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Findings for COVID-19 from the World Bank's Support to Address Ebola Outbreaks

Independent Evaluation Group | *July 28, 2021*

Background

What have we learned from support for Ebola outbreaks? Over the past five years, Ebola has seized global interest in relation to the threat of widespread disease outbreaks. This note presents findings from a rapid review of the World Bank's support for Ebola outbreaks between 2014 and 2019, with the objective of informing the coronavirus (COVID-19) pandemic response and future crisis responses.

Methodology

The Independent Evaluation Group carried out a rapid review of the World Bank's support addressing Ebola outbreaks in Liberia, Guinea, Sierra Leone (2014–16), and the Democratic Republic of Congo (2017–19). The review identified a portfolio of operational projects and analytical and advisory work supporting Ebola-related projects using a keyword search of titles, objectives, and descriptions in the operations portal, which was then manually reviewed for inclusion. The final portfolio included 57 operational projects (27 active and 30 closed projects) supporting the emergency and recovery response to the epidemic and 23 analytical and advisory work projects. Evidence was extracted from project documents (such as Implementation Completion and Results Reports, Implementation Completion and Results Report Reviews, and aide-mémoire), analytical outputs on the Ebola response, and interviews.

Findings

The review identified findings from Ebola to support responses to COVID-19 and other crises (summarized in box 1).

Box 1. Findings from Ebola to Address Crises

1. Collaboratively planning the response and monitoring with exchange across and within countries and with community involvement promoted operational efficiencies.
2. Providing emergency budget support lay the groundwork for addressing previously diagnosed needs for public financial management reforms.
3. Extensive training and transparent and accountable financial incentives system proved key to the successful and adequate scale up of workforce capacity.
4. Building the capacity of response systems to reach communities involved strengthening contact tracing and subnational laboratory access.
5. Enhancing the capacity of laboratory networks improved the timeliness of response to disease outbreaks and required longer-term systems investment.
6. Assisting consistent local media communications helped avoid misinformation and promote behaviors to prevent the spread of disease.
7. Supporting treatment centers with adequate supplies and capacity to cope with caseloads helped to prevent disease transmission.
8. Emergency response plans required addressing the continued use of essential health services by women and children.
9. Addressing mental health and nutrition at the response's onset protected vulnerable groups, especially women and children.
10. Supporting teacher training and school classroom and sanitation improvements expedited the safe return of students.

Finding 1

Collaboratively planning the response and monitoring, with exchange across and within countries, combined with community involvement promoted operational efficiencies. For Ebola, each of the countries faced the challenge of simultaneously setting up an organizational response, establishing comprehensive plans and procedures, and reconciling different priorities, approaches, and practices. For example, political commitment was often delayed, technical guidelines were not shared at decentralized levels, and joint planning was hampered by varying priorities across agencies. The establishment of joint monitoring of the situation and response provided a useful way to improve coordination of emergency operations efforts at all levels. Strengthening information sharing from the response at the subregional level across countries and within countries

nationally reaching communities was important. Establishing incident management systems provided a platform to coordinate monitoring and planning of disease response activities with multiple partners to control the main outbreak. Building incident management system capacity in countries for other diseases also benefited response efforts to risks beyond their original target establishment. For example, the effective control of an Ebola outbreak in Nigeria after the travel of an infected person in July 2014 was facilitated by an established polio incident management system. At the community level, monitoring strengthened the engagement of local actors. For Ebola, smartphones were used for real-time reporting and data tracking in the community and for patient feedback.

Finding 2

Providing emergency budget support lay the groundwork for addressing previously diagnosed needs for public financial management reforms. Emergency macroeconomic and fiscal support operations during Ebola aimed to ensure that the governments' response plans could be executed through adequate budgeting and financial management. The operations' reform programs built on earlier diagnostics of bottlenecks in the national health and public financial management systems. In Guinea, at a time when fiscal revenues were reduced because of Ebola and the decline of mining revenue, World Bank projects (i) provided budget support, (ii) strengthened the management of funds intended to compensate Ebola workers, and (iii) improved the transparency and functioning of the broader public expenditure framework. The Emergency Macroeconomic and Fiscal Support Operation contributed to Ebola-related spending in the national budget that financed treatment centers, training of health workers, and national sensitization campaigns. In Liberia, the Integrated Public Financial Management Reform Project increased the health budget execution rate during the outbreak. In Sierra Leone, the Emergency Economic and Fiscal Support Project ensured financing and audits of the formal hazard pay system for workers supporting the response.

