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COVID-19 and Other Public Health Emergencies (PHE) Technical Organizational Capacity Tool

A Facilitated Self-Assessment Tool

November 2024

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ABBREVIATIONS

COVID-19	Novel Coronavirus 2019 Disease
CS	Capacity Strengthening
HCW	Health Care Worker
IPC	Infection Prevention and Control
MHPSS	Mental Health and Psychosocial Support
MIS	Management Information System
NGO	Non-Governmental Organization
NPI	New Partners Initiative
PHC	Primary Health Care
PHE	Public Health Emergencies
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
TOCA	Technical Organizational Capacity Assessment Tool
USAID	U.S. Agency for International Development

INTRODUCTION

PURPOSE

During 2020, NPI EXPAND prepared this Technical Organizational Capacity Assessment (TOCA) tool to assess the technical capacities of the NPI EXPAND grantees involved in the COVID-19 pandemic response. This tool was developed by NPI EXPAND Brazil, who worked on all aspects of COVID-19 mitigation, from community mobilization to data management to production and distribution of personal protective equipment (PPE) to case detection and vaccination logistics. The "COVID-19 TOCA" goal was to assist grantees in assessing their capacities for effective COVID-19 implementation. More broadly, and for similar public health emergencies, we believe this tool could be a helpful guide to any civil society organization that wants to work in any further emergency response or infectious disease management—be it for COVID-19 or other highly contagious diseases. Therefore, wherever the document mentions COVID-19, it could be understood as any new pandemic disease or future public health emergency. These technical capacity assessments should help grantees identify areas that need further capacity strengthening or development for their organization to provide quality public health emergency preparedness or infectious disease control programming.

The tool sets criteria to assess the organization's current capacity to implement a COVID-19 response in keeping with generally accepted best practices, identify key areas that need strengthening or development, and highlight program aspects that can serve as a model for other infectious disease outbreak response programs. Grantees can use this tool to track capacity improvements in the context of a project. In that case, they should respond to the "TOCA tool" at the start of implementation and a second time at the end of the period of performance. The change from baseline to end lines should help to assess whether the grantee organization's capacities improved through tailored "capacity-strengthening strategies" and the experience of implementing the project.

To support and respond to a potential public health emergency, all organizations and grantees must perform a situational analysis and individual self-assessment to evaluate their capacity before starting any response activation actions. The objective of the assessment is to evaluate the level of preparedness, identify potential gaps and/or vulnerabilities, and detect areas for improvement. Individual capacity strengthening plans will be developed by each NGO based on their assessment results. In a very practical way, we have developed this tool using three core capacity areas: organizational strategy; management strategy that includes data and information system; and operational strategy that addresses specific clinical response activities for an integrated strategy.

STRUCTURE

The COVID-19 TOCA tool is organized into 3 core capacity areas:

1. **Organizational Strategy**
    a. COVID-19 strategic focus
    b. Technical capacity and training
    c. Implementation plan and budget
    d. Quality Programming
    e. Advocacy
    f. Diversity and inclusion

g. Monitoring, Evaluation and Learning
h. Performance oversight

2. Data and Management Information System (MIS)

a. MIS
b. Data collection
c. Patient records
d. Using data for Decision-making
e. Feedback and information sharing

3. Public Health Emergency (PHE) Clinical Response Strategy

3.1 PHE Management and Service Delivery

a. Access to the PHE Clinical Guidelines and Tools
b. Technical Expertise in the PHE
c. Local Healthcare workforce capacity
d. Logistics (medical equipment/commodities procurement, forecasting and distribution)

3.2 Infection Prevention and Control (IPC)

a. IPC policy
b. PHE prevention practices
c. First line health workers' training in IPC guidelines

3.3 Other operational functions

a. Laboratory
b. PHE related Psychosocial Support
c. Vaccine readiness

3.4 PHE Risk Communication and Community Engagement (RCCE)

a. RCCE Strategy
b. RCCE Messages
c. RCCE Implementation

Each capacity area is subdivided into sub-capacity areas, each of which has specific standard statements that will be verified during the assessment process.

IMPLEMENTING THE TOCA TOOL

Each sub-capacity area in the COVID-19/PHE TOCA tool has a set of standards/criteria that all grantees will self-assess. For each criterion, four possible scores are on a grading scale, from one, indicating the lowest capacity, to four, indicating the highest capacity. The conditions present for each of the four capacity levels are described within the tool. The facilitator and the participants in the assessment should choose the description that most closely represents the organization's situation.

The organization's representatives will conduct a facilitated self-assessment using the TOCA tool and follow the next steps:

1. Discuss and agree on their capacity to meet a specific criterion under each sub-capacity area.
2. Select the appropriate score.
3. Provide a justification when needed (in the last column) to support the score.

The facilitator should have expertise in infectious disease mitigation and will be able to judge whether the evidence provided means the organization has met the standard for each criterion. To the greatest extent possible, TOCA scores should be objectively verifiable and, therefore, can be used to track an organization's progress in technical capacity over time.

