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REFLECTIONS

Investments in learning during the Ebola outbreak shape COVID-19 responses in West Africa: evidence from Sierra Leone and Nigeria

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In emergency response investing in learning is often seen as a luxury that will take resources and focus away from the people most in need. However, in COVID-19, building on learning from the Ebola outbreak in 2014, and from previous experiences responding to Ebola, was critical to getting an effective response mobilized quickly. The time and investments in documenting lessons learned and in building learning and collaboration spaces allowed many countries in West Africa to quickly respond to COVID-19 in more effective ways. In particular, we were able to quickly apply lessons about communicating risk more effectively, about engaging with community leaders to reinforce healthy behaviors that would protect people, and about collaborating across partners to develop tools and resources that would support the government's public health response. We are applying the lessons from Ebola about how to learn and document good practices to our COVID-19 response. This includes special attention to working with communities to document learning and understand what is and is not working.

Keywords: epidemics; Risk Communication and Community Engagement (RCCE); Ebola; COVID-19; knowledge management; After Action Review; leadership; public health; learning; public health in emergencies: Sierra Leone; Nigeria; West Africa; CARE

I am Alfred S Makavore, a Public Health Professional from Sierra Leone. I have worked for CARE International in the West Africa Region for well over a decade now. Given my background, I was tasked to lead and coordinate the Ebola Emergency Response for CARE Sierra Leone when the epidemic struck in 2014. It was a herculean task since Sierra Leone was faced with an epidemic of such magnitude for the very first time and the consequences were huge. CARE Sierra Leone's response at that time, was mainly focused on Risk Communication and Community Engagement, community-based surveillance, coupled with an integral element of institutional support to both National and District Ebola response Coordinating structures. With that firsthand experience in the emergency Ebola response, I was a frontline responder to

the COVID-19 pandemic with CARE Nigeria, which gave me an opportunity to practically adapt and apply most of the learning, models and good practices from the past Ebola epidemic in Sierra Leone, Guinea, Liberia and Cote d'Ivoire. Invariably, the models adapted, particularly the Risk Communication and Community Engagement (RCCE) proved to be very effective in Nigeria since there are lots of cultural similarities. Epidemics can be a time of information overload and great confusion leading to rumors and stigma associated with the disease. RCCE focuses on providing accurate, timely information from credible sources, delivered in a way that expresses empathy, promotes action (not fear!) and shows respect for all.

Never give up hope: the importance of learning from communities in times of crisis

In my 20 years as a professional working in the health sector, I've seen that we learn best from a wide range of sources —not just one or two, including unofficial ones. The most important way we can learn is actively interact with and listen to local communities' own experience. They are the actual people whose lives are affected. We have to buy-in more to what they tell us than just work with technocrats' perspectives, who sit in offices and come up with recommendations. When Ebola hit Sierra Leone in 2014, we knew we quickly had to learn how to respond, because this was the first time Sierra Leone had to deal with a viral epidemic. This was a massive crisis that affected the country as whole, including the humanitarian sectors and actors. There was an urgent need for action to save lives. We tried to learn everything we could about the disease, as we save lives and learn how to better organize the respond. Ebola wasn't new to the world, but it was new in our context. So we used the internet, radio shows, and other people's experiences to find out more about what to do.

Learning from the past

A lot of the learning was based around people. One of the first things that happened was we tried to learn from what had been happening in Uganda and the Democratic Republic of the Congo (DRC), because they had a lot more experience with Ebola. A lot of the experts who came to Sierra Leone to deal with the outbreak had worked in Uganda and DRC, and they brought a lot of their tools with them—like risk messaging tools such as posters, handbooks, and key messages they had used in previous Ebola outbreaks.

