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COVID-19 Strategic Preparedness and Response Plan

OPERATIONAL PLANNING GUIDELINES TO SUPPORT COUNTRY PREPAREDNESS AND RESPONSE

World Health Organization

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INTRODUCTION

On 30 January 2020, the Director-General of World Health Organization (WHO) declared the coronavirus disease 2019 (COVID-19) outbreak a public health emergency of international concern (PHEIC) under the International Health Regulations (IHR 2005), following advice from the International Health Regulations Emergency Committee. On 4 February 2020, the Director-General of WHO briefed the Secretary-General of the United Nations and requested the activation of the United Nations crisis management policy to establish a Crisis Management Team (CMT) to coordinate the United Nations system-wide scale up to assist countries[1] prepare for and respond to COVID-19.

On 6 February 2020, the United Nations Development Coordination Office (UNDCO) hosted a call with WHO to brief all Resident Coordinators and United Nations Country Teams (UNCTs) on the COVID-19 Strategic Preparedness