ASSESSMENT INSTRUCTIONS

The assessment should be completed by representatives of the organization responsible for or knowledgeable about the PHE activities in the work plans. The assessment process should follow these general steps, customized to the organizational context as needed:

1. The facilitator should share a copy of the tool with the organization's staff for a preview to support the review of the items assessed before commencing the assessment. The organization's representatives should discuss the assessment before working with the facilitator to agree on the scores. It should be emphasized that there is no advantage to scoring highly on the tool. Having an accurate assessment will help so the results may be used to support capacity-strengthening activities. This collaborative approach ensures that all voices are heard and considered in the assessment process.
2. The facilitator should work with the organization to conduct the assessment, which should take approximately two hours to complete. If possible, the facilitator should also be accompanied by someone to take notes of the discussion around the scores and the evidence that the organization has met or not met the standard.
3. At the end of the assessment, the facilitator should share the draft report with the organization's representatives to review the assessment answers and make any corrections or provide additional evidence before the report is finalized. This process ensures that the final report accurately reflects the organization's PHE activities and provides a clear roadmap for capacity strengthening.
4. Role of the assessment facilitator: The facilitator should be external to the organization that is being assessed. This is important for ensuring a degree of objectivity, so that all participants have an equal voice, and that a few people with the most authority in the organization do not dominate the scoring. Although the scoring is based on a consensus of the participants, the facilitator has a role to play in providing technical advice and grounding the scores in evidence. The facilitator should avoid imposing scores on the organization, which reduces the organization's sense of ownership over the results of the assessment and any capacity-strengthening plan that might emerge after that. The facilitator should help the organizations identify how to increase their capacity level for each criterion. The participants can also decide the weight given to each score. Still, the facilitator might use their expertise to suggest why one criterion is more important.
5. Once an organization has gone through the process a couple of times and the evidence for each standard is well understood, the organization might be able to assess itself fairly without the need for an external facilitator.

NEXT STEPS AFTER CAPACITY ASSESSMENT

DATA ANALYSIS AND SUMMARY REPORT

The assessment methodology described in the sub-section above will generate qualitative and quantitative data. The raw score that corresponds to the level the organization is at is the quantitative

data and any notes or details that are made to clarify the interpretation of the standard or what needs to be done constitutes the qualitative data. To the extent possible, the facilitator and the participants should agree on a score during the meeting. The role of the facilitator is to explain the standard and give examples of what each level would require. The participants should provide examples or evidence of what they are doing or have done and ideally, a consensus can be reached during the meeting about where the organization compares to the standard. Some of the standards have an element of subjectivity, so it would be useful to document specific tasks or processes the organization would need to complete to reach a new level. This is particularly important if the organization plans to do an endline assessment to ensure that the same interpretation of the standards are used at endline as at baseline.

The facilitators should process and analyze the quantitative scores using a Microsoft Excel spreadsheet pre-designed for this purpose to facilitate summarizing the data into frequency tables and graphs. A hypothetical example is shown in Annex A.

Once all the categories have been assessed, the responders can separate each category and give the organization an overall score based on the average score for most of the subsections. The organization should identify the activities or investments that they may want to make to improve their score in one category or another. However, this should be done with the organizational strategy and mission in mind. If an organization feels that community mobilization and advocacy is more central to its mission, they may choose to strengthen that area even if they already have high scores in that category and they may deemphasize vaccine logistics if they feel that doesn't fit with their organizational goals and mission. These decisions may change over time, so the organization may wish to reassess priorities and capacity every six months or every year.

The facilitator should also review discussion notes and comments to analyze the reasons and justification assigned to the scores as well as to identify strengths and gaps. Any areas of disparities/contradictions for further discussion and clarification with the management/staff of the organization should also be noted for further discussion during the debrief. In some cases, the facilitators may have to point out where there are gaps between the organization's perceived capacity and associated scoring and global standards and best practices. During the debrief, such discussions may lead to adjustments in self-assessment scores.

Following the verbal debrief and any corrections, the facilitator will summarize the information into a written report to be shared with the organization. The summary report may include scores per capacity area, key strengths, gaps, and issues requiring clarification.

CAPACITY STRENGTHENING PLANNING MEETING

Once the written assessment report is final, the facilitator should meet with the organization's management and staff to prioritize capacity needs, discuss capacity strengthening (CS) interventions, and prepare CS plans. Ideally, the planning meeting should be convened within a week after the assessment meetings.

During the meeting to develop capacity strengthening plans, the facilitator will present and discuss the summary assessment of the TOCA report, discuss and clarify any areas of disparity, prioritize capacity needs, discuss appropriate interventions for each need, assign appropriate capacity strengthening indicators, and prepare a capacity strengthening plan.

The facilitator and participants should group the capacity needs by category—e.g., staffing skills, technical capacities, structures, systems, policies, equipment/tools, strategies, etc.

In most cases, the organizations will identify many capacity needs, so the organization will have to prioritize them. The facilitators and participants will agree on a prioritization criterion. The following are questions that can be considered to help prioritize needs:

- What resources in time and money are available internally and from funders to support the capacity strengthening?
- Does the targeted funder have any restrictions on funding specific activities?
- How long would it take to implement the recommended intervention?
- What are the easy, quick win needs that can be achieved in a few months?
- Which interventions would have a multiplier effect if/when implemented?
- Which interventions will do the most to improve the performance of the organization?