Finding 3

Extensive training and transparent and accountable financial incentive systems proved key to the successful scale up of workforce capacity. Incentives for frontline workers helped scale up human resource capacities for timely response. During the Ebola outbreak, rapid measures to increase the number and training of health workers included hiring foreign medical teams, training and redeploying health workers, and enrolling volunteers. The more successful strategies supported health workers and volunteers in the countries. Over 30,000 health workers were trained with the support of the World Bank during the West Africa outbreak. In hard-to-reach areas, com-

munity health workers and volunteers took on roles to conduct early case detection, safe burials, information sharing, referral, isolation, and tracking of suspected patients as well as contact tracing. They could also be trained to address cultural barriers and gender norms. At the height of the epidemic, approximately 40,000 volunteers received a graduated rate of compensation, depending on the risk category assigned to their role. Emergency workers also benefited from a formal hazard payment system through bank accounts or mobile payments. Importantly, a transparent and accountable financial incentives system proved key to the success of this workforce. The system included a list of beneficiaries, a reliable cash transfer system, and routine monitoring and reporting (including public audits). After the Ebola crisis, efforts were made to train a pool of health workers in the countries in field epidemiology and other areas to more quickly draw on their knowledge to support future epidemics.

Finding 4

Building the capacity of response systems to reach communities involved strengthening contact tracing and subnational laboratory access. During Ebola, improved disease surveillance required support at the community level to identify cases and staff laboratories in "hot spot" areas. Contact tracing in Ebola involved local stakeholders, including traditional and religious leaders, women, and youth, to share information and prevent delays to identify cases. Contact tracing was largely inconsistent at the onset of the outbreak in West Africa. Persons who might have been infected by Ebola were not systematically identified and followed, and symptomatic patients were not always referred to health care providers or isolated. Thus, case detection was one of the activities supported by the Ebola Emergency Response Project and the Regional Disease Surveillance Systems Enhancement. Data for Guinea, Liberia, and Sierra Leone show that (i) over 37,000 community health workers and other volunteers were deployed for door-to-door communication and case identification and (ii) registered contacts were followed during the mandated period to detect new Ebola cases. A comprehensive database of contacts was critical to track the number of Ebola cases from contact lists and provide analyses of the epidemic trend. Community access to laboratory testing capacity—such as equipment and the staffing and training of technicians—was crucial to identify cases. These efforts helped strengthen integrated disease surveillance and response systems, which countries developed to build interrelated community surveillance, laboratory testing, and other capacities.

Finding 5

Enhancing the capacity of laboratory networks improved the timeliness of responses to disease outbreaks and required longer-term systems investment after the crisis. In the West Africa outbreaks, the Ebola Emergency Response Project and the Regional Disease Surveillance Systems

Enhancement supported enhancing the limited laboratory capacities in Guinea, Liberia, and Sierra Leone. Better access to testing in communities is important because long lead times between the onset of symptoms and the communication of confirmed lab results increase the risk of further transmission. Strengthening the connection between geographical levels and laboratory facilities enabled rapid sample collection and improved the laboratory information management system. Cross-border collaboration and networking among laboratories in the subregion also helped mitigate the weak laboratory diagnostic capacity in the countries. Although this support helped enhance the capacities of national laboratories post-Ebola, the three countries still have limited capacities. Sustainably building laboratory capacity requires longer-term investments. Countries often requested funds for COVID-19 for the same activities as for Ebola, such as improving surveillance, laboratory capacities, and health workforce recruitment and training. Thus, the World Bank should ensure that investments in the response systems be preserved and built on between outbreaks to meet ongoing need.

Finding 6

Assisting consistent local media communications helped avoid misinformation and promote behaviors to prevent the spread of disease. Weak information sharing on Ebola contributed to continued spread. At the outbreak's start, messaging by local media caused confusion in communities. Messaging was critiqued for being too technical and failing to lead to behavior change. To help address this, communication strategies of the government were assisted by partners. In addition, contracting of sensitization and information activities to nongovernmental organizations facilitated stakeholders' participation in planning and implementation and prevented, in part, social exclusion. Communication support included training spokespeople on messaging and encouraging behavioral change through messages across a range of media.

Finding 7

Supporting treatment centers with adequate supplies and capacity to cope with caseloads helped prevent disease transmission. When the number of treatment centers was insufficient, particularly in remote areas, Ebola patients tended to remain at home, leading to further transmission among families. In late 2014, over 50 treatment centers were needed and only 16 were operational. To treat large numbers of patients and reduce transmission through patient isolation, Ebola Care Units and Community Care Centers were established. These treatment centers enabled infected persons who were isolated to receive basic curative and palliative care and access to food, drink, clean clothing, and linens. The care facilities were set up and maintained with local support,

thereby reducing the transportation of sick patients, which can otherwise lead to infections among transporters and helpers. The World Bank supported the establishment of the treatment centers and the rehabilitation of health centers to national infection prevention and control standards. The World Bank also provided drugs and other medical supplies, including protective gear for health care personnel, and contributed to the successful setup of logistic hubs, jointly used by all partners to stock supplies for the emergency response, at the district level. These logistic hubs increased capacity, reduced storage costs, and improved the timeliness of distributing essential supplies. However, initially the procurement of supplies through United Nations agencies was not fast enough. Staff suggested that direct contracting of local providers could be used in emergency situations, as has been done in Guinea during COVID-19.

