Community needs, perceptions and demand: community assessment tool

A module from the suite of health service capacity assessments in the context of the COVID-19 pandemic

INTERIM GUIDANCE

5 February 2021

World Health Organization

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WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire two years after the date of publication.

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Contents

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Introduction

Context

On 30 January 2020, the Director-General of the World Health Organization (WHO) declared the COVID-19 outbreak to be a global public health emergency of international concern under the International Health Regulations. Following the spread of COVID-19 cases in many countries across continents, COVID-19 was characterized as a pandemic on 11 March 2020 by the Director-General, upon the advice of the International Health Regulations Emergency Committee.

The COVID-19 pandemic has continued to shine a light on the fragility of health services and public health systems globally. It has revealed that even robust health systems can be rapidly overwhelmed and compromised by an outbreak. Many routine and elective services have been postponed or suspended, and existing delivery approaches must be adapted as the risk–benefit analysis for any given activity or service has changed in the current pandemic context. At the same time, primary care facilities are being called upon to manage asymptomatic and mild COVID-19 cases, to engage the community and raise awareness, to assist with various aspects of testing and contact tracing, and to refer worsening cases to secondary and tertiary care facilities. More serious cases continue to be managed at hospital level.

Against this rapidly evolving situation, many countries are facing challenges in the availability of accurate and up-to-date data on the capacity to respond to COVID-19 while maintaining the provision of essential health services. Few countries have reliable and timely data on existing and surge health workforce and service capacities. Even fewer can track and monitor the extent of disruptions to essential health services as a basis for informing mitigation strategies, guiding responses to evolving community needs, and overcoming barriers to accessing care.

In response to this situation, WHO has developed the *Community needs, perceptions and demand: community assessment tool*. This tool has been designed to help identify health system bottlenecks in order to monitor and track community needs, behaviours and barriers to care during the COVID-19 pandemic. It forms part of a wider suite of health service capacity assessments in the context of the COVID-19 pandemic *(1)*. These different monitoring tools focus on different aspects of the dual track of maintaining essential health services while continuing to manage COVID-19 cases. The suite and the different modules are described in Annex 1.

Objectives of this tool

The *Community needs, perceptions and demand: community assessment tool* can be used by countries to conduct a rapid pulse survey of community health needs and perceptions around effective use of essential health services during the COVID-19 outbreak. The assessment helps to establish an early warning system on the need to implement coping strategies to continue to respond to communities' health needs throughout the course of the pandemic. This assessment tool is informed by WHO and partner tools and guidance on community health needs, continuity of essential health services and readiness planning for COVID-19 *(2–7)*.[1]

[1] Unpublished sources include: COVID-19 et mise en œuvre des subventions: sondage effectué auprès des SR et BP des subventions du fonds mondial en Algérie, au Maroc et en Tunisie [COVID-19 and implementing subsidies: survey carried out with SR and PB of Global Fund grants in Algeria, Morocco and Tunisia], Global Fund to Fight AIDS, Tuberculosis and Malaria; Access to COVID-19 Tools Accelerator health systems preparedness and performance: COVAX item; COVID-19 behaviour tracker: insights on vaccinations, World Health Organization; Enquête auprès les volontaires et le personnel de la Croix-Rouge [Survey of Red Cross volunteers and staff], International Federation of Red Cross and Red Crescent Societies; and Measuring behavioural and social drivers (BeSD) of vaccination, World Health Organization.

Content areas

This assessment tool covers community perceptions of the use of essential health services in the context of the COVID-19 outbreak, specifically:

- unmet need for essential health services
- perceived barriers to use of essential health services, considering supply and demand factors
- attitudes towards COVID-19 vaccination
- community assets and vulnerabilities
- barriers to the provision of community-based services.

Target audience

Potential users of this assessment tool include:

- national and subnational health authorities
- national and subnational COVID-19 incident management teams
- facility managers.

Key questions that this tool can help to answer

This tool can help to answer the following questions:

- How has the COVID-19 pandemic affected utilization of essential health services?
- What are the main barriers to people's use of essential health services during the COVID-19 pandemic?
- Are there marginalized groups more affected during the COVID-19 pandemic?
- Where or what is the first point of contact during the COVID-19 pandemic?
- What are perceived attitudes towards a potential COVID-19 vaccine?
- Have community health workers been able to continue their work in the COVID-19 pandemic context?
- Have community health workers experienced stigma in pursuing their function?