For each prioritized capacity need, the team will discuss and assign appropriate interventions (actions that should be taken to resolve the issue). The intervention assigned will depend on the type of capacity being addressed. Some capacity needs may require a combination of actions.

Here are examples of some of the general interventions at different levels of capacity:

- *Individual level:* Training, coaching, mentoring, peer-to-peer learning
- *Organizational level:* Exchange/study tour, technical assistance, financial assistance, knowledge management, design workshops, system or policy improvements
- *Local system level:* Policy change advocacy, social change advocacy, leveraging other efforts, networking/partnerships

Ideally, there will be a balance between capacity strengthening at different levels. Too much investment in individuals' capacity runs the risk of not staying with the organization if those individuals leave the organization. Too much investment in organizational systems without training the staff who need to use the improved systems might also mean the organization doesn't realize the intended benefits.

Once the team has selected the priority gaps to address, then they can prepare a capacity strengthening plan. The capacity strengthening plan can include details about the capacity needs the organization will address using its own resources and those that would require financial support from the project. Whenever possible, the capacity strengthening plan should be completed at the planning meeting, or if time does not permit, the meeting can assign a specific staff member to work with the facilitator to complete it after the meeting. Below is a sample capacity strengthening plan.

SAMPLE: CAPACITY STRENGTHENING PLAN FOR COVID-19 IMPROVEMENTS

Priority Capacity Gap	Suggested Interventions	Expected Outputs	Expected Outcomes	Indicators	Resources needed	Responsibility
Limited staff capacity to address widespread COVID-19 misinformation and disinformation in the target community	Train staff in COVID-19 risk communication and community engagement (RCCE) (individual and organizational level) Provide technical assistance in the preparation and implementation of RCCE action plan (organizational level) Organize community outreach events (local systems level)	All COVID-19 response staff and volunteers trained on COVID-19 RCCE The organization has an up-to-date COVID-19 RCCE action plan At least 1 Community outreach event held in each of the targeted villages.	Staff and volunteers have capacity to deliver accurate messages through RCCE, ultimately reaching more individuals in communities with COVID-19 mitigation messaging Organization is able to reach more people with accurate COVID-19 messaging, ultimately improving COVID-19 behaviors and outcomes	No. of staff and volunteers trained in COVID-19 RCCE No. of COVID-19 RCCE Actions implemented. % of RCCE Actions Implemented in time as scheduled No. of community outreach events conducted.	COVID-19 RCCE Consultant (5 months) COVID-19 RCCE materials (12 months) Budget for staff travel and community meetings (12 months)	COVID-19 Program Manager

IMPLEMENTING CS PLANS AND TRACKING PROGRESS

Once final, the organization should begin implementing the capacity strengthening plan with coaching and mentoring by the project staff. The project staff will support the organization to track and report progress on the selected capacity strengthening indicators. Regular reviews of progress should be scheduled to ensure the plan is achieving the intended results and sufficient progress is being made.

SAMPLE SUMMARY OF ASSESSMENT AND PLANNING PROCESS TIMELINE

A summary of the steps included in the assessment, data analysis, and capacity strengthening planning processes is provided below. Please note that this is a sample and should be customized to the organization and project's available time and resources to complete the assessment and conduct capacity strengthening activities.

Stage	Activity	Time Required	Individuals Included
Assessment	Facilitator and organization familiarizes themselves with assessment process and discuss together to ensure shared understanding of what is expected.	2- 3 hours	• Facilitator • Organization's representatives
	Facilitator and organization conduct assessment.	3 – 4 hours	• Facilitator • Organization's representatives • Notetaker
	Facilitator and organization review responses to ensure accuracy before finalizing scores.	1 hour	• Facilitator • Organization's representatives
Analysis	Facilitator processes and analyzes quantitative scores, discussion notes, and comments made during assessment to summarize strengths and gaps.	5 - 6 hours	• Facilitator
	Facilitator and organization conduct verbal debrief.	1 hour	• Facilitator • Organization's representatives
	Facilitator finalizes the summary report with scores per capacity area, key strengths, gaps, and issues requiring clarification.	1 day	• Facilitator
Capacity Strengthening Planning	Facilitator and organization meet to prioritize capacity needs, discuss capacity strengthening (CS) interventions, and prepare CS plan.	Approximately one week after assessment is conducted	• Facilitator • Organization's representatives and relevant staff

Implement Capacity Strengthening and Track Progress	Activities in CS plan are implemented with coaching and mentoring by project staff.	As outlined in CS plan and as project resources permit	1. Organization's representatives and relevant staff 2. Project staff
	Ongoing monitoring and reporting of progress against CS plan.	As outlined in CS plan and as project resources permit	3. Organization's representatives and relevant staff

