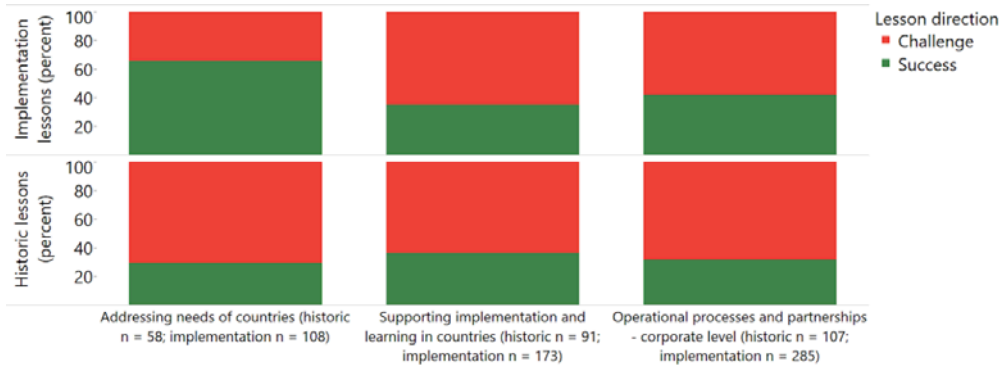
Benchmarking Factors from Past Crises Against the COVID-19 Response

The same factors that facilitated or hindered implementation of past crisis responses are also present in the COVID-19 response, with evidence that the World Bank learned from experience. Figure F.1a compares the distribution of lessons on successes and challenges between past crisis and COVID-19. Figure F.1b presents the areas of successes and challenges reported by World Bank project teams in the early COVID-19 response.

- » Compared with past crisis responses, the COVID-19 response shows more success in supporting the needs of countries. Support to operational processes and partnerships also shows improvement in the COVID-19 response relative to past crises. Successes reported by COVID-19 projects frequently relate to streamlining operational processes and to World Bank teams being continuously responsive to help government to navigate the situation in countries. Notably, operational flexibility and streamlining operational processes were also challenges, given the confusion about the real-time development of operational guidance and the lack of flexibility in operational guidance for projects. Partner collaboration was also a challenge in some countries, where relationships were not established before COVID-19.
- » Quality support to implementation and learning is a persistent challenge from past crises that has carried over to the COVID-19 response. There was some success in providing support to corrective actions in countries, though the challenge was the limited access to data to inform course corrections. Moreover, working by distance due to travel restrictions made local project supervision challenging. Other specific challenges reported relate to supporting multisectoral and subnational coordination of the response as few countries had platforms setup for this purpose. Box F.2 lists examples of successes and challenges reported in the early COVID-19 response.

Figure F.1. Successes and Challenges Reported in the COVID-19 Response and Past Crises

a. Share of successes and challenges reported in the COVID-19 response, compared with past crises by area



b. Breakdown of factors of successes and challenges reported in COVID-19 response areas



Source: Independent Evaluation Group lessons analysis.

Note: The COVID-19 portfolio includes 566 lessons (252 successes and 314 challenges) extracted from 158 projects. The historical portfolio of past lessons includes 256 lessons extracted (84 successes and 172 challenges) from 114 projects. Ongoing responsiveness to needs considers ongoing support to dialogue, diagnostics, drawing on existing capacities, prioritization of support to sectors, and targeting vulnerable groups. Coordinating roles and areas of support looks at the alignment with development actors and plans. Multisector coordination considers coordination across sectors nationally and of sub-national actors. Continuous support for corrective actions considers adjustments made through project supervision and management. Monitoring priorities looks at use of monitoring data with clients improve the quality of the response in local areas. Monitoring of behavior change considers communication and the monitoring of barriers and behaviors. Partnership and collaboration considers partnerships to support implementation, information sharing, and joint analyses. Flexibility in operational procedures looks at the timely processing of new financing for the response. Streamlining implementation support to projects considers factors that facilitated rapid client support in projects.

Box F.2. Examples of Successes and Challenges Reported in COVID-19 Response

Successes

- » Integrating sanitation and learning activities into school-based performance contracts.
- » Using digital tracking measures to monitor community implementation.
- » Adopting emergency procurement procedures to expedite the hiring of needed experts.
- » Streamlining procedures and delegating approval processes for agile project implementation.
- » Conferring with clients and regularly using available data to manage implementation, assess progress, and make adjustments.
- » Constantly monitoring and sharing knowledge among the project implementers and the World Bank team to innovate and solve problems.
- » Reviewing how risk factors are communicated through various channels and tailoring communication messages to different target groups.

Challenges

- » Weak communication and coordination among line ministries in sectors to deliver support.
- » Slow processes in ministries that are not conducive to quick decision-making on emergency actions.
- » Limited readiness of actors in countries to take rapid actions to implement health measures.
- » Difficult procurement processes forcing ministries to seek items from other sources or cancel requests.
- » Delays in project implementation due to burdensome national guidelines for procurement and recruitment and onerous requirements for parliament approval and opening a bank account.

Source: Independent Evaluation Group portfolio.

These findings suggest that the extent of successes and challenges reported in projects matters. Projects supporting the COVID-19 response that have a higher share of success factors reported in their Implementation Status and Results Reports are likely to have satisfactory project implementation ratings, and conversely, projects with more challenges may risk an implementation rating below satisfactory below satisfactory below satisfactory.⁴

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¹ Keywords used for the targeted search of lessons relevant to the COVID-19 health and social response framework were “crisis” AND “health”; “emergency” AND “health”; “emergency” AND “disease”; “crisis” AND “disease”; “emergency” AND “laborator”; “crisis” AND “laborator”; “crisis” AND “surveillance”; “emergency” AND “surveillance”; “crisis” AND “infection”; “emergency” AND “infection”; “epidem*” “disease outbreak*” “disease” AND “outbreak*”; “pandemic*”; “risk” AND “communication”; “food security”; “livelihood”; “informal”; “asset” AND “accumulation”; “psycho*”; “mental health”; “youth”; “parent”; “girl”; “adolescent”; “child AND school”; “child AND learn”; “child AND welfare”; “child”; “local government”; “local” AND “service*”; “public good”; “sanitation”; “water supply”; “hygiene”; “safety”; “food supply”; “supply chain*”; “coordination”; “multisector*” “service*” AND “deliver*”; “policy”; “digital*”; “strengthening”; and “institut*” AND “capacity.”

² The remaining lessons were manually excluded for lack of completeness or for being outside the scope of the evaluation framework.

³ A Chi-Square test of independence between project outcome rating and lesson direction yields a Chi-Square Test Statistic equal to 39.85 with a p-value of 0.000. The null hypothesis of no association between these variables is rejected at the 1 percent significance level. Moreover, a significant positive correlation exists between the share of successes reported in these factor areas with project outcome ratings; and conversely a significant negative correlation between the share of challenges reported in these factor areas with project outcomes. The Pearson Correlation coefficients are significant at $p < 0.1$. $N = 112$ projects and 250 lessons; two projects of the original 114 do not have development outcome ratings.

⁴ A significant positive correlation exists between the share of successes reported in the nine factor areas with satisfactory project implementation ratings (highly satisfactory or satisfactory); and a significant negative correlation between the share of challenges reported in the nine factors with less than satisfactory project implementation ratings (moderately satisfactory or moderately unsatisfactory). The Pearson Correlation coefficients is significant at $p < 0.1$. $N = 147$ projects and 524 lessons; 11 projects of the original 158 do not have implementation ratings.

Appendix G. Review of COVID-19 Support by Regional Projects

Objective

The regional project review sought to document how regional projects have added value to support COVID-19 responses in countries. The review looked at four regional projects: Regional Disease Surveillance Systems Enhancement (REDISSE) project in 16 countries in West and Central Africa; Africa Centres for Disease Control and Prevention (CDC) project supporting all African Union (AU) member states and linked to national-level support in Ethiopia and Zambia; East Africa Public Health Laboratory Networking (EAPHLN) project in five countries; and Organization of Caribbean States (OECS) Regional Health project in four Eastern Caribbean countries. These projects were the main regional projects identified in the portfolio supporting COVID-19, and in discussion with GPs. The projects are summarized in table G.1 at the end of this appendix.

Methodology

Outcome harvesting (Grau-Wilson 2019) was used to identify emerging results, with a focus on how the four projects facilitated actions for the COVID-19 response in the regions and countries supported. Detailed information in verified “outcome statements” was collected from project documents (such as Implementation Status and Results Reports, Aide Memoires, and meeting reports) and about 30 key informant interviews (from World Bank task teams and implementing actors in countries) about response actions achieved to support the COVID-19 response. The outcome statements were documented using a protocol to detail consistent information across projects on what actions were taken to support COVID-19 responses, who was involved, when and where, why it was significant, and how the project provided financing or other support. The outcome statements were verified in a review process with project teams and implementers in the countries.

The timeline of the analysis is the evaluation period (February 1, 2020, to April 30, 2021), and interviews were conducted between April and June 2021. The findings were organized by thematic areas to identify early results stories of regional project support to COVID-19 responses and analyze the value-added of this support to the countries. A limitation of this analysis was it looked at early resulted support of regional projects to COVID-19, but it did not assess regional project support outside of that to COVID-19. Moreover, while outcome harvesting provides a useful means of backward-tracing verified outcomes, selecting on outcomes may introduce biases of omission relative to which areas were and were not explored in interviews and identified in documents.