When to use this tool

This tool can be used from the early stages of an emergency to recovery and continuity after recovery.

Mode of data collection

Paper-based and electronic collection of data is used. The questionnaire is administered through phone interviews. These can be completed with focus group discussions to answer specific policy questions in more detail.

Respondents

The questionnaire should be administered to key informants representing community perspectives. These include community leaders, representatives of local nongovernmental organizations or health committees, and community health workers.

Tool adaptation

The tool will require tailoring according to country context to reflect policy-makers' priorities, the burden of disease, definitions and terminology (for example, definition of "community"), list of services provided by community health workers, and other factors. Questions and response options in orange rows or columns indicate where country-specific adaption is required. Words or phrases in brackets also indicate that country-specific adaptation is required. Questions in grey rows are completed by the interviewer.

Ethical considerations

The guidance provided is not considered research; there is therefore no need to submit it to the WHO Research Ethics Review Committee. Individual countries may need the approval of local ethics committees,

depending on local law and guidelines and current practice. National authorities should ensure that they fulfil their ethical obligations by submitting the document to the pertinent local ethics boards.

Respondents are asked for their informed consent before the survey commences. No personal or facility identifying details will be reported. The WHO data-sharing agreement “Policy on use and sharing of data collected in Member States by the World Health Organization (WHO) outside the context of public health emergencies” specifies arrangements with regard to usage and dissemination of the data gathered. The agreement is attached as Annex 2.

Section 1. Identification and informed consent

The questions in this section are to introduce the tool, collect respondent information, and obtain informed consent.

No	Question	Response options
1.1	Interviewer name	
1.2	Interviewer code	
1.3	Date	
1.4	Time	
1.5	Respondent code	
1.6	Respondent phone number	
1.7	Hello. My name is [INTERVIEWER'S NAME] calling from the [ORGANIZATION]. May I speak to [RESPONDENT'S NAME]?	
1.8	Record the result of the phone call	1. Reached correct participant 2. Correct number, but participant not available 3. No answer 4. Wrong number 5. Number no longer working
1.9i	Hello, good day! I am calling on behalf of the [MINISTRY OF HEALTH/IMPLEMENTING AGENCY]. The [MINISTRY OF HEALTH/IMPLEMENTING AGENCY] is conducting an assessment among [COMMUNITY HEALTH WORKERS AND CIVIL SOCIETY ORGANIZATIONS] to assist the government in knowing more about access to essential health services during the COVID-19 pandemic in [COUNTRY]. You were selected to participate in this study. We will be asking you questions about communities' experience in accessing services in your catchment area, not your own experience. Information collected during this study may be used by the [MINISTRY OF HEALTH/IMPLEMENTING AGENCY], organizations supporting services in your facility, and researchers for planning service improvement or for conducting further studies of health services. Your name will not be included in the data set or in any report. We are asking for your help in order to collect this information. The interview will take about [15] minutes. You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit communities in the country. At this point, do you have any questions about the study? Do I have your agreement to proceed?	
1.9	May I begin the interview?	1. Yes 2. Yes, but respondent asked to call back at a different time – skip to question 7.4 3. No – STOP. Skip to question 7.4
1.10	Type interviewer name indicating consent obtained	_____

1.11	What is your gender?	1. Male 2. Female 3. Not responded
1.12	How old are you?	_____ (numerical entry)
1.13	What is your title or occupation?	**(Country-specific response options: adapt the list based on the types of key informants interviewed)** 1. Community leader (e.g. village elder, chairperson of local board or institution) 2. Community health care worker (paid) 3. Community health care worker (volunteer) 4. Community outreach programme manager 5. Civil society organization staff or member 6. Other
1.14	In what type of residential area is the community you work in or represent located?	1. Urban 2. Peri-urban **(country-specific option, if relevant)** 3. Rural

Section 2. Need for and use of essential health services in communities

Now, I will ask about need for and use of health services in the community you work in or represent.