COVID-19/PUBLIC HEALTH EMERGENCY (PHE) CAPACITY ASSESSMENT TOOL TEMPLATE

ORGANIZATIONAL STATEGY

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
a. Emerging infectious disease strategic focus	The organization's strategic plan does not address public health medical emergencies or pandemics such as COVID-19.	The organization's strategic plan has a limited focus on public health medical emergencies such as the COVID-19 pandemic.	The organization's strategic plan includes a description on how to respond to infectious disease emergencies such as the COVID-19 pandemic. The plan, however, does not address all potential medical emergencies.	The organization's strategic plan includes an extensive description on how to address infectious disease emergencies, emerging disease outbreaks in the organization's area of operation as for the COVID-19 pandemic, for example.	
b. Technical capacity	The organization does not have a track record of successfully implementing health emergency response projects. The organization just started implementing projects in this sector/sub-sector.	The organization has limited experience implementing health emergency response projects, such as COVID-19 response. The organization does not have significant experience in medical response in its projects and activities in these areas.	The organization has a strategic focus on health and more recently has started to implement health emergency response projects considering the COVID-19 pandemic. The organization has several years of experience in health projects. M&E results indicate success in implementing health response projects, including some health emergency response to COVID-19.	The organization has a strategic focus on health and emergency response projects. The organization has several years of experience in successfully implementing projects in these areas. M&E reports indicate that the organization has successfully implemented projects in emergency response, including COVID-19.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
c. Implementation Plan	The organization does not have a current PHE workplan. Any health emergency response activities are ad hoc.	The organization has a PHE work plan. However, the work plan is not sufficiently detailed.	The organization has a detailed PHE workplan, but the work plan is not up to date.	The organization has a detailed and up to date PHE workplan with: i. specific tasks ii. detailed timelines iii. defined roles and responsibilities iv. clear outputs and outcomes	
d. Quality Assurance COVID-19 or any other prior PHE Programming	The organization has not implemented a COVID-19 or any other prior PHE program review and lacks clearly defined quality standards.	The organization conducts, or has conducted, at least once in the last year, a COVID-19 or other prior PHE program review, and has included the results in the annual report. Quality standards are defined for most program areas.	The organization conducts, or has conducted, at least once in the last year, a COVID-19 program review, and has included the results in the annual report, and provides staff feedback on their performance in COVID-19 response activities or any other prior PHE. Performance is measured against clearly defined, comprehensive standards.	The organization conducts, at least twice a year, a program review, which includes data review, activity tracking, budgets, etc. soliciting stakeholder and community input, and provides guidance to staff based on the review and has records of gaps identified and addressed/solved in COVID-19 programming or any other prior PHE based on comprehensive quality standards.	
e. Aligning the budget and workplan to the PHE response activities	The organization has not aligned the PHE response activities, budget and workplan, and does not conduct budget tracking.	The organization has aligned the PHE response activities, budget and workplan to a limited extent. Tracking of any PHE budgets is rare/ limited.	The organization has completely aligned the PHE response activities, budget and workplan. Tracking of prior PHE budgets is not consistently implemented.	The organization tracks the implementation of its PHE response workplan against budgets and takes action to optimize resource utilization.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
f. Advocacy on any PHE infection prevention control, including vaccination, and RCCE	The leadership and senior management are not involved in any PHE policy dialogue, advocacy or fundraising.	The leadership and senior management address any PHE policy dialogue, advocacy and fundraising in an ad hoc manner.	The leadership and senior management identify any PHE as one of the organization's current priorities. They actively participate in some PHE policy dialogue, advocacy, and fundraising activities.	The leadership and senior management identify the PHE as a key priority are actively involved in the response policy dialogue, advocacy, and fundraising at local and/or national levels.	
g. Diversity and inclusion	The organization has limited or no understanding of the gender and diversity situation in the country. The organization does not consider issues of gender, diversity and minority groups in its plans for an emergency response or hiring practices.	The organization has some understanding of the gender and diversity situation in the country. To a limited extent, the organization considers the issues of gender, diversity and minority groups in its emergency response work. The organization does not have a tracker or data collection system to monitor results in gender, diversity and minority groups' integration during emergency response	The organization has a detailed strategy for integrating gender and diversity and minority groups into projects including medical emergency response as well as in their hiring and promotion practices. Implementation of gender and diversity actions is, however, not consistent in all projects. The organization has a gender and diversity focal point, but staff may not have all the necessary skills in gender integration.	The organization has a detailed strategy for integrating gender, diversity and minority groups in projects including medical emergency response. Implementation of the gender and diversity integration is consistent in all projects. The organization has a gender and diversity focal point who is sufficiently skilled and experienced in gender integration. Staff have the necessary skills in gender and diversity integration.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
h. Monitoring, evaluation, and Learning (MEL) during the current PHE	The organization does not monitor any PHE indicators and does not have MEL plan for these activities. The organization implements reports, but the PHE MEL activities are ad-hoc and are implemented only as a requirement by donors.	The organization has some objectives and targets for the PHE response strategy but there are no clear indicators to measure them. The organization collects some of the PHE data for some of the objectives and targets but not consistently. The organization does not have a MEL plan for these activities.	The organization has a PHE MEL plan with clear objectives, activities, indicators and targets. The organization does not consistently collect and process any PHE MEL data for most of its objectives and targets. Reports generated from the PHE MEL are shared with most stakeholders.	The organization has a well-developed COVID-19 MEL plan with clear theory of change, objectives, activities, indicators and targets. The organization consistently collects and processes MEL data and prepares reports. The reports generated are shared with all relevant stakeholders, including senior management, governments, beneficiaries, and donors.	
i. Performance Oversight of the PHE activities.	The organization does not have any senior manager or technical advisor overseeing achievement of PHE activity results.	Oversight of the PHE outcomes by senior staff is ad hoc. Senior Management meetings rarely focus on the health emergency performance as one of its agenda items.	Senior staff have some oversight of the PHE results, occasionally discuss the organization's health emergency performance in its meetings, and makes specific recommendations on outcomes.	The senior staff consistently oversees high-level organizational performance in the PHE response and makes decisions to drive the achievement of better results.	