Findings: Early Results Stories

The outcome harvesting identified early results for all four projects, though intensified for countries with a longer duration of regional support before COVID-19 (such as Senegal and Togo, covered by early phases of REDISSE). Regional projects were well-situated to support critical health services for the COVID-19 response when the projects were established years before COVID-19, were supported by a regional organization with capacity to facilitate knowledge exchange and coordination and were well integrated with project support in their respective countries. Stories of early results reported by interviewees relate to 1) regional coordination to facilitate rapid country responses to COVID-19 response; 2) human resources capacities to implement the COVID-19 response; and 3) expansion of surveillance, testing, border screening, case management, and infection prevention and control (IPC) for COVID-19 response. There was also limited support to vaccination.

Regional Coordination to Facilitate Rapid Country Responses for COVID-19

Regional coordination supported by the projects—whether of ministerial committees, public health institutes, or project leaders—contributed to rapid COVID-19 responses in all regions (box G.1). Coordination mechanisms were used to share real-time information and knowledge on detection and best practices, engage with regional and international partners, develop guidance

on surveillance, and exchange peer support. In three of the projects (Africa CDC, REDISSE, and EAPHLN), the cooperation structures established before COVID-19 emerged, allowing immediate political and technical coordination when the emergency was declared. For the fourth project, the formation of a regional advisory committee by OECS Regional Health coincided with the onset of COVID-19 and complemented existing region-wide structures.

All 15 Economic Community of West African States countries have benefited from REDISSE, not just the 11 countries implementing the project. The spillover effect of REDISSE came through countries' participation in regional activities and development of policies, strategic documents, and meetings, such as the regional ministerial meetings and monthly meetings convened by the West African Health Organization (WAHO) to monitor the COVID-19 situation. For example, Burkina Faso, Cabo Verde, Côte d'Ivoire, and Ghana (all non-REDISSE countries) benefited from WAHO's guidance on their national COVID-19 plans, and REDISSE supported strengthening a regional reference laboratory in Ghana that has been valuable during the pandemic.

Box G.1. Regional Coordination and Country Leadership for COVID-19

In West Africa, the COVID-19 response benefited from rapid and ongoing high-level political leadership and technical coordination at the regional level supported by REDISSE. The coordinated political response contrasts with the 2014–16 Ebola outbreak, when countries struggled to integrate their responses. Regional ministerial committees formed after the earlier Ebola outbreak were already organized and better prepared (with the required leadership support) to make rapid decisions when COVID-19 emerged. For example, in early 2020, the West African Health Organization (WAHO) developed a regional COVID-19 response plan agreed to by ministers. This plan has been regularly updated and used to guide consistent plans, messaging, guidelines, and policies at regional and national levels. An important area of regional political coordination and planning has been the strong cooperation between initially weak national public health institutes on COVID-19 guidelines, surveillance, and training. This cooperation provided a basis to coordinate technical support and resources with partners, such as Africa Centres for Disease Control and Prevention (CDC), WHO, and UNICEF. High-level coordination also facilitated testing of travelers within the region when the

(continued)

Box G.1. Regional Coordination and Country Leadership for COVID-19 (Cont.)

cost of polymerase chain reaction (PCR) testing was agreed to in a ministerial committee and approved at a heads of state summit.

Source: Independent Evaluation Group outcome harvesting analysis.

In East Africa, the surveillance teams of EAPHLN countries regularly met online to discuss their COVID-19 strategies and exchange experiences on the implementation of their response plans. These discussions allowed governments to learn from each other and adjust their COVID-19 responses accordingly.

As countries in the Caribbean raced to set up polymerase chain reaction (PCR) testing, more than half benefited from timely testing and variant surveillance provided by regional institutions supported by the OECS Regional Health, namely the Caribbean Public Health Agency (CARPHA) and University of West Indies. Many countries benefited from CARPHA's guidance on establishing in-country PCR testing. This shows the value of both direct service delivery by regional expert institutions and technical support to government agencies.

In early 2021, the government of Zambia launched Southern Africa's Regional Collaboration Center (RCC) for the Africa CDC, with the newly independent Zambia National Public Health Institute as the host organization. The creation of this key part of the Africa CDC structure demonstrates strong political will by Zambia, a country that shares its borders with eight others, to strengthen coordination, capacity building, and information sharing between Southern African countries. RCCs are hubs for disease surveillance, prevention, preparedness, control, and emergency response activities. The establishment of this RCC has already supported regional collaboration on disease surveillance and preparedness for COVID-19, and Ebola and other outbreaks that have overlapped with COVID-19. This coordination shows how fostering collaboration and networking can later help countries agree on common response frameworks for diseases threatening a region. The independence of the institute and the creation of a national public health

laboratory mandated in the Zambia National Public Health Institute Act, 2020, provide a strong basis to strengthen the role of the Southern Africa RCC in supporting COVID-19 responses in the 10 AU member states in the region. Granting autonomy to a national public health institute is unprecedented in Africa and was completed rapidly in December 2020, showing the government's strong commitment.

Regional knowledge sharing through project committees and other platforms in Africa and the Caribbean accelerated COVID-19 responses by allowing experts from different disciplines to exchange experiences and information in real time. In the Eastern Caribbean, peer-to-peer sharing of knowledge on local expertise in health waste management and the installation of laboratory and health equipment allowed governments to respond faster, a key consideration at a time when the travel of global expert technicians was restricted. In Africa, public health institutes and health ministries used the Africa CDC regional Extension for Community Health care Outcomes platforms for interdisciplinary knowledge exchange and training on COVID-19. Other uses of Extension for Community Health care Outcomes include surveys to identify strategies and training in surveillance, case management, and planning, knowledge management delivered to several hundred participants from nearly all AU countries. The Zambia National Public Health Institute, in its role as the interim Southern Africa RCC, used Extension for Community Health care Outcomes weekly to connect in AU countries. Kenya and Ethiopia used the platform for real-time exchange on COVID-19 testing and risk communication.

The regional public health bodies for Africa (Africa CDC) and the Caribbean (CARPHA) updated emergency procurement procedures to facilitate rapid COVID-19 response. Intense global demand for the same products and the urgent need to organize COVID-19 responses meant that standard procedures were insufficient for regional bodies to provide timely technical and logistic support to member countries. In Africa, with the emergency guidelines, the Africa CDC played its intended role as coordinator and facilitator of procurement to address the needs of AU members and provide timely expert technical, logistical, and operational support. For example, through using emergency procurement procedures, Africa CDC now has full staff ca-

capacity (increased to 65 staff from about 30). In the Caribbean, the procedures made the timely purchase of COVID-19 test kits and supplies possible, and good practices learned through the project are now being used by CARPHA to improve procurement practices across different grants.

Human Resource Capacities to Implement the COVID-19 Response

Contributions to human capacity development from three of the projects—REDISSE, EAPHLN, and OECS—immediately benefited the front line of national COVID-19 responses. The review found examples of how these projects accelerated the deployment of epidemiology trainees, leveraged capacities developed before COVID-19, and engaged in simulation and team development for a more rapid response.

Countries in West Africa and the Eastern Caribbean deployed field epidemiology graduates in leading strategic and frontline roles. COVID-19 created a sudden and great demand for health professionals competent in field epidemiology. In the Economic Community of West African States region (box G.2) and the Eastern Caribbean, the projects helped address these immediate needs and improved long-term capacity in readiness for future pandemics. In the Caribbean, CARPHA had an existing Field Epidemiology and Laboratory Training Program but had not used a train-the-trainer approach. The new approach was first used in 2020 with the training of cohorts from Saint Vincent and the Grenadines and Saint Lucia. The graduates have been on the front line of the COVID-19 response. For example, in Saint Lucia, they are on the national committee coordinating the response, sharing knowledge on epidemiological data, and demonstrating technical competence that is trusted by committee members and authorities, including providing just-in-time advice to high-level political leaders. In Saint Vincent and the Grenadines, trainees worked on a team responding to both COVID-19 and the volcanic eruption.

Box G.2. Field Epidemiology Capacity for Frontline Response

Economic Community of West African States (ECOWAS) countries deployed more than 200 field epidemiology graduates on the front line of the pandemic response, reducing a reliance on foreign epidemiologists and filling critical capacity needs. Field epidemiology capacity has long been inadequate in ECOWAS countries, and many relied on foreign epidemiologists. To support the COVID-19 response in 2020, governments from all REDISSE and ECOWAS countries deployed more than 200 graduates of the Field Epidemiology and Laboratory Training Program. The trainees include a range of human and animal health professionals. They quickly became involved in all areas of preparedness and response, including monitoring, risk assessment, data management, and reporting; health surveillance at airports and seaports; tracing of quarantined persons; screening of exposed target groups; case investigation; laboratory sampling; infection prevention and control; and establishing a database of COVID-19 response volunteers.

Source: Independent Evaluation Group outcome harvesting analysis.

Capacities developed before COVID-19 were crucial to rapid responses in East and West Africa. In East Africa, before the EAPHLN project started, the capacity of lab technicians, assessors, and disease surveillance officers was low. When COVID-19 started, governments were able to rely on highly skilled people for their response because they had already been trained through the project. Government authorities in EAPHLN countries deployed graduates of the project to be at the front line in rapid response teams, conducting testing and contact tracing.