Depending on previous experiences wasn't always positive. We have to adapt and tailor other's experiences to suit our own realities on the ground. Ebola presented differently in Sierra Leone that it had in different outbreaks. For example, in Uganda and DRC, people with Ebola often

bled from all body openings. That was never the case with the type of virus we had in Sierra Leone. By using communications tools from DRC and teaching communities to look for those symptoms meant we lost a lot of time because communities thought they didn't have Ebola because they didn't have those symptoms, so they didn't take action early enough.
The big advances we got by learning from the previous experiences was on social behavior change communication. That gave us a place to start. From other contexts, we learned to work with religious leaders to promote change. That was especially important in Sierra Leone, where religious leaders were initially main contributors to Ebola transmission because they reinforced traditions around burial practices that spread Ebola. Uganda taught us a lot about how to work around that. We were able to apply that to our context. We also were able to apply learning about how critical it was to work with the government to set up coordinated responses, and not just do something on our own.

After implementing for a few months, we realized we needed to have a paradigm shift. We had to think of risk communication more as social mobilization. Instead of thinking of the response as purely sharing information with communities about the disease, we had to find ways to engage the community in responding to Ebola. We had to engage people's emotions instead of just presenting facts by using real examples and having conversations. The measures you need to control Ebola are a contrast to some of people's most deeply held values about caring for the sick, connecting to their families, and respecting the dead. Those values matter a lot to them, and just giving them information is not enough.

Learning in the present

The most valuable learning investments were when we shared between people responding to Ebola in Sierra Leone. We were part of the cluster coordination meetings, and the government set up other platforms to share. The Risk Communication and Social Mobilization coordination group—through the Health Education Division of the Ministry of Health and UNICEF—that brought together civil society and different government actors was the most useful. In that group, we had our ears to the ground and are always learning from communities. I really appreciated that because it allowed us to exchange that information we were hearing from communities and adapt what we were doing based on their perspectives. When we adapted our messages and communication strategies, that was informed by first-hand information we received from the communities.

Online platforms were helpful as a way to harmonize messages and key priorities across different actors. The Ministry of Health had a website that took in messages from all kinds of different

actors and validated them so people were consistent with the information they shared. We were always consulting the CDC website, which helped us understand how the disease was evolving and what was happening.

Not only did we learn from others, we were also able to share our learning from our own work. The whole process was done with lots of reflection in between the implementation. When things didn't work, we could always go back to the drawing board, do some reflection, and think about new ways to adjust our strategies and approaches. The cluster system and coordination meetings gave us an opportunity to present our learning to others. As a team, we had a whole unit for communication to document what we learned and share it out so other people could access it and work from it.

Learning for the Future

After the Ebola crisis was over, we did an After Action Review (AAR) with CARE in Sierra Leone and Liberia to document what worked, and what we would do differently if something similar ever happened. CARE's regional team hosted that meeting, documented it, and saved the information into CARE's Knowledge Management Systems for the long term. This learning is paying off. That's especially true because one of our biggest learning in the Ebola experience is that we are very slow to apply previous learning, and often reinvent learning and tools instead of drawing from what we already knew. As soon as the COVID-19 crisis happened, we were able to learn our After Action Review from Ebola, and combine it with findings from AARs in Haiti and the cholera epidemic to quickly produce guidance about what we needed to do in COVID-19. We were able to share that document with CARE teams all over the world. We also recorded a podcast capturing recommendations for what to do differently to share with staff all over the world. That podcast highlighted the importance of community engagement—not just health messages—because we needed that lesson to be ringing in the ears of everyone responding to COVID-19, especially if they had not worked in an epidemic before.

Applying learning now

The biggest lesson we have brought forward from the Ebola crisis into the COVID-19 response is that we need to bring hope to the communities. When Ebola first started, the whole way it was presented was so scary. Even when communities had potential and capacities, they did not make use of those because they had already given up hope. That's something that we have taken even further in the COVID-19 response, and it has already given dividends. It has mattered so much in

the COVID-19 response because the entire world is overwhelmed. In Ebola, we were still able to access resources from other countries and we got donations from lots of other parts of the world. That hasn't happened as much this time because the situation is affecting everyone, and not just a few countries.