DATA AND MANAGEMENT INFORMATION SYSTEM (MIS) STRATEGY)

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
a. PHE related data Collection	The organization has no specific tool or process for PHE data collection.	The organization has data collection tools for the PHE. The tools are either incomplete, outdated or the data is already collected elsewhere, duplicating efforts and data sources.	The organization has complete and up to date PHE data collection tools (registers and forms and, where applicable, electronic data entry procedures), duplication of data collection is limited. Staff and volunteers have been trained in the tools, but they do not all use them effectively/ regularly/ in a timely manner.	The organization has complete and up to date data collection tools (registers and forms and, where applicable, electronic data entry procedures) and uses them for the PHE data collection. Data is shared among stakeholders and data collection is not duplicated. All relevant staff and volunteers have been trained on the tools and use them effectively.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
b. Data Protection Policy and Governance	The organization does not comply with national data protection policies and works with no oversight from relevant government agencies Data confidentiality and privacy policies are not defined or enforced, patient records may be copied or exposed without the owner's knowledge.	The organization partially complies with national data protection policies and works under some oversight from relevant government agencies Data confidentiality and privacy policies are defined but training and enforcement is limited. There are no staff assigned to ensuring hardware and software are up to date and protected from external threats	The organization complies with national data protection policies and works in close collaboration with relevant government agencies. Data confidentiality and privacy policies are defined, staff are trained only when they join the organization and enforcement is limited. There is one staff that shares responsibility for ensuring hardware and software are up to date and protected from external threats	The organization complies with national data protection policies. Data Sharing Agreements document and govern collaborations with other organizations An information security specialist applies international best practices and ensures hardware and software are up to date and protected from external threats. There are well defined policies for data confidentiality, privacy and information security, the organization trains its staff at least once a year, implements controls and routinely verifies compliance.	
c. Data Integration and Interoperability	The organization's data systems are not aligned with national architecture or data exchange standards. Digital solutions are designed to operate in isolation and data is not exchanged between systems.	The organization's data systems are partially aligned with national architecture or data exchange standards. Data is exchanged through manual means.	The organization's data systems align with national architecture or data exchange standards. Data is exchanged through automated means.	The organization's data systems fully align with national architecture or data exchange standards. Data systems are interoperable, and all required data is exchanged via interoperability mechanisms with national systems reducing the amount of data collected.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
d. Data Quality	The organization has no processes in place to ensure any data quality.	The organization has guidelines on how to collect and register data. The guidelines are either incomplete or outdated. Staff do not consistently follow the guidelines. There is no policy or guideline on data quality assessments.	The organization has a policy and guidelines on data quality assessments. Staff do not consistently implement guidelines on data quality assessments (DQA). Digital solutions automate some data quality checks Gaps and issues in data quality are not promptly addressed.	The organization has a detailed policy and guidelines on data quality assessments. Digital tools for data collection and management fully enforce and automate data quality checks. The organization consistently implements DQA and takes measures to promptly address any gaps and data quality issues.	
e. Patient records* * If your organization does not provide clinical services please skip this item.	The organization has no single client/ patient records system in place and uses several different disjointed tools	The organization has a client/ patient records system in place, perhaps developed in-house, that offers limited functionality. The organization also has limited capacity to manage the server machine and system's users. The patient/ client records are incomplete or not up to date.	The organization has a complete and up to date client/ patient records system. The system is a well-known Global Good that implements critical use cases. There is a small IT team dedicated to managing the system and responding to user reported issues. .	The organization has a complete and up to date client/ patient records system that has been adapted to meet the specific needs of the clients and the local context. There is an IT team that works hand in hand with users to understand and meet their needs and to continuously improve the system and to ensure technical documentation is up to date.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
f. Using data for decision making on any PHE response	Senior management does not use the PHE data and reports in decision making.	Staff share with senior management PHE data and reports. Management rarely uses the data and reports to make decisions about any PHE response activities.	Staff share the PHE data and reports with senior management. Management uses the data and reports to make decisions about the PHE activities, but not consistently.	Staff share the PHE data and reports with senior management. Management compares its performance against pre-set benchmarks and modifies its strategies, approaches, activities, and, if required, the tools to improve performance on the PHE response activities.	
g. Feedback and information sharing on ways of working and learning on the PHE response	The organization does not collect or document the PHE information from staff and stakeholders and does not actively learn from the PHE response activities implemented.	The organization occasionally collects and documents feedback from and shares the PHE information with staff and stakeholders. Learning is not a formal process or happens in an ad-hoc manner.	The organization has policies and procedures on collecting and documenting feedback and information dissemination on the PHE from staff and stakeholders. The organization collects feedback from staff and relevant stakeholders but rarely utilizes this information to learn from and improve the PHE response.	The organization has policies and procedures about gathering feedback and information dissemination on the PHE with staff and stakeholders. The organization consistently collects feedback from staff and relevant stakeholders and utilizes this information to improve the PHE response. The organization also has a PHE information dissemination plan and a MEL plan that is consistently followed.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
h. Any PHE DATA and MIS	The organization does not have any data management information system.	The organization has a manual or a basic electronic MIS. Only 1-2 staff understand and use the system. The system is not used for PHE data collection and storage. Data security is a big issue in the organization.	The organization has a well-developed electronic MIS. The system has sufficient data security features but is not regularly reviewed and updated. Some relevant staff do not know how to use the system. The MIS has some PHE data.	The organization has a well-developed electronic MIS. The system has sufficient and up to date security features. All relevant staff have access to and know how to use the system. The PHE data is stored and analyzed via the MIS.	