Finding 8

Emergency response plans required addressing the continued use of essential health services by vulnerable women and children. The Ebola crisis and recovery effort affected the delivery of essential health services by absorbing funds originally allocated for maternal and child health and stretching health management and service delivery capacity. Also, the process to recover essential health services and strengthen the resiliency of health systems in the three countries was slower than expected. Despite progress in some areas, such as disease surveillance and immunization, delays occurred in recovering and improving reproductive, maternal, neonatal, child, and adolescent health services. Some measures taken during Ebola to promote the continued use of essential health services included providing free medical supplies for non-Ebola illnesses, reimbursing travel costs or offering transport to facilities, providing psychosocial support and food and nutrition assistance, and improving water and sanitation in facilities. These measures helped overcome the population's fear of using health services. The experience in Sierra Leone showed that addressing cultural barriers helps improve access to health care by encouraging closer links between traditional and modern health system providers in the community and training health care workers in cultural sensitivity. Moreover, strategies should consider how to handle an outbreak reemergence while preparing to regain the capacity to deliver essential health services, and how to distribute human resources to quickly stop any reemergence while restoring services.

Finding 9

Addressing mental health and nutrition at the response's onset protected vulnerable groups, especially women and children. During Ebola, some interventions were designed to reduce depression, decrease stigma, and increase levels of trust at the community level. In Liberia, the

World Bank supported over 20,000 beneficiaries in receiving services, ranging from treatment at mental health facilities to community healing dialogues. In Guinea, the World Bank supported psychological support provided by over 1,000 trained community volunteers. In regard to nutrition in Ebola, quarantines, travel restrictions, and fear of infection complicated efforts to organize farming teams, prepare fields for planting, maintain a steady supply of seed, and market produce. As a result, hungry farming families resorted to eating seed originally stored and intended for the next cropping cycle. Thus, nutrition and agriculture need to be dealt with at a pandemic's onset by including emergency components in the overall response. Some support for nutrition occurred through social protection projects during the Ebola outbreak in West Africa, but support was needed to protect the planting season. Measures to provide food alleviated malnutrition: people in quarantined areas and Ebola-affected households received food and basic supplies, and children in Guinea benefited from school feeding.

Finding 10

Supporting teacher training and school classroom and sanitation improvements expedited the safe return of students. In Sierra Leone, addressing the education system's emergency needs was part of the Ebola recovery plan to ensure the safe return of students and teachers to classrooms. A World Bank project disinfected and supplied handwashing stations to about 6,000 schools. In Guinea, the donor community combined their education sector resources in a pooled fund, which supported national efforts to get children in classrooms post-Ebola. The project supported training about 15,000 teachers, building classrooms, and improving school hygiene by providing handwashing kits, latrines, and water points.

Finding 11

Strengthening the national social protection delivery system was linked to efforts to rapidly expand income, in-kind, or cash transfer support to protect vulnerable groups. Flexible grants and cash transfers helped support vulnerable households and geographical areas affected by Ebola, such as funds for safety nets, orphanage care, female-headed households, reopening of schools, and seed and fertilizer supply for farmers. In Liberia, the World Bank funded cash transfers to quickly deploy emergency funding to the extreme poor and Ebola-affected households. The government of Liberia requested additional support to build an integrated safety net delivery system, which would enhance its longer-term capacity to increase the resilience of extremely poor people and respond to future shocks. These efforts built on existing social protection support that had improved the food security, health, education, and economic conditions of beneficiary house-

holds, and produced multiplier effects for the community. In Sierra Leone, social safety nets were launched in the poorest districts initially and then quickly expanded to districts affected by Ebola. As the epidemic waned, the safety nets returned to allocating resources geographically based on poverty, thereby laying the foundation for a national safety net program.

Finding 12

Providing short-term employment support helped vulnerable groups recover their assets and reengage in services. In Sierra Leone, Guinea, and Liberia, employment activities, such as those provided through micro and small subprojects, were important post-Ebola, particularly for youth. In Sierra Leone, the World Bank's support to the Labor-Intensive Public Works program included subprojects and temporary employment opportunities for over 60,000 unskilled or low-skilled persons. The employment activities and unconditional cash transfers helped poor people recover their lost assets. The Labor-Intensive Public Works project identified spillover effects on women's empowerment in beneficiary households by reducing the incidence of domestic violence and increasing their control over contraceptive use. Labor-Intensive Public Works also increased use of health services, which can assist in restoring the country's health system by relieving demand-side constraints. In Guinea, the Productive Social Safety Net helped temporarily increase the revenues of the underemployed and unemployed. Micro and small subprojects were drawn from local municipal development plans, selected in consultation with local populations, and included such activities as road rehabilitation, painting, gardening, and sanitation. In Liberia, interventions such as the YES Project provided a crucial source of short-term and temporary income, but they offer limited prospects for sustainable pathways out of poverty if they are implemented in isolation. The fragmentation of programs and approaches significantly hindered systems building among types of interventions or for social protection more broadly; strategic opportunities should be used to unlock the synergistic potential among them.

This note was produced by Peter Bachrach, Jenny Gold, and Vincent Turbat. It received useful comments and inputs from Oscar Calvo-Gonzalez, Rasmus Heltberg, Stephen Porter, Richard Seifman, and Galina Sotirova.

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