Countries prepared for rapid response through simulation exercises and team development. Before the first cases of COVID-19 were even identified in the five EAPHLN countries, the national teams that were leading the response ran simulation exercises for COVID-19. They saw simulation exercises as a way to test the level of preparedness and ability to foster a coordinated multisectoral response to disease outbreaks. As soon as COVID-19 was identified in these countries, laboratories were able to react. REDISSE countries also benefited from capacity developed before COVID-19, as the WAHO had advised countries to set up national rapid response teams. The

countries tailored the design of their rapid response teams to their own context, creating multidisciplinary teams with expertise in human health and animal health that are ready to cover all areas of outbreak preparedness and response (box G.3).

Box G.3. Capacity of Rapid Response Teams in Countries

Economic Community of West African States (ECOWAS) countries used rapid response teams supported by REDISSE to address COVID-19 needs. The West African Health Organization (WAHO) advised countries to set up national rapid response teams before COVID-19, this capacity was used to implement the COVID-19 response. In Togo, health officials noticed the mental health impact of COVID-19 and potential loss of livelihoods due to the countrywide lockdown. Hence, their mobile rapid response teams were adjusted to include psychosocial support for affected households. In Mauritania, mobile rapid response teams made it possible for authorities to establish disease surveillance systems in communities and districts.

Source: Independent Evaluation Group outcome harvesting analysis.

Expansion of Surveillance, Testing, Border Screening, Case Management, and Infection Prevention and Control for COVID-19 Response

Support from the REDISSE, EAPHLN, and OECS Regional Health projects helped participating countries to introduce screening, testing, and quarantine at their borders. Economic Community of West African States countries implemented point of entry (POE) control policies as early as April 2020. By October 2020, most of the 11 REDISSE countries had started surveillance and contact tracing; screening at POE; quarantine; laboratory testing and diagnosis; infection prevention and control; case management; and risk communication. East African countries deployed laboratory capacity built by the EAPHLN project for COVID-19 testing (box G.4). In the Caribbean, tourism all but stopped by mid-2020 due to travel restrictions. Surveillance at POE and measures to reduce risk of transmission helped restore tourist confidence that travel, once permitted, could again be enjoyed with man-

ageable risks. By October 2020, the ministries of health in OECS Regional Health countries had implemented timely screening for COVID-19 and quarantine measures at POE, including the introduction of more specimen transportation to laboratories and passenger transfers to quarantine facilities in Dominica.

Box G.4. Networked Laboratories across Countries for COVID-19 Testing

EAPHLN contributed to rapid testing at borders to facilitate the movement of goods in East Africa. Travel restrictions imposed when COVID-19 started meant that the drivers of vehicles transporting goods across borders in East Africa needed to be tested, resulting in 24–48 hours delays while they awaited polymerase chain reaction (PCR) test results. Soon after COVID-19 started, governments in EAPHLN countries initiated testing in cross-border areas for COVID-19 using rapid GeneXpert RT-PCR technology (initially purchased for tuberculosis testing), which is more robust, versatile, and easier to use than more common PCR machines. The technology allowed people to get results in 2–3 hours without needing to transport specimens to distant laboratories. This greatly facilitated the flow of goods and people across the borders, supported contact tracing, and showed the value of having modern, versatile diagnostic technologies.

Source: Independent Evaluation Group outcome harvesting analysis.

Note: EAPHLN = East Africa Public Health Laboratory Network.

Community networks in remote areas of some REDISSE countries were used for identifying COVID-19 cases and providing referrals to health services. The involvement of community networks allowed information to flow from the community and district levels to the national level, which sometimes had been hampered by limited communications means.

In 2021, CARPHA innovated in its approach to syndromic surveillance to distinguish COVID-19 infections from dengue fever by developing a tool to conduct the surveillance virtually rather than in the field. One of the challenges of COVID-19 is the danger of working in the field; another is that its symptoms are shared with other diseases. In the Caribbean, dengue fever has symptoms similar to COVID-19. For infection control it is critical to be able to distinguish which disease a symptomatic person is carrying.

Since March 2020, three OECS Regional Health countries (Dominica, Grenada, and Saint Vincent and the Grenadines) have created COVID-19 isolation facilities. Without isolation facilities, essential health services would have been much reduced, and the risk of COVID-19 spreading in hospitals would have been higher. The isolation facilities prepared the countries to manage a surge of cases at a time when government revenues were significantly reduced by the loss of tourism, increasing their reliance on external funding to finance COVID-19 activities.

Health facilities and public buildings in Grenada increased infection prevention and control measures. Reduced government revenues due to the loss of tourism meant there was an urgent need to finance this critical action in the country's COVID-19 plan.

The countries participating in the four projects rapidly expanded testing capacity. Between February and August 2020, the ability to diagnose COVID-19 increased from two to almost all AU countries (box G.5). Where laboratory capacities had already been strengthened to International Organization for Standardization certification standards, as in the EAPHLN countries, governments almost immediately designated more than 90 percent of the project laboratories as national testing centers. As soon as COVID-19 test kits were available, these laboratories started to provide testing services.

OECS Regional Health countries scaled up their PCR testing capacity. In the Caribbean, OECS countries initially had limited PCR testing capacity, and supplies were difficult to procure in bulk due to global demand. But Dominica has increased its testing capacity to more than 100 persons per day using real-time PCR. Grenada has newly started PCR testing for COVID-19, with CARPHA doing the initial tests.

Box G.5. Rapid Expansion of Testing Capacity Across Countries

Africa CDC contributed to the rollout and expansion of COVID-19 testing in Africa. At the start of COVID-19, only two laboratories in Africa (Senegal and South Africa) could reliably test for the disease. By mid-March 2020, 43 countries had testing capability, and by August almost all African Union countries could test. This situation contrasts with the Ebola outbreaks, when samples were sent to Europe for testing and it took up to five weeks to receive results. EAPHLN and REDISSE capacity building pre-COVID-19 helped countries to quickly initiate and scale up testing. Other countries had much weaker pre-existing laboratory and human resource capabilities, making the near-universal ability to conduct COVID-19 testing in Africa even more remarkable since capacity building had to be responsive to diverse needs. In-country testing has been important for containing COVID-19 because of lockdowns and the time it takes to transfer specimens between countries. By October 2020, Africa completed 25 million tests. Also important was the ministry of health support to decentralize the material and equipment for testing and pre-existing laboratory networks supported by EAPHLN and REDISSE. As a result, remote and rural populations could access testing outside the capital cities.

Source: Independent Evaluation Group.

Note: EAPHLN = East Africa Public Health Laboratory Network.

Vaccines

As of early-2022 vaccine programs in project countries were just getting underway or were in the planning stage. Nonetheless, OECS Regional Health has produced two early outcomes that demonstrate the project's role in preparing facilities and populations for vaccination. There may have been an opportunity for wider regional dialogue on vaccines among countries early in the response.

Between October 2020 and January 2021, the governments of Dominica and Grenada strengthened their vaccine readiness by installing refrigerators for storing vaccines and coolers for keeping doses ready for administration in health centers. Refrigeration is essential for vaccine storage, thus local re-

refrigeration capacity in health centers needed to be upgraded in line with the large volume of vaccines anticipated.

To maximize vaccine uptake, CARPHA reactivated its ethical committee to guide research on vaccine hesitancy. Focal points from OECS member states in the Regional Health Communicators Network used the initial findings in communications campaigns to dispel vaccine myths.

Value-Added of Regional Support

Governments and regional health agencies used the four regional projects to support rapid health responses to the COVID-19 crisis in countries with weak health or limited capacities to respond to crises. Among the four projects, REDISSE and EAPHLN had well-established networks in countries when COVID-19 hit, the Africa CDC and OECS Regional Health project were at early stages of implementation. For all projects, the knowledge exchange and real-time dialogue and coordination facilitated by regional engagement was viewed consistently as an added value to help support country actions (box G.6). The regional coordination capacity developed through REDISSE before COVID-19 enabled the WAHO to facilitate exchanges across countries. The coordination experience of the Africa CDC, CARPHA supported by the OECS project, and Economic Community of Central African States supported by a later stage of REDISSE were strengthened through the COVID-19 response.

Box G.6. Value-Added Areas of Regional Projects for the COVID-19 Response

Regional exchange during COVID-19 supported leadership, dialogue, technical quality, and real-time learning.

- » Established regional coordination mechanisms supported political leadership across countries for a more rapid COVID-19 response, with consistent plans and policies.
- » Strong cooperation between regional and national health institutions on COVID-19 guidelines and training enabled coordinated technical support among development partners for quality implementation.

(continued)

Box G.6. Value-Added Areas of Regional Projects for the COVID-19 Response (Cont.)

- » Knowledge and experience sharing in real time through regional project committees, networks, and platforms allowed governments and experts to address implementation challenges to accelerate and adjust their COVID-19 response.

Structures for coordination and epidemic surveillance and response teams set up in countries with regional support were used for COVID-19.

- » Regional resource hubs enhanced surveillance and preparedness for COVID-19 and overlapping disease outbreaks, exemplifying how collaboration can help countries agree on common response frameworks for disease threats in a region.
- » Coordination platforms and community networks established before COVID-19 helped countries to quickly scale up testing in-country.
- » Countries tailored the design of their rapid response teams established before COVID-19 to support COVID-19 surveillance and case management.