PUBLIC HEALTH EMERGENCY (PHE) AND CLINICAL RESPONSE STRATEGY

3.1 PHE MANAGEMENT AND SERVICE DELIVERY GUIDELINES*

*If your organization does not plan to conduct clinical services, please skip this item.

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
a. Access to the PHE Clinical Guidelines and Tools. (For example, in the COVID setting: USAID-funded Open Critical Care COVID-19 Resource Hub, WHO, national Ministry of Health etc.)	The organization does not perform medical care. The organization has no access to Clinical Management Guidelines or PHE Tools and or does not know how to find them.	The organization has access to PHE Clinical Management Guidelines or related clinical tools, but they are not available for all staff and service providers.	The organization has access to PHE Clinical Management Guidelines or related clinical tools, and these are available for reference. The organization has trained at least 50% of the staff and service providers in the latest PHE clinical guidelines/tools.	The organization has access to PHE Clinical Management Guidelines/Tools and these are regularly consulted. All relevant staff and service providers, including all new hires, are trained in the latest PHE clinical management guidelines/tools.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
b. Technical Expertise in PHE	The organization does not perform medical care. The organization has no health workers on staff but will hire an external medical expertise and/or staff for this project.	The organization's health workers are community leaders, and/ or social workers, and/ or nurse assistants, but they have not been trained in PHE clinical management.	The organization's health workers are community leaders, and/ or nurse assistants, and/ or nurses, and/ or medical doctors. They had prior experience in COVID-19 or other PHE patient management, but they have not received formal training from or through the organization.	The organization's health workers are community leaders and/ or, social workers, and/ or nurse assistants, and/ or nurses, and/ or medical doctors. They received prior formal training from or through the organization in COVID-19 management or the actual PHE.	
c. Local health care workforce capacity*	The organization does not perform medical care. Therefore, has no clinical providers ready to provide service delivery at the community level.	The organization has some health care workers ready to provide care at the community level but will need to engage more people.	The organization has enough health care workers ready to deploy and provide care at the community level. Some of them received proper training in the PHE.	The organization has enough health care workers ready to deploy and provide service delivery at the community level. All staff was trained on the PHE guidelines and are following international standards.	
d. Logistics (medical equipment/commodities procurement, forecasting and distribution, this includes lab testing, therapeutics or vaccination)	The organization does not perform medical care. Therefore, has never procured or distributed medical products	The organization has logistics capacity to complete this task but has no prior experience distributing medical commodities at the community level.	The organization has prior experience providing medical supplies procurement and allocation but not to the extent of responding to a massive PHE.	The organization has proven experience in medical equipment/supplies procurement, forecasting and distribution. Proven experience during the COVID 19 pandemic or other infectious disease PHE.	

3.2 INFECTION PREVENTION AND CONTROL (IPC)

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
a. IPC policy (For example, during COVID: use of posters or infographics indicating hand hygiene, proper use of masks, etc.)	The organization does not have an IPC policy/guideline for employees to ensure safe face-to-face working conditions/ return to the office.	The organization has an IPC policy/guideline in place to ensure safe face-to-face working conditions/ return to the office. However, it could be incomplete or outdated. The staff and have not been trained.	The organization has a clear internal IPC policy about emergency biosafety measures to ensure safe face-to-face working conditions/ return to the office and at least 50% some staff have been trained in these measures.	The organization has clear IPC policy about PHE biosafety measures to ensure safe face-to-face working conditions/ return to the office and all staff have been trained in these biosafety measures.	
b. PHE prevention practices before, during and after travel (For example, during the COVID pandemic: use of masks, vaccination requirements, triage, COVID-19 testing, contact tracing etc.)	The organization has no clear guidelines/ instructions about PHE prevention practices before, during, and after travel.	The organization has some recommendations about PHE prevention practices before, during, and after travel. The recommendations are either incomplete or outdated.	The organization has complete and up to date guidelines about PHE prevention practices before, during, and after travel. Most staff have been trained and/ or have been made aware of the guidelines.	The organization has complete and up to date guidelines about COVID-19 prevention practices before, during, and after travel. All staff have been trained and/or made aware of those guidelines.	
c. First line health workers' training in IPC guidelines/measures (e.g., poster explaining how to use and dispose of PPE, hand hygiene, mask use, prevention measures when providing patient care, etc.).	The organization has no policy or has not delivered training to avoid infection in the health workers.	The organization has some basic PPE use and IPC guidelines. The guidelines are not sufficiently detailed. There is no training program for first line health workers.	The organization has a detailed and up to date PPE policy and IPC guidelines. The organization has sufficiently trained its staff in IPC measures for first line HCWs but is not able to provide enough PPE for staff.	The organization has a comprehensive and up to date PPE use and IPC policy and guidelines for first line HCWs. The organization has sufficiently trained its staff in IPC measures and has an adequate supply of PPE for staff.	