We see learning paying off beyond just CARE. When COVID-19 hit, the Health Education Division reactivated the Risk Communication and Social Mobilization group, and it's really active now. That group is actively responding to COVID-19 and using learning from the Ebola experience to shape that, as well as continuing to learn from the current crisis.
Maybe the biggest change we see is how we work more with communities, and how we are better partners now—so community responses are much more effective. We communicate more confidently and reassure communities, because we have seen what they can do. We know what is possible. More importantly, the communities themselves know what they can do. The communities in Sierra Leone don't feel overwhelmed, because they understand that they can take action to change the situation. We see local communities producing their own facemasks. If they had waited for other countries to bring them masks, it would have been catastrophic.
In Ebola, we were all so scared at all levels. Nobody had seen anything like that before. Nobody knew how to do it. But in COVID-19, we already had structures in place so we could work with communities. We were already proactive to restore trust and confidence with communities. We didn't lose sight of their potential and their capacities. We engaged communities to solve problems right from the beginning, rather than focusing on ourselves as the experts who were bringing information to communities the way we did with Ebola. That disconnect at the beginning of Ebola didn't happen this time.

Learning about learning

We're still learning about how to do this better. In COVID-19, we haven't had the same kinds of platforms and coordination because everything is remote. It can be harder to find ways to connect when we can't have the same kinds of interactions and connections with each other. Even with online meetings and coordination, it doesn't work quite the same way; learning has to be more formal and structured. There are also some things I would do differently next time. I would publish more externally and try to find more ways to ensure that what we learned was available through the media and online. I would focus more on written documentation and less on presentations and in-person learning, because it's harder to do the in-person learning and the exchange of experts in COVID-19 than it was during Ebola. I'd invest more in internet infrastructure because the lack of good internet infrastructure in West Africa has limited our

capacity to exchange with each other to a large extent. And it changes who we can exchange with, because not everyone can access the internet or virtual coordination meetings.
I'd also invest more in sharing learning with communities. We learn from all kinds of sources, but from the communities most of all. We need to make sure that we are giving feedback and sharing lessons. We often find it very difficult to go back to communities to share what we have learned with them. But we need to take that time. Responding to emergencies should be a collective effort. Given that communities are the ones who are affected, they should always be at the forefront of the effort. We should specifically involve affected people in identifying appropriate learning mechanisms, in understanding what their preferences are with regards to sharing information, to providing feedback and complaints, to discussing solutions etc. Often an AAR is just done in house, and we need to step out and get the communities' side of the story.

What's next?

As we compare lessons from Ebola and COVID-19, we're seeing that both crises have personal hygiene as critical causes of the emergency. We need to invest in Water, Sanitation, and Hygiene programming for the long term, and not just as an emergency response. That means investing in water systems that will benefit people all the time. To do that, we have to focus on long-term inclusive governance and community-based management of such efforts.
We're also in the process of holding COVID-19 reflection sessions to see what we need to change in our COVID-19 response. The team in Sierra Leone used findings from their Rapid Gender Analysis to engage communities more around preventing Gender-Based Violence in the pandemic and to scale up the way they share GBV and COVID-19 information. In Nigeria, we're using our learning to We are pioneer cash & voucher assistance (CVA) among women headed households and SGBV survivors as a risk mitigation measure to reduce the risk of negative coping options such as survival sex, early/forced marriage etc.

Conclusion

Investing in learning during the Ebola outbreak didn't just help us respond to Ebola at the time. It also taught us invaluable lessons about the importance of community trust, communications strategies that built on connecting to people's emotions, and truly engaging with communities and leaders to respond to a pandemic. We also learned practical ways to connect different experts across the whole country and between countries to accelerate learning and programming in a crisis. Those lessons have helped us respond more effectively to COVID-19 and react more

quickly and effectively because we could apply them to the situation in front of us. That learning investment is critical to rapid responses in emergencies.

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