Regional exchange facilitated a rapid response to deliver critical health services, with trained human capacity and spillover effects.

- » Regionally trained personnel within countries filled immediate strategic and front-line roles in the COVID-19 rapid response, improving human resources to manage and deliver the response.
- » Countries engaged in a collaborative response to introduce screening, rapid testing, and quarantine at their borders and in cross-border areas, which reduced the risk of COVID-19 transmission and facilitated the flow of goods and people.
- » Regional projects facilitated adoption of emergency procurement procedures for technical, logistic, and operational support and timely purchase of COVID-19 test kits, personal protective equipment, and other supplies.
- » The spillover effect of regional projects benefited the COVID-19 response of neighboring countries that were not part of the projects, through participation in regional activities and meetings and development of policies.

Source: Independent Evaluation Group outcome harvesting analysis.

The early results suggest that regional projects were able to play a role because of the efficiencies gained from cooperation in pandemic responses across countries, especially in regions where capacity or resources were limited. Once established regional networks filled a critical need to support implementation learning and leadership of various actors (such as technical experts in public health institutes and higher-level decision makers), though the coverage of countries by regional projects was limited in the COVID-19 response (less than 30 percent of countries had regional project support). Countries joined the learning and then adapted the regional guidance to their context, and peer influence encouraged wide adoption of critical health services across countries. Regional support can be used to leverage political leadership and dialogue and address efficiencies across countries to speed up actions.

Systematic approaches to cross-country learning may be similarly useful to help countries to adopt new approaches for other implementation challenges, such as those related to essential health services, as part of the COVID-19 recovery. Learning across countries could also be supported by advisory services and analytics that support a regional organization to coordinate knowledge sharing across countries. Often, minimum regional project financing and disbursement were required to influence these results. Hands-on support to convene actors, support learning, and provide technical advice were key to the early results identified. This was supported by staff time, consultants, and project coordinators in countries. In some cases, technology needed to be purchased to facilitate online access to the exchanges.

Challenges of Regional Support

The main limitation of regional projects is they do not comprehensively respond to the needs of countries to strengthen their preparedness and protect human capital. Regional projects were less prepared to support risk communication, citizen engagement, gender, urban risk, and essential services. Another challenge in the response was access to real-time data on the quality of implementation of COVID-19 response support in countries--regional projects did support real-time exchange of technical and tacit knowledge to expand actions and policy dialogue and shared epidemiological information,

but they rarely shared data on implementation quality. Another challenge was that dialogue across countries and partnerships can be complex to set up and required having a regional partner with the capacity to facilitate these exchanges. Moreover, challenges in regional projects, when they happen, can slow implementation across all countries, but once resolved, they can help build institutional capacities and tackle implementation challenges at scale across a region.

Overview of Regional Projects

Table G.1 summarizes the four regional projects and the main types of support that contributed to the documented results. Many activities have yet to begin and are likely to lead to further results in coming years.

Table G.1. Summary of Regional Projects and Activities in Support of COVID-19 Response

Project	Support contributing to COVID-19 milestones
<p>The Regional Disease Surveillance Systems Enhancement project (REDISSE) was created after the 2014–16 Ebola outbreak in West Africa. REDISSE has grown to cover 16 countries in West and Central Africa since its launch in 2016. The objectives are twofold: (i) to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in West Africa; and (ii) in the event of an eligible emergency, to provide immediate and effective response. Project implementation in West Africa is coordinated by the West African Health Organization (WAHO), the health institution mandated by the Economic Community of West African States (ECOWAS), which also serves as the Project Secretariat. REDISSE IV, covering Central Africa, was approved in 2019; therefore, it is still early to identify results supported in this region through the Economic Community of Central African States (ECCAS).</p> <p>REDISSE I supports Guinea, Senegal, and Sierra Leone; REDISSE II supports Guinea-Bissau, Liberia, Nigeria, and Togo; REDISSE III supports Benin, Mali, Mauritania, and Niger; and REDISSE IV supports Angola, Central African Republic, Chad, Democratic Republic of Congo, and Republic of Congo.</p>	<p>REDISSE provided financing and advisory support to countries that facilitated the World Bank's COVID-19 response. Moreover, REDISSE contributed to strengthening the capacity of regional and national laboratories, disease surveillance systems at various levels, human resources, and emergency preparedness for about five years in some West African countries; this has provided capacity for the COVID-19 response. An interviewee said: "Without REDISSE's support, none of our national activities [to respond to COVID-19] would have been possible..." The project support contributing to the results are the following:</p> <ul style="list-style-type: none"> » Development, strengthening, and facilitating regional cooperation: <ul style="list-style-type: none"> » Technical support for the development of regional plans, including exchange of experience between WAHO and ECCAS on how to design and use the regional plan to guide countries, and developing operating procedures for working electronically » Development of technical coordination mechanisms for exchange across countries and for aligning available technical support of partners and resources to more efficiently support country needs, for example, in exchanges on POE interventions » Assistance to ECOWAS, and increasingly ECCAS, to strengthen regional coordination mechanisms among ministers » Support to WAHO for developing the coordinating of national public health institutes » Financing of country plans: <ul style="list-style-type: none"> » Mobilization of more than \$200 million for countries' COVID-19 responses » Support for some countries to rapidly procure test kits, mobile laboratories, and technology for virtual work » Strengthening capacity and regional cooperation between reference laboratories: <ul style="list-style-type: none"> » Strengthening 12 regional reference laboratories in West Africa by funding laboratory equipment, training, and intercountry agreements and protocols » WAHO has leveraged funds from different donors to scale up the regional laboratory network

(continued)

Project	Support contributing to COVID-19 milestones
<p>The East Africa Public Health Laboratory Networking (EAPHLN) project was approved in 2010 and additional financing was provided in 2015. The project closed in Rwanda in 2016, and in Burundi, Kenya, and Tanzania in September 2020, but in Uganda it was extended until March 2021. The project focused on: supporting centers of excellence that provide specialized services; facilitating cross-border disease surveillance and investigations; and promoting evidence-based approaches and knowledge sharing. The regional network promotes innovations in service delivery and serves as a platform for cross-country collaboration. Most support under the project was provided before COVID-19 began, but it helped countries to react quickly during the pandemic.</p>	<ul style="list-style-type: none"> » Training: <ul style="list-style-type: none"> » Support for, and regional coordination of, basic, intermediate, and advanced field epidemiology training of more than 200 trainees with regional and national partners » Training of rapid response teams, including simulation exercises » Training of laboratory technicians in collaboration with Africa CDC » Support for training, bonuses, and mobile phones for community surveillance teams <p>The EAPHLN project built a network of 41 laboratories (of which 35 were refurbished) mostly in cross-border areas, which serve more than 12 million beneficiaries in Burundi, Kenya, Rwanda, Tanzania, and Uganda. The serves as regional network promotes innovations in service delivery and provides a platform for cross-country collaboration. In the past decade, the project has been critical to supporting frequent disease outbreaks it proved instrumental for the COVID-19 pandemic.</p> <p>Many technical partners were involved throughout the 10-year period of this project, including WHO, United States CDC, and African Society for Laboratory Medicine. An interviewee said: "The greatest role the project played across all countries was in ensuring that the basic infrastructure that you need for laboratory diagnostic and surveillance was there. Not just for COVID-19 but for any other diseases."</p> <p>In addition to financing equipment, laboratory consumables, and other costs, the support contributing to the results are the following:</p> <ul style="list-style-type: none"> » Coordination and collaboration mechanisms and facilitation <ul style="list-style-type: none"> » Creation of technical working groups and regional coordination committees » Creation of cross-border committees between countries to strengthen communication, reporting, and coordination of responses at border points during public health events and outbreaks » Facilitation of dialogue on surveillance between countries

(continued)

Project	Support contributing to COVID-19 milestones
	<ul style="list-style-type: none"> » Training: <ul style="list-style-type: none"> » Training of response teams in five countries » Support for simulation exercises on various diseases before the COVID-19 outbreak » Training of more than 19,000 trainees and about 80 master's degree and 7 doctoral graduates in the five countries, including 30 residents in the gold standard Field Epidemiology and Laboratory Training Program » Lab capacity: <ul style="list-style-type: none"> » Support for laboratories in receiving ISO-certification: 97 percent of all project-supported laboratories in the four countries that participated in both phases attained the target of three stars or more on the Stepwise Laboratory Improvement Process toward accreditation, and nearly half reached ISO accreditation » Strategic development of the capacity of a network of satellite labs across countries, including in cross-border areas » Health facilities: construction of isolation facilities for Ebola and other diseases
<p>The Africa Centres for Disease Control and Prevention (CDC) project supports the Africa CDC, newly created in 2017, and the governments of Ethiopia and Zambia. The objective is to strengthen continental and regional infectious disease detection and response systems. The World Bank's support complemented the financial and technical assistance of other partners, such as WHO, the US CDC, and USAID. The project was approved in December 2019 before the onset of COVID-19 and closes in 2025. The Africa CDC response to COVID-19 started in February 2020 with the African Union Commission pan-African response strategy.</p>	<p>The Africa CDC project helped provide an unprecedented foundation for a coordinated response across the continent. An interviewee said, "Africa stood up for itself. In the past... what you usually see as with Ebola in 2014, people rush from Geneva, United States, and other places to help. This was not possible with COVID-19 as it is global pandemic. I think 2020 must go down as the year we in Africa decided to use our local resources to fight our collective health security challenges. This pandemic will be the defining moment for Africa CDC, coming just three years after it was set up we had to learn to walk and run at the same time."</p> <ul style="list-style-type: none"> » The main areas of support contributing to the results are the following activities of the Africa CDC project and synergistic national COVID-19 projects: » Technical assistance in network development of the Regional Integrated Surveillance and Laboratory Network, establishment of a Regional Collaboration Center, and regional and national cross-sector public health knowledge exchange