3.3 OTHER OPERATIONAL FUNCTIONS

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
a. Laboratory screening, testing and collection capacity	The organization has limited knowledge about laboratory screening and appropriate tests (for example, antigen tests, serology tests, RT-PCR tests).	The organization has experience in screening and performing antigen test (rapid tests) but does not have guidelines on how to proceed before, during, and after the specimen collection, or adequate disposal of tests and/ or PPE post-test/ collection.	The organization has experience in any PHE screening and in performing antigen tests (rapid tests), and/ or RT-PCR testing. There are guidelines on how to proceed before, during, and after (e.g., PPE disposal and sample transportation processing) the specimen collection. Some staff involved have been trained in the PHE screening, testing, and collection guidelines.	The organization has experience in lab screening and in performing all PHE tests, there are guidelines on how to proceed before, during, and after (e.g., PPE disposal and sample transportation processing) the specimen collection. All staff involved have been sufficiently trained in the PHE screening, testing, and collection guidelines.	
b. Psychosocial Support	The organization has no psychosocial support experience and does not provide psychosocial support for any communities dealing with impacts of infectious disease outbreaks.	The organization provides psychosocial support but does not have an approach adapted to needs of communities dealing with any infectious disease outbreaks or PHE.	The organization provides psychosocial support and has included a strategic focus on psychosocial stressors and support amidst a PHE.	The organization provides psychosocial support, and the staff have been trained on how to integrate Mental Health and Psychosocial Support (MHPSS) within USAID's or WHO guidelines.	

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
c. PHE vaccination readiness	The organization has promoted any prior COVID-19 or any other PHE vaccination campaign. Has no previous experience or capacity in implementing vaccination campaigns and/ or supporting vaccination campaigns with logistical, equipment or human resources.	The organization has promoted vaccination and RCCE for prior COVID-19 vaccination campaigns. Has supported any other PHE vaccination efforts with logistical support, equipment, or human resources.	The organization has promoted vaccination and RCCE for COVID-19 or any other PHE vaccination campaigns. Has cold chain capacity for vaccine transportation logistics and storage. Has supported prior PHE vaccination efforts with logistical support, equipment and/ or human resources.	The organization has promoted vaccination and RCCE for COVID-19 or any other PHE vaccination campaigns. Has provided training on COVID-19 vaccination, storage and transportation to health workers. Has cold chain capacity for vaccine transportation logistics and storage. Has supported COVID-19 or any other prior PHE vaccination efforts with logistical support, equipment, and human resources.	

3.4 RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

Capacity Area	1. Low Capacity	2. Basic Capacity	3. Moderate Capacity	4. Strong Capacity	Score (1 to 4)
a. PHE RCCE Strategy	The organization does not have a PHE RCCE strategy. Implementation of any PHE RCCE is ad hoc.	The organization has a basic PHE RCCE plan. The plan is not sufficiently detailed, and/ or staff do not follow it.	The organization has a detailed PHE RCCE strategy. The organization is not able to implement all the strategies and activities in its PHE RCCE plan. Few staff have been trained on how to implement the RCCE strategy.	The organization has a comprehensive PHE RCCE strategy. Implementation of the PHE RCCE strategy is on schedule and complete. All the staff have been trained to implement the RCCE strategy.	
b. PHE RCCE Messages	The organization has no experience with any prior COVID-19 or PHE RCCE message development or dissemination	The organization worked with COVID-19 developing appropriate RCCE messages related to COVID-19 infection and symptoms identification, prevention and/ or COVID-19 vaccination and choosing appropriate channels for dissemination.	The organization has a clearly defined approach to any PHE RCCE with staff and stakeholders in its program. Messages are developed using qualitative research and pretested prior to dissemination. Messages are disseminated through channels appropriate to the target population.	The organization involves community members, in development and dissemination of any PHE RCCE messages. Messages are developed using qualitative research and pretested prior to dissemination. Messages are disseminated through channels appropriate to the target population.	

c. PHE RCCE Implementation	The organization has no experience with PHE RCCE activities.	The organization implemented very few prior COVID-19 RCCE activities effectively. The actual PHE activities are not tailored to the local context and/ or to the needs of the target population.	The organization implements most of the PHE RCCE activities and distributes materials, and messages that are consistent with their strategy. Most of the activities are tailored to the local context and/or the needs of the target population.	The organization effectively implements all the PHE RCCE activities and distributes materials and messages that are consistent with their strategy. The materials and activities are tailored to the local context and/or the needs of the target population. The organization evaluates its activities and PHE RCCE materials periodically and makes any necessary revisions.	