No	Question	Response options		
2.1	People have different experiences in getting health care, especially during the COVID-19 pandemic. In the community during the past three months, would you say most people, some people or few people received the following health services when they needed them?	1. Most people	2. Some people	3. Few people
2.1.1	Urgent medical care	☐	☐	☐
2.1.2	Planned elective surgery	☐	☐	☐
2.1.3	Usual medication for chronic care diseases such as diabetes or hypertension	☐	☐	☐
2.1.4	Recommended laboratory or imaging test	☐	☐	☐
2.1.5	Mental health services	☐	☐	☐
2.1.6	Contraception services	☐	☐	☐
2.1.7	Antenatal care	☐	☐	☐
2.1.8	Delivery with assistance from a skilled birth attendant			
2.1.9	Immunization services	☐	☐	☐
2.1.10	Home-based long-term care (such as rehabilitation or palliative care) **(Country-specific options: if relevant)**	☐	☐	☐

Section 3. Barriers to seeking essential health services in communities

I will now ask about difficulties that people may experience when they need health services. This is again about people's experience in the community you work in or represent, and is not specific to your own experience.

No	Question	Response options
3.1	In general, before the COVID-19 pandemic, what were the main reasons people did not receive the health services they needed? Anything else? **DO NOT READ RESPONSE OPTIONS ALOUD.** **SELECT ALL APPLICABLE ANSWERS.**	*Informational and cultural reasons* 1. Not knowing about available services 2. Traditional or folk medicines preferred *Physical access and cost reasons* 3. Health facility too far 4. Lack of transportation to facilities 5. Lack of transportation for referral between facilities 6. Service fees too high 7. Informal payments or bribe expected *Facility reasons* 8. Perceived lack of health workers at facilities 9. Perceived lack of medicines at facilities 10. Perceived lack of equipment at facilities 11. Perceived lack of culturally or religiously sensitive services 12. Disrespectful providers at facilities 13. Mistrust of providers or facilities 14. Discrimination against certain communities 15. Inconvenient opening hours 16. Long wait time 17. Administrative requirements that exclude certain people (e.g. registration in local area, citizenship) 18. Other
3.2	During the COVID-19 pandemic, would you say people's experience in getting health care has generally remained stable, been moderately affected, or been strongly affected? This refers to any type of health services, not only COVID-19 care.	1. Remained stable – skip to question 3.4 2. Moderately affected 3. Strongly affected
3.3	Currently, what are the main reasons related to the present context that people are not receiving the health services they need? Anything else?	*Reasons related to information, perception and government recommendations* 1. Fear of getting infected with COVID-19 at facilities 2. Fear of getting infected with COVID-19 by leaving house 3. Recommendations to the public to avoid facility visits for mild illness during the pandemic

	DO NOT READ RESPONSE OPTIONS ALOUD. **SELECT ALL APPLICABLE ANSWERS.**	4. Recommendations to the public to delay routine care visits until further notice during the pandemic 5. Not knowing where to seek care during the pandemic *Reasons related to physical access and cost* 6. Lockdown, curfew or stay-at-home order 7. Disruption in public transportation 8. Household income dropped during the pandemic 9. Lost health insurance during the pandemic 10. Higher cost because of unavailability of regular care provider (e.g. need to go to providers who charge higher fees) *Reasons related to health facilities* 11. Facility closure due to COVID-19 12. Reduced or changed opening hours at facilities due to COVID-19 13. Provision of specific services suspended at facilities due to COVID-19 14. Disrupted or poor service provision at facilities due to COVID-19 (limited availability of medicines, commodities and staff) 15. Longer wait time at facilities because of current crisis context 16. Other
3.4	Currently, when people in the community feel unwell, who do they contact first to seek advice or receive care? Anything else? **DO NOT READ RESPONSE OPTIONS ALOUD.** **SELECT ALL APPLICABLE ANSWERS.**	**(Country-specific response options: adapt the list based on the country context)** 1. Community health worker 2. Dispensary or health post 3. Hospital 4. Pharmacist or drug/medicine shop 5. COVID testing centre 6. COVID phone line 7. Other trained health care provider 8. Traditional healer 9. Internet or virtual forum 10. Other 11. None (postpone care seeking)
3.5	Certain groups of people are disadvantaged in how they access health care for economic, social or cultural reasons. In the community where you work, are there such groups of people?	1. Yes 2. No – skip to next section
3.6	Who are those groups of people? Any others?	**(Country-specific response options: adapt the list based on the country context)** 1. People in extreme poverty 2. Persons working in the informal sector 3. Unemployed persons 4. Single parent household

	DO NOT READ RESPONSE OPTIONS ALOUD. **SELECT ALL APPLICABLE ANSWERS.**	5. Isolated household with elderly person 6. Persons with disabilities 7. Lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals 8. Indigenous and tribal populations 9. Religious minorities 10. Nomadic populations 11. Migrants and refugees 12. Ethnic minorities 13. Homeless people 14. Orphans and vulnerable children 15. Other

Section 4. Attitudes towards COVID-19 vaccine

I will now ask about attitudes towards COVID-19 vaccination in the community you work in or represent.