(continued)

	<ul style="list-style-type: none"> » High-level dialogue and technical assistance on emergency procurement guidelines » Pan-African training on Polymerase Chain Reaction (PCR) testing with WAHO and others, and training in surveillance, contact tracing, and data management » Initiation of a specimen transport and referral system by Africa CDC's African Task Force for Coronavirus Preparedness and Response
Project	Support contributing to COVID-19 milestones
<p>The Organization of Eastern Caribbean States (OECS) Regional Health project supports the Caribbean Public Health Agency (CARPHA), OECS, and the governments of Dominica, Grenada, Saint Lucia, and Saint Vincent, and the Grenadines. The project's objective to improve the preparedness of health systems for public health emergencies in the OECS region was timely: COVID-19 began as the project became effective in January 2020 (closing in 2024), and in March the countries declared a state of emergency.</p>	<p>The OECS Regional Health project support included activation of the Contingency Emergency Response Component and a grant from the Pandemic Emergency Financing Facility for Grenada. The project also collaborated with the Pan American Health Organization and the CDC. The project financed laboratory and vaccination equipment and supplies, retrofitting of buildings, vehicles, personal protective equipment, and laboratory equipment maintenance. In addition, the project support contributed to</p> <ul style="list-style-type: none"> » Coordination and exchange: <ul style="list-style-type: none"> » Convening regional project meetings to share advice and data and facilitate sharing between countries and CARPHA » Coordination with other donors to align needs for equipment and materials and technical expertise » Communication campaigns for COVID-19 » Train-the-trainer curriculum development for the established Field Epidemiology and Laboratory Training Program » Surveillance and testing: <ul style="list-style-type: none"> » CARPHA supported lab functions in all OECS countries through guidelines for testing, sequencing, and various protocols

(continued)

Project	Support contributing to COVID-19 milestones
	<ul style="list-style-type: none"> » Virtual training for laboratory staff in PCR testing » Technical support to develop the tool for remote syndromic surveillance » Design of a training in surveillance and mitigation of COVID-19 risks » Financing tourism sector training delivered by CARPHA

Source: Independent Evaluation Group review of project documents for outcome harvesting analysis.

Note: CARPHA - Caribbean Public Health Agency; EAPHLN - East Africa Public Health Laboratory Network; ECCAS - Economic Community of Central African States; ECOWAS - Economic Community of West African States; OECS - Organization of Eastern Caribbean States; PCR - polymerase chain reaction; POE - point of entry; WAHO - West African Health Organization.

Reference

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Appendix H. Analysis of Multiphase Programmatic Approach of Health

What has been the quality of the early support of the Multiphase Programmatic Approach (MPA) led by the Health, Nutrition, and Population Global Practice in terms of addressing needs of countries, supporting implementation and learning, and timely operational processes to support the World Bank’s COVID-19 response in countries?

Methodology

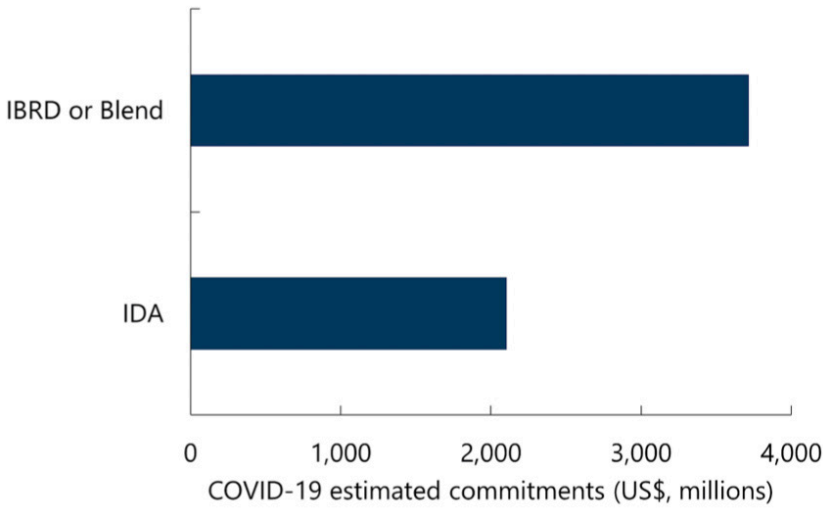
The analysis draws on evidence from the evaluation portfolio, case studies, regional project analysis, and innovation stocktaking to assess the MPA projects led by the Health, Nutrition, and Population Global Practice (World Bank 2020a, 2020b). The focus is on the first year of the MPA support from when the first projects were approved in April 2020 to April 30, 2021, within the portfolio period covered by the evaluation.¹ The analysis of the quality of the MPA support applies the evaluation’s theory of action (support to needs, implementation and learning, and operational processes and partnerships). It then assesses overall progress of the first year of support of the MPA toward its program development objectives.

Background on Multiphase Programmatic Approach

The Strategic Response and Preparedness Program (from here the MPA), launched in April 2020, supports countries to save lives, protect poor and vulnerable populations, and strengthen institutions for recovery. The MPA’s program development objectives are twofold: to prevent, detect, and respond to the threat posed by COVID-19 and to strengthen national systems for public health preparedness. World Bank country programs implementing the MPA were expected to draw from the global framework that has a menu of options and to orient support to needs. The MPA, therefore, envisioned a

flexible public health emergency response with cross-sectoral links to address COVID-19 while serving as a global platform for collaborative learning and quicker response (World Bank 2020a). It was important for coordination that the menu areas aligned with the World Health Organization strategic areas to guide the COVID-19 response in countries—this allowed the MPA financing to quickly complement other partner financing to COVID-19 plans in countries.

Figure H.1. Multiphase Programmatic Approach COVID-19 Commitments for Early Response by Lending Group



Source: Independent Evaluation Group.

Note: COVID-19 estimated commitments are defined as the full project commitment amounts for projects approved on or after February 1, 2020, and as the sum of undisbursed balances and disbursements for projects approved before February 1, 2020. Commitment amounts were retrieved on May 12, 2021. COVID-19 = coronavirus; IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

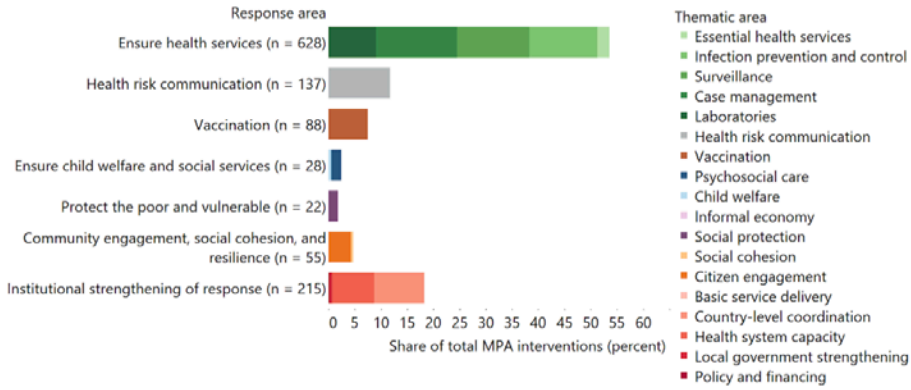
MPA operations covered by this evaluation were implemented across 70 countries with \$5.8 billion in early commitments. About 60 percent of MPA projects were in International Development Association (IDA) countries, and the remaining 40 percent were in International Bank for Reconstruction and Development (IBRD) countries. IBRD projects had higher commitments, with 48 percent of the financing. The remainder went to IDA (36 percent) and IDA and IBRD blended countries (15 percent; figure H.1). Although IDA projects had lower average commitment amounts, they often sought to undertake a broader range of interventions than IBRD projects.

Support to Needs

The MPA was highly relevant and innovative in the early response to quickly expand support to critical health services for prevention and control of COVID-19. The MPA provides 53 percent of the interventions for the relief phase of the health response, emphasizing critical health services. Planned interventions mainly targeted areas of immediate importance, such as case management (16 percent), surveillance (14 percent), infection prevention and control (13 percent), risk communication (12 percent), and laboratories (9 percent; figure H.2). However, the intensity and targeting of risk communication support reaching communities was often a challenge. Support was also provided to early institutional strengthening regarding country-level health coordination (10 percent) and health system capacity (8 percent). The MPA accounts for 22 percent of all interventions on institutional strengthening—the second highest amount after regional projects. Box H.1 presents examples of MPA interventions.