IMPROVEMENT PLANS FOLLOW-UP

Date of original assessment	
Primary Point of Contact	Name: Title: Telephone: _____ Email: _____
Name of external facilitator who validated data	
Score for Organizational Strategy	
Score for Data and Management Information System (Management Strategy)	
Score for PHE Clinical Response Strategy (Operational Strategy)	
Targeted specific interventions are required	_____ Yes _____ No If yes, describe:
Date of follow up assessment	

ANNEX A: SAMPLE PUBLIC HEALTH EMERGENCY (PHE) TOCA SCORE

No.	Capacity Area/Statements of Excellence	Raw Score	Weight	Av. weighted Score	Notes
	Overall PHE Score			**3.8**	
1.0	**PHE Strategy and Experience**			**3.5**	
a.	The local organization describes PHE for health as one of its strategic approaches.	4	1.00	4.0	One of four program areas.
b.	The local NGO has experience in planning, implementing, and monitoring interventions to respond to public health emergencies.	3	1.50	4.5	Previous experience under a COVID-19 mitigation activity.
c.	The NGO has or has previously developed a detailed implementation plan for responding to PHEs.	3	1.25	3.8	Previous experience under a COVID-19 mitigation activity.
d.	The NGO has or has previously developed a quality assurance plan for responding to PHEs.	2	1.25	2.5	Limited experience with QA in program implementation.
e	The NGO has experience budgeting for a detailed workplan for PHE response activities	3	1.25	3.8	
f	The NGO has experience or is conducting advocacy on any PHE infection prevention control, including vaccination, and RCCE.	4	1.25	5.0	Strong experience in community mobilization and advocacy.
g	The NGO has demonstrated expertise in integrating diversity and inclusion in its organization and program design.	2	1.25	2.5	Limited evidence of targeting of excluded groups or promoting diversity.
h	The NGO has experience in designing MEL plans for PHE activities.	3	1.25	3.8	Previous MEL plan development for COVID-19 activities.
i	The NGO has experience managing and monitoring complex programs for PHE activities.	2	1	2	Limited experience managing complex programs.
2.0	**Data Management and Information Systems**			**3.3**	
a.	The NGO has experience and systems for reliable data collection for PHE activities.	3	1.50	4.5	Basic data collection experience under COVID-19 project.

No.	**Capacity Area/Statements of Excellence**	**Raw Score**	**Weight**	**Av. weighted Score**	**Notes**
b.	The NGO has strong policies and systems for ensuring data confidentiality and security.	3	1.25	3.8	
c.	The NGO ensures data integration and interoperability.	2	1.25	2.5	Limited experience ensuring integration and interoperability.
d.	The NGO has good data quality processes and systems.	2	1.00	2.0	
e	The NGO has a good system for managing patient records to serve the needs of patients.	3	1.25	3.8	Limited clinical services but good patient record management.
f.	The NGO effectively uses data for decision making in a timely manner.	2	1.50	3.0	Limited examples of data driven decisions.
g.	The NGO has systems for collecting and addressing stakeholder feedback to improve performance.	1	1.00	1.0	
h.	The NGO has strong MIS for PHE data that facilitate storage, security and use.	3	1.25	3.8	MIS system is functional and adequate storage , but security needs to be improved.
3.1	**PHE Management and clinical capacity**			**3.8**	
a.	The NGO accesses and uses the relevant clinical management guidelines and protocols.	4	1.25	5.0	Evidence of consistent use of government protocols.
b.	The NGO has necessary clinical capacity and technical expertise in PHE response.	3	1.25	3.8	Senior staff are strong
c.	The NGO has adequate workforce to deploy for PHE response.	3	1.25	3.8	
d.	The NGO has adequate logistics capacity (forecasting, procurement, distribution, storage) to support PHE response activities.	2	1.25	2.5	Small scale procurement and logistics
3.2	**Infection Prevention and Control**			**4.5**	
a.	The NGO has appropriate IPC policies and practices to implement PHE activities.	4	1.25	5.0	Documented internal protocols
b.	The NGO has appropriate biosafety policies and IPC practices during travel for activities.	4	1.00	4.0	Good reference materials

No.	**Capacity Area/Statements of Excellence**	**Raw Score**	**Weight**	**Av. weighted Score**	**Notes**
c.	The NGO has appropriate policies and training for front line providers of PHE care.	3	1.25	3.8	Training curricula exist.
3.3	**Other operational functions**			**2.8**	
a.	The NGO has experience, policies and practices for collecting, testing and storing of samples for PHE pathogens.	3	1.25	3.8	Documented protocols from COVID-19 activity
b.	The NGO integrates psychosocial support into PHE activities and trains staff using relevant curricula.	2	1.25	2.5	Very limited integration of psychosocial support content.
c	The NGO has experience and systems for vaccine program support (cold chain capacity, equipment and trained staff.)	2	1.00	2.0	Limited vaccine logistics support experience. No cold chain capacity.
3.4	**Risk Communication and Community Engagement**			**5.0**	
a.	The NGO has a clear RCCE strategy and staff have been trained in or developed the strategy.	4	1.50	6.0	Good training materials and a clear communications strategy
b.	The NGO uses clear messages that have been tested and are appropriate for the context.	4	1.50	6.0	Documentation of evidence-based message development.
c.	The NGO has experience implementing an RCCE strategy with use of multiple channels and monitoring audience comprehension.	3	1.00	3.0	Conducted multichannel communications campaign for COVID-19.

For more information, contact:

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