No.	Question	Response options
4.1	Approximately how many people in the community do you think are concerned about the spread of COVID-19 in the community?	1. Most people 2. Some people – more than half 3. Some people – less than half 4. Few people
4.2	If a COVID-19 vaccine becomes available in the next 3 months in the community, approximately how many adults do you think would want a COVID-19 vaccine for themselves?	1. Most people 2. Some people – more than half 3. Some people – less than half 4. Few people
4.3	If a COVID-19 vaccine becomes available in the next three months in the community, approximately how many parents do you think would want a COVID-19 vaccine for their children?	1. Most parents 2. Some parents – more than half 3. Some parents – less than half 4. Few parents
4.4i	Check responses for questions 4.2 and 4.3. If "1. Most people/Most parents" is selected in both questions, skip to next section.	
4.4	What are the main reasons for those people not wanting a COVID-19 vaccine? Anything else? **DO NOT READ RESPONSE OPTIONS ALOUD.** **SELECT ALL APPLICABLE ANSWERS.**	1. Not concerned about getting infected with COVID-19 2. Uncertain if the COVID-19 vaccine will be effective 3. Concerned about side-effects of the COVID-19 vaccine 4. Do not want to go to facilities for fear of getting infected with COVID-19 5. General mistrust of or opposition to any vaccine 6. Too busy to get vaccinated 7. Concerned about cost 8. Other

Section 5. Community assets and vulnerabilities

In this section, I will ask you questions on the context of the community you work in or represent to understand how the community has coped with the pandemic.

No.	Question	Response options
5.1	Overall, would you say the economic impact of the COVID-19 pandemic on the community has been limited, moderate, or significant?	1. Limited 2. Moderate 3. Significant
5.2i	The following questions are about government- or community-led initiatives on socioeconomic aspects, education, health and environmental hygiene implemented in the community.	
5.2	Since the start of the COVID-19 pandemic [alternative: over the last three months], would you say socioeconomic and educational initiatives have increased, remained stable or decreased? **(Country-specific adaptation: time period to be adapted as appropriate to frequency of implementation in country)**	1. Increased 2. Remained stable – skip to question 5.4 3. Decreased – skip to question 5.4
5.3	What types of initiatives have increased in the community? **DO NOT READ RESPONSE OPTIONS ALOUD.** **SELECT ALL APPLICABLE ANSWERS.**	1. Cash transfers provided by government, corporates or individuals 2. Setting up shelters to prevent gender-based violence 3. Provision and distribution of food baskets or vouchers 4. Implementation of community schooling 5. Provision and distribution of hygiene packs 6. Support to isolated (quarantined) or vulnerable (elderly) people 7. Tax relief incentives 8. Support for local innovations, e.g. desks, beds, masks 9. Others
5.4	Since the start of the COVID-19 pandemic [alternative: over the last three months], would you say health and environmental hygiene initiatives have increased, remained stable or decreased in the community? **(Country-specific adaptation: time period to be adapted as appropriate to frequency of implementation in country)**	1. Increased/enhanced 2. Remained stable – skip to next section 3. Decreased – skip to next section
5.5	What types of initiatives have increased in the community?	1. Health promotion activities (e.g. sports, handwashing demonstrations)

	DO NOT READ RESPONSE OPTIONS ALOUD. **SELECT ALL APPLICABLE ANSWERS.**	2. Distribution of information, education and communication promotion materials 3. Support to isolated or vulnerable people 4. Provision of transportation services for health care workers 5. Provision of transportation services for essential service providers or vulnerable groups (e.g. pregnant women) 6. Provision of face masks for vulnerable groups 7. Setting up handwashing facilities 8. Financial and material support to access health services (donation, lending) 9. Provision of water 10. Others

Section 6. Barriers to delivery of community-based services

Note: This section will only be administered to key informants who provide community-based services.

I will now ask about your experience as a community health worker to understand how you are able to continue performing your tasks during the COVID-19 pandemic and identify what additional support you may need.