The relevance of the MPA was reduced in that few countries supported continued essential health services, gender, and community engagement. Areas identified as important in the MPA framework to engage communities and protect human capital had limited emphasis in the early response, such as citizen engagement (4 percent), essential health services (2 percent), and psychosocial care (2 percent; figure H.2). The address of gender in MPA projects was also limited (46 percent of MPA projects). This is despite evidence and lessons from previous crisis responses (appendix E) emphasizing the importance of these interventions (Gold and Hutton 2020; World Bank 2021b). Moreover, even though there was a strong emphasis on country-level coordination, this rarely had a multisector or subnational focus as proposed in the MPA framework, though coordination was often well supported where there was regional project support. MPA projects likely had some spillover effects that supported essential health services. For example, support to infection prevention and control likely also helped continue essential health services. In some countries, existing projects were repurposed to provide complementary support for essential health services and community engagement.

Figure H.2. Response Areas Supported by Multiphase Programmatic Approach



Source: Independent Evaluation Group.

Note: Percentage allocation is based on 1,173 interventions in 70 MPA projects. MPA = Multiphase Programmatic Approach.

Box H.1. Examples of Multiphase Programmatic Approach Support to Critical Health Needs

In India, the Multiphase Programmatic Approach (MPA) enabled a rapid response that strengthened health service systems, for example, on surveillance and laboratories. The project disbursed \$200 million within 10 days of approval. With the support of the MPA, country COVID-19 testing was increased from a little more than 10,000 tests per day in early April to more than 1 million tests per day in September. To increase testing, the project helped engage about 1,300 private sector laboratories. The project also supported the conversion of more than 5,000 railway coaches to COVID-19 care centers to accommodate the large patient load.

In Djibouti, the MPA supported the development of guidelines and standardized sample collection methods, established transportation, and determined sites to introduce point-of-care diagnostics.

(continued)

Box H.1. Examples of Multiphase Programmatic Approach Support to Critical Health Needs (Cont.)

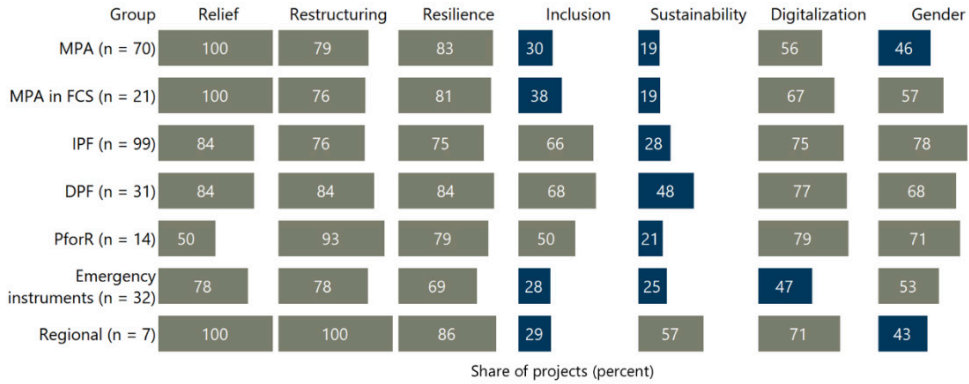
Having defined the guidelines, the MPA also supported the procurement and disbursement of necessary supplies to health facilities, such as polymerase chain reaction machines, sample collection kits, test kits, and other COVID-19 testing and surveillance and equipment. By December 2020, more than 79,000 reported COVID-19 cases were investigated based on national guidelines, 100 health workers had been trained in infection prevention and control after the ministry of health protocols, and 100 percent of acute health-care facilities had triage capacity.

Source: Independent Evaluation Group case study analysis.

The MPA undertook more interventions with fewer resources in the least prepared countries, emphasizing the difficulty of prioritizing support in countries with weak systems to respond to the crisis. The MPA covers countries of all preparedness levels. However, low preparedness countries had lower commitments per capita (\$1.6 million per million population) and the highest average number of interventions planned, spreading limited funds across a broad scope of interventions, whereas MPA projects in better prepared countries often had a narrower scope focused on fewer priority interventions, with high commitments at almost twice the level of low preparedness countries (\$2.9 million per million population).

The MPA emphasized relief stage support and early support to build resilient systems, but more support is needed to sustain these achievements (figure H.3). There is not yet a defined strategy to build on the early support of the MPA to ensure that systems changes are sustained, especially in countries that had limited preparedness capacity before COVID-19. Moreover, MPA projects in some countries provided limited support to ensure inclusion of vulnerable groups because financing has often gone to national plans for broad population benefits. Strengthening the digitalization of systems was also less emphasized in the MPA, compared with other areas of the response.

Figure H.3. Stages of Support and Orientation of Project Design



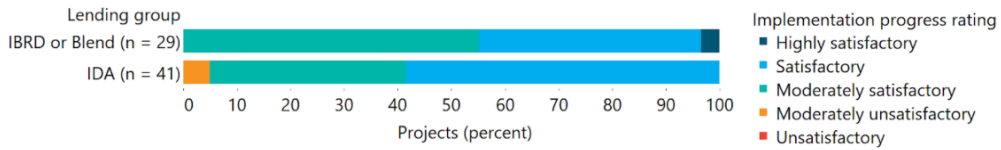
Source: Independent Evaluation Group portfolio.

Note: The bar size represents the percent of projects that support the specified stage of the response or orientation of project design. Emergency instruments include COVID-19-activated CERC and CAT DDO projects coded in the portfolio covering eligible countries and selected Global Practices. The blue bars denote areas with less than 50 percent of projects. The number of projects is 253. "Relief" refers to whether a project includes support for the emergency stage of the COVID-19 response. "Restructuring" refers to whether the project includes support for recovery. "Resilience" looked at whether a project supported preparing people, communities, systems, and assets for shocks, such as those that could emerge from diseases, shutdowns, and income loss. "Inclusion" looked at whether a project supported increasing the access of disadvantaged groups to services and other resources. "Sustainability" looked at whether project activities supported planning for long-term consequences in terms of the management of the services, systems, resources, or people to ensure continued benefit. Digitalization and gender looked whether project interventions included any interventions to address these areas. CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component; DPF = development policy financing; FCS = fragile and conflict-affected situation; IPF = investment project financing; MPA = Multiphase Programmatic Approach; PforR = Program-for-Results.

Implementation and Learning

About 56 percent of MPA projects had satisfactory implementation progress in the early COVID-19 response. Implementation progress ratings are slightly higher for IDA than for IBRD countries (figure H.4). This may in part reflect differences in COVID-19 caseloads across countries.

Figure H.4. Implementation Progress Ratings of Multiphase Programmatic Approach Projects in Early COVID-19 Response



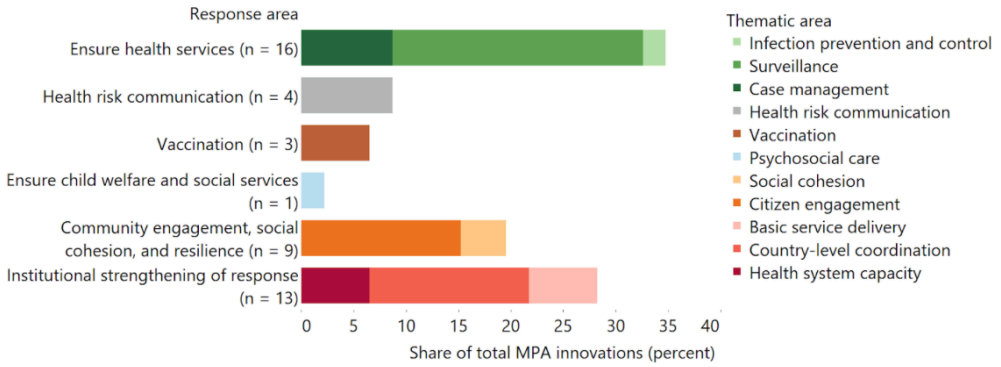
Source: Independent Evaluation Group portfolio.

Note: Projects with no implementation progress rating and projects with financing other than IBRD, IDA, and blend are excluded from the analysis. Implementation Status and Results Report data are from November 5, 2021. The total number of countries is 70. COVID-19 = coronavirus; IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

Existing relationships with ministries of health facilitated quick implementation of the MPA. Case studies found that implementation of the MPA in countries drew on existing relationships with ministries of health and was guided by knowledge work. Good existing dialogue with national health ministries facilitated quick MPA implementation; for example, in Senegal, the response built on existing dialogue on disease preparedness. In other countries, such as Honduras and the Philippines, new relationships were established, which took some time to build in the early months of the response.

Innovations often focused on challenges in the MPA response, such as digitalization and community engagement (figure H.5). The largest single innovation area supported by Health, Nutrition, and Population was in improving surveillance systems. Five areas make up 73 percent of innovations: surveillance, community engagement, country coordination, case management, and risk communication. Of these innovations, about half sought to develop an aspect of the community response, whereas one-quarter enhanced the digitalization of the response. Box H.2 provides examples of planned innovations supported by the MPA.

Figure H.5. Areas of Innovation Supported by the Multiphase Programmatic Approach



Source: Independent Evaluation Group.

Note: The total number of innovations is 46 in 29 MPA projects. MPA = Multiphase Programmatic Approach.

Box H.2. Examples of COVID-19 Multiphase Programmatic Approach Response Innovations

Surveillance: The ministry of health in Maldives has developed and maintained a COVID-19 information dashboard on its website since April 2020, which provides critical information on the epidemiological situation of COVID-19. In addition to detailed data on cases, the epidemic monitoring score provides a composite score of five indicators relevant for decision-making in tightening or relaxing restrictive measures. The dashboard is publicly available and adds to the transparency of the government's decision-making.

Risk communication: Health-related communication activities in Benin engage political, religious, and traditional leaders' platforms to support community mobilization that reaches the local population, especially in rural areas.

Vaccines: In the Philippines, support is provided for using digital information systems that can track the real-time supply of vaccines from hubs to vaccination points.

(continued)

Box H.2. Examples of COVID-19 Multiphase Programmatic Approach Response Innovations (Cont.)

Community engagement: In Georgia, support is provided for developing an online platform for all stages of community feedback. Priority will be given to the use of civic technology that is mobile-friendly, easily accessed, and can manage translations and outreach to rural and urban communities.

Source: Independent Evaluation Group Innovations stocktaking.

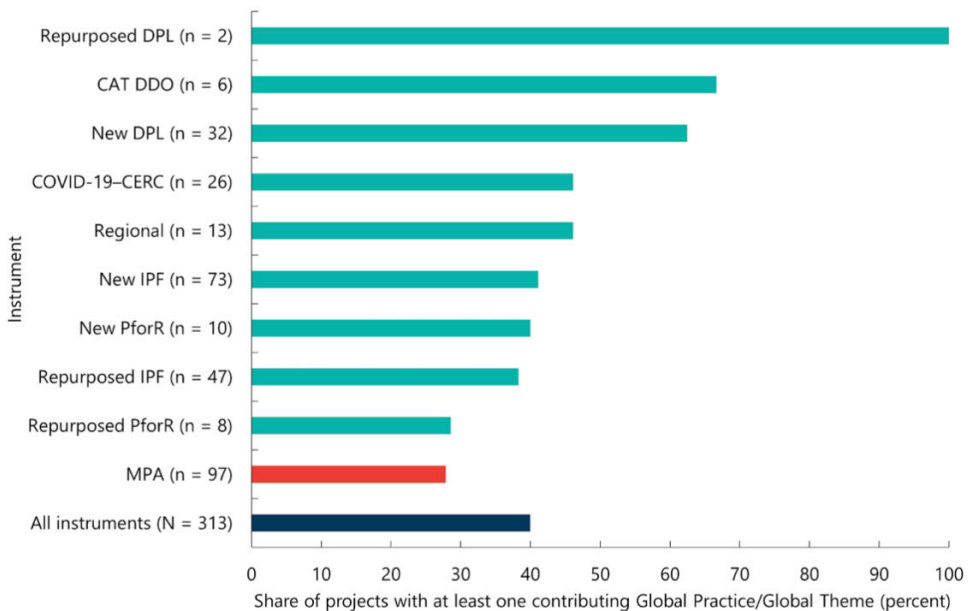
Knowledge work was key to help guide implementation, but health-focused advisory services and analytics were rare. Only 36 percent of countries had knowledge work in health to support COVID-19 in the early response. In Honduras and Senegal, the MPA drew on previous knowledge work on emergency preparedness to guidance actions. Some global knowledge work also facilitated MPA implementation. The vaccine readiness assessments supported with the World Health Organization and other partnerships in most MPA countries informed the development of the vaccine MPA financing, such as in Djibouti, the Philippines, and Tajikistan (World Bank 2021a). Also at the global level, to review early progress on the first phase of MPA projects, a technical assessment was conducted through a partnership between Resolve to Save Lives and the Swiss Tropical and Public Health Institute. This country-level analysis included a review of national COVID-19 plans, MPA Project Appraisal Documents, work plans, and disbursement and mapped MPA indicators and actions areas of the World Health Organization Joint External Evaluation framework.

Regional learning helped some countries to implement the MPA; however, such regional support to complement the MPA was limited. Despite the demonstrated strengths of regional knowledge sharing and cooperation to support countries in critical health services in Africa, most countries lacked this support to facilitate the implementation of the MPA. Regional support in countries such as Senegal and Zambia reinforced the MPA project, facilitating quick implementation. It helped address challenges of technical support of public health institutes and facilitated country leadership and responsiveness.

Operational Policies and Partnerships

MPA projects often fell short of the cross-sectoral implementation envisioned by the MPA framework. About 28 percent of MPA projects collaborated with another Global Practice to support implementation (figure H.6). The MPA was most often implemented in collaboration with Social Protection and Jobs (16 percent). For example, in Pakistan, the MPA financed emergency cash transfers to poor households and related communications materials. The Water Global Practice accounts for 5 percent of collaborations with MPA projects, such as in Nigeria, where planned support included the provision of safe water and hygiene services within affected communities, with an emphasis on poor and vulnerable populations. The Agriculture Global Practice collaborated in 3 percent of MPA projects, such as in the Democratic Republic of Congo, where planned support included the One Health system at the provincial level.

Figure H.6. Global Practice Collaboration in Multiphase Programmatic Approach Projects and Other Instruments Supporting the COVID-19 Response



Source: Independent Evaluation Group.

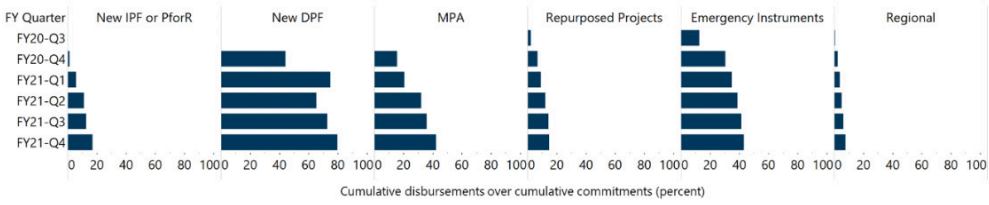
Note: Analysis includes collaboration in parent and additional financing projects. For the MPA, the number of projects is 97 (70 parents and 27 additional financing). The total number of projects is 313 (253 parents and 60 additional financing). CAT DDO = catastrophe deferred drawdown option; CERC = Contingency Emergency Response Component; DPL = development policy loan; IPF = investment project financing; MPA = Multiphase Programmatic Approach; PforR = Program-for-Results.

In some countries, Health, Nutrition, and Population had good coordination of MPA implementation with other Global Practices to draw on cross-sector expertise. For example, the social protection project in Tajikistan and the governance advisory services and analytics in Tajikistan coordinated with the MPA. This also happened in Senegal through the coordination of national COVID-19 planning with other sectors and World Bank support in areas such as agriculture and water.

The MPA provided a streamlined instrument for the World Bank to quickly process new projects and build on early crisis and repurposed support. The MPA design was fast to process new projects. The MPA was slow in disbursing in the early weeks and months of the crisis compared with crisis instruments and regional and repurposed projects, although it was faster than other new investment project financing projects (figure H.7). Complementing the MPA with regional project support, advisory services and analytics, and repurposing of projects, where done, helped fill early advisory and financing needs before the MPA started disbursing in April 2020.

The MPA disbursement sped up quickly after April 2020 in most countries. About 66 percent of countries had medium to high shares of MPA financing disbursed in the early response (at least about one-third of financing disbursed; figure H.8). In total, 42 percent of MPA financing was disbursed in the early response. In IDA countries, disbursement was slightly faster, with 68 percent of countries having disbursed more than a third of their financing in the early response (first 15 months), in contrast to 62 percent of IBRD countries. Some countries (about 15 percent) did not record any MPA disbursements, raising questions about the usefulness of new project support during a crisis in countries with typically slow project processes because of parliamentary approvals, elections, and other delays. To speed up disbursement further, some countries proposed the use of performance-based financing approaches within the MPA, such as disbursement-linked indicators, aligned with COVID-19 plans. Notably, the speed of the MPA disbursement was surpassed by development policy financing and crisis instruments (figure H.7).

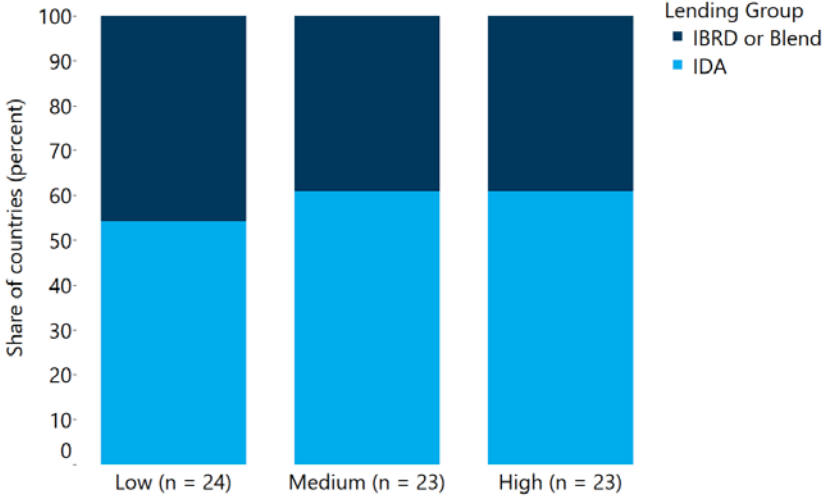
Figure H.7. Cumulative Disbursements over Cumulative Commitments, by Fiscal Year Quarter and Instrument COVID-19 Response



Source: Independent Evaluation Group.

Note: The figure shows cumulative disbursement shares of cumulative estimated commitments by instrument and fiscal year quarter (in percentages). Denominators are the total cumulative estimated commitments for each instrument and FY quarter, where estimated commitments are defined as the full project commitment amounts for projects approved on or after February 1, 2020 (including additional financing) and as the sum of undisbursed balances and disbursements for projects approved before February 1, 2020 (data were retrieved on May 12, 2021, for parent projects, additional financing, commitments, and undisbursed balance amounts; disbursement data are updated to June 1, 2021). Numerators are monthly cumulative disbursements adjusted by the COVID-19 response content share in each project. The total number of projects is 246. COVID-19 = coronavirus; DPF = development policy financing; FY = fiscal year; IPF = investment project financing; MPA = Multiphase Programmatic Approach; PforR = Program-for-Results.

Figure H.8. Extent of Multiphase Programmatic Approach Project Disbursement in Early Response, by Lending Group



Source: Independent Evaluation Group, based on monthly snapshots of project disbursements from the World Bank's Standard Reports.

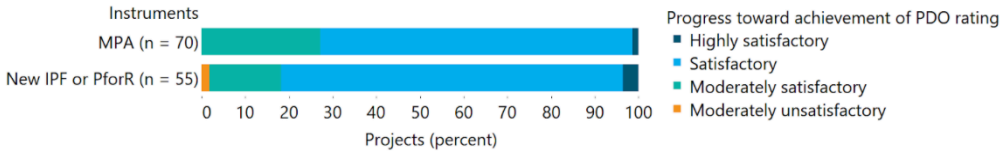
Note: The figure covers 70 MPA projects and countries; it shows the share of countries by lending group and within levels of the disbursement share of commitments, defined by terciles. These levels are low = 0 percent to 31.2 percent, medium = 31.3 percent to 62.5 percent, and high = 62.6 percent to 100 percent. MPA disbursements are assumed to be fully directed to the World Bank's COVID-19 response. COVID-19 = coronavirus; IBRD = International Bank for Reconstruction and Development; IDA = International Development Association; MPA = Multiphase Programmatic Approach.

About 67 percent of all procurement of goods for the early health and social response was supported by the MPA. Procurement was also supported by the Contingency Emergency Response Component of projects (16 percent). The largest share of MPA procurement was for protective gear and masks for infection prevention and control, which accounted for 35 percent of the total. Test kits and laboratory equipment were 30 percent of the total. Other common procurement categories under the MPA were medical equipment (12 percent), facility improvement (5 percent), and technology purchases (4 percent). The remaining items procured (about 14 percent) included sanitation items, medications, waste management, learning materials, vaccines, and nutrition products.

Progress Toward Program Development Objective

About three-quarters of MPA projects reported satisfactory progress toward their development objectives in the early response. Regarding progress of MPA projects toward their development objectives, about 72 percent reported satisfactory or highly satisfactory progress in the early COVID-19 response (66 percent of IBRD and 76 percent of IDA countries). This is slightly lower than other new investment project financing support to the response, which perhaps reflects the extensive burden of the early response on ministries of health implementing MPA support (figure H.9). More projects were rated as moderately satisfactory for IBRD countries, suggesting that more attention may be needed to implementation in some countries, or rating of progress toward meeting the development objective in IDA countries may be at risk of downgrade.

Figure H.9. Multiphase Programmatic Approach Project Ratings Compared with Other COVID-19 Projects

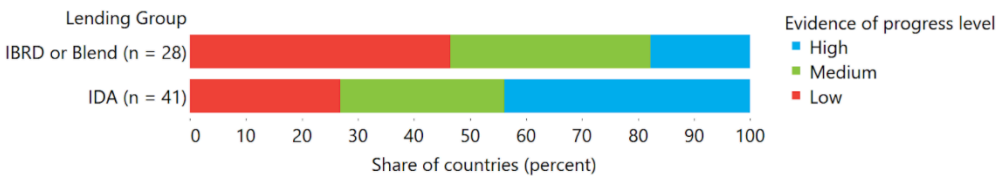


Source: Independent Evaluation Group.

Note: Projects with no project development objective progress rating are excluded from this analysis. Implementation Status and Results Report data are from November 5, 2021. The total number of projects is 193. IPF = investment project financing; MPA = Multiphase Programmatic Approach; PDO = project development objective; PforR = Program-for-Results.

Sixty-eight percent of MPA projects had indicators reporting some evidence of progress in the early response. MPA projects were actively monitored by Health, Nutrition, and Population, compared with other new operations implemented as part of the COVID-19 early response. As of April 30, 2021, 36 percent of MPA indicators demonstrated evidence of progress, compared with only 12 percent of indicators for other new projects. Meanwhile, 81 percent of MPA projects showed evidence of tracking or progress in at least one indicator, although 59 percent of indicators were not yet being tracked. Evidence of early progress is most pronounced in IDA countries, with more than 70 percent of MPA projects showing medium to high evidence of progress in early reports (figure H.10).

Figure H.10. Evidence of Progress on the Multiphase Programmatic Approach Projects, by Lending Group



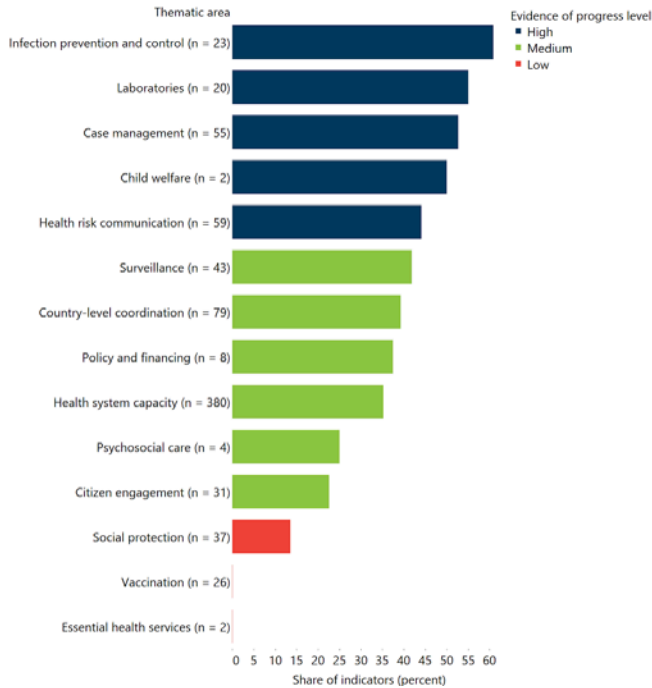
Source: Independent Evaluation Group portfolio monitoring analysis.

Note: Indicators are based on 184 parent or substitute parent projects coded for the evaluation. Evidence of progress levels is defined as terciles of the cross-country distribution of the evidence of progress indicator share of total indicators in a country. Low = 0 percent to 11.1 percent, medium = 11.2 percent to 50 percent, high = 51 percent to 100 percent. The total number of countries is 69. IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.

Early evidence of progress on the first MPA objective (to prevent, detect, and respond to the threat posed by COVID-19) is apparent in some countries. MPA projects expanded critical health services quickly. There is good evidence of progress on indicators in some countries related to infection prevention and control, laboratories, case management, and health risk communication, which is all reinforced by case study findings (figure H.11). However, the relevance of this early progress is reduced by the limited emphasis to protect vulnerable groups from the secondary impact of COVID-19 on maternal and child health. Moreover, the lack of consistent monitoring of behavior changes from risk communication and limited tracking of the quality of critical health services raises questions about the extent of benefits to communities. Some outlier countries stand out for reporting evidence of progress in areas of child welfare such as nutrition and early learning, psychosocial support, and citizen engagement (these countries include Benin, Burundi, The Gambia, Ghana, Indonesia, Myanmar, and Sri Lanka). Countries that had better preparedness and focused interventions to address needs for health emergency services, essential services, and community engagement are likely to have better early progress in responding to the threat of COVID-19.

Progress on the second objective to strengthen national systems for public health preparedness was limited in the early response. With MPA projects primarily focusing on immediate expansion of critical health services in the early response, there is some early evidence of progress on indicators related to surveillance systems, country-level coordination, and health systems strengthening. Indicators related to policy and financing show evidence of progress in a few countries. To advance this objective, ongoing and future support will need to build on early institutional strengthening efforts to develop more sustained and resilient systems. Given the waning pandemic, there may be an opportunity for the MPA to be reorientated toward recovery interventions that help strengthen national systems for public health preparedness, including for continuation of essential health services. Moreover, early innovations once reviewed, could be diffused to other countries to support expanded systems improvements (figure H.11).

Figure H.11. Evidence of Progress toward Objectives in the Multiphase Programmatic Approach



Source: Independent Evaluation Group portfolio review.

Note: The figure shows the share of indicators with evidence of progress toward their objective for 69 MPA projects. Evidence of progress levels are defined as terciles of the distribution across thematic areas of the evidence of progress share of total indicators. Low = 0 percent to 13.5 percent, medium = 13.6 percent to 41.9 percent, and high = 42.0 percent to 60.9 percent. The total number of indicators is 775. The figure shows selected thematic areas, excluding basic service delivery, informal economy, and social cohesion. Each of these three excluded areas has two indicators with no evidence of progress, which are nonetheless accounted for in the evidence of progress levels. Areas with zeros do not have indicators in the early MPA response showing evidence of progress, although later support may report on these areas. MPA = Multiphase Programmatic Approach.

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¹ The analysis covers only early vaccine support, since many Multiphase Programmatic Approach vaccine projects were approved after April 30, 2021, and became active toward the end of the evaluation period of analysis.



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