No	Question	Response options
6.1i	Check response for Question 1.13. If it is "2. Community health care worker (paid)", "3. Community health care worker (volunteer)", or "4. Community outreach programme manager", proceed to the next question. If not, skip to next section.	
6.1	Do you feel confident in your knowledge about COVID-19?	1. Yes 2. No
6.2	How would you rate your own risk of contracting COVID-19 in your work?	1. No risk – skip to question 6.4 2. Slight – skip to question 6.4 3. Moderate 4. High 5. Very high
6.3	What do you think makes you at risk of contracting COVID-19 in your work? Anything else? **DO NOT READ RESPONSE OPTIONS ALOUD.** **SELECT ALL APPLICABLE ANSWERS.**	1. Contacting many people 2. Not having adequate protection 3. My age or underlying health conditions 4. My long work hours 5. Using public transportation to commute or to make home visits 6. General public not following the guidelines to prevent transmission
6.4	As a community health worker, do you never, sometimes, or often feel stigmatized by people in the community fearing you might transmit COVID-19?	1. Never 2. Sometimes 3. Often
6.5	Currently, do you feel you receive most, some, or little of the support you need to properly perform your work, including both your usual and your COVID-19-related work?	1. Most support – skip to question 6.7 2. Some support 3. Little support
6.6	What support do you need that you are not currently receiving? Anything else? **DO NOT READ RESPONSE OPTIONS ALOUD.** **SELECT ALL APPLICABLE ANSWERS.**	**(Country-specific response options: adapt the list based on the country context)** 1. Monetary support 2. Personal protection equipment 3. Other supplies, commodities and equipment to deliver care 4. Training and information on COVID-19-related issues 5. Other training and information 6. Support for transport 7. Health insurance 8. Other

6.7	**(Country-specific question)** Have you maintained provision of the following services in the previous three months, compared to the same three months last year?	1. Slightly reduced	2. Substantially reduced or suspended	3. Increased	4. No change
6.7.1	Immunization outreach services	☐	☐	☐	☐
6.7.2	Malaria prevention campaigns, including distribution of insecticide-treated nets	☐	☐	☐	☐
6.7.3	Neglected tropical disease outreach activities, including mass drug administration	☐	☐	☐	☐
6.7.4	Social support for tuberculosis patients (e.g. packages of food and hygiene kits)	☐	☐	☐	☐
6.7.5	Home visits	☐	☐	☐	☐

Section 7. Follow-up consent and interview result

No	Question	Response options
7.1	Thank you for responding to the interview. We may want to speak with you again in the future. Do you have a better number on which we can reach you in case we follow up with you?	1. Yes 2. No, the current number is good
7.2	What is the updated number?	
7.3	Can you repeat the number again?	
7.4	Record the result of the interview.	1. Completed 2. Postponed 3. Partly completed and postponed 4. Partly completed 5. Refused 6. Other

References

1. Suite of health service capacity assessments in the context of the COVID-19 pandemic [website]. Geneva: World Health Organization; 2020 (https://www.who.int/teams/integrated-health-services/monitoring-health-services, accessed 12 January 2021).
2. Maintaining essential health services: operational guidance for the COVID-19 context. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1, accessed 12 January 2021).
3. Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic: interim guidance. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Comm_health_care-2020.1, accessed 12 January 2021).
4. PMA COVID-19 survey. Performance Monitoring for Action; 2020 (https://www.pmadata.org/sites/default/files/2020-04/PMA-COVID-19-QRE-2020.04.28-v8-ENGLISH.pdf, accessed 12 January 2021).
5. High frequency mobile phone surveys of households to assess the impacts of COVID-19 (Vol. 4): questionnaire template. Washington (DC): World Bank; 2020 (https://documents.worldbank.org/en/publication/documents-reports/documentdetail/567571588697439581/questionnaire-template, accessed 12 January 2021).
6. The Global Fund results report 2020. Global Fund to Fight Aids, Tuberculosis and Malaria (https://www.theglobalfund.org/media/10103/corporate_2020resultsreport_report_en.pdf, accessed 29 January 2021).
7. "Front line talk": South African health care workers' response to the coronavirus (COVID-19) pandemic. Human Sciences Research Council and University of KwaZulu-Natal's Nelson R. Mandela School of Medicine (http://hdl.handle.net/20.500.11910/15341, accessed 29 January 2021).

Annex 1. Suite of health service capacity assessments in the context of the COVID-19 pandemic

On 30 January 2020, the Director-General of the World Health Organization (WHO) declared the COVID-19 outbreak to be a global public health emergency of international concern under the International Health Regulations. Following the spread of COVID-19 cases in many countries across continents, COVID-19 was characterized as a pandemic on 11 March 2020 by the Director-General, upon the advice of the International Health Regulations Emergency Committee. In response to this situation, the suite of health service capacity assessments in the context of the COVID-19 pandemic has been developed to support rapid and accurate assessment of the current, surge and future capacities of health facilities throughout the different phases of the COVID-19 pandemic.[2] The suite consists of two sets of modules (listed in Table A1.1) that can be used to inform the prioritization of actions and decision-making at health facility, subnational and national levels:

1. **Hospital readiness and case management capacity for COVID-19**
   This set of modules can be used to assess health facility readiness and case management capacities for COVID-19.
2. **Continuity of essential health services in the context of the COVID-19 pandemic**
   This set of modules can be used to assess health facility capacities to maintain delivery of essential health services. It can also be used to assess community needs and access to services during the COVID-19 pandemic.

Countries may select different combinations of modules according to context and need for one-time or recurrent use.

Table A1.1 Suite of health service capacity assessment modules

Module	Purpose
Hospital readiness and case management capacity for COVID-19	
Rapid hospital readiness checklist	To assess the overall readiness of hospitals and to identify a set of priority actions to prepare for, be ready for and respond to COVID-19
COVID-19 case management capacities: diagnostics, therapeutics, vaccine readiness, and other health products	To assess present and surge capacities for the treatment of COVID-19 in health facilities with a focus on availability of diagnostics, therapeutics and other health products as well as vaccine readiness, availability of beds and space capacities
Biomedical equipment for COVID-19 case management – inventory tool	To conduct a facility inventory of biomedical equipment reallocation, procurement and planning measures for COVID-19 case management
Ensuring a safe environment for patients and staff in COVID-19 health-care facilities	To assess the structural capacities of hospitals to allow safe COVID-19 case management, maintain the delivery of essential services and enable surge capacity planning
Infection prevention and control health-care facility response for COVID-19	To assess infection prevention and control capacities to respond to COVID-19 in health facilities
Continuity of essential health services in the context of the COVID-19 pandemic	
Continuity of essential health services: facility assessment tool	To assess the capacity of health facilities to maintain the provision of essential health services during the COVID-19 pandemic To assess workforce capacity during the pandemic, including availability, absences, COVID-19 infections, support and training
Community needs, perceptions and demand: community assessment tool	To conduct a rapid pulse survey on community needs and perceptions around access to care during the COVID-19 pandemic

[2] Suite of health service capacity assessments in the context of the COVID-19 pandemic [website]. Geneva: World Health Organization; 2020 (https://www.who.int/teams/integrated-health-services/monitoring-health-services, accessed 12 January 2021).

Annex 2. Data sharing

Policy on use and sharing of data collected in Member States by the World Health Organization (WHO) outside the context of public health emergencies

Data are the basis for all sound public health actions and the benefits of data sharing are widely recognized, including scientific and public health benefits. Whenever possible, WHO wishes to promote the sharing of health data, including but not restricted to surveillance and epidemiological data.

In this connection, and without prejudice to information sharing and publication pursuant to legally binding instruments, by providing data to WHO, the Ministry of Health of your Country confirms that all data to be supplied to WHO have been collected in accordance with applicable national laws, including data protection laws aimed at protecting the confidentiality of identifiable persons;

Agrees that WHO shall be entitled, subject always to measures to ensure the ethical and secure use of the data, and subject always to an appropriate acknowledgement of your Country:

- to publish the data, stripped of any personal identifiers (such data without personal identifiers being hereinafter referred to as “the Data”) and make the Data available to any interested party on request (to the extent they have not, or not yet, been published by WHO) on terms that allow non-commercial, not-for-profit use of the Data for public health purposes (provided always that publication of the Data shall remain under the control of WHO);
- to use, compile, aggregate, evaluate and analyse the Data and publish and disseminate the results thereof in conjunction with WHO’s work and in accordance with the Organization’s policies and practices.
- Except where data sharing and publication is required under legally binding instruments (IHR, WHO Nomenclature Regulations 1967, etc.), the Ministry of Health of your Country may in respect of certain data opt out of (any part of) the above, by notifying WHO thereof, provided that any such notification shall clearly identify the data in question and clearly indicate the scope of the opt-out (in reference to the above), and provided that specific reasons shall be given for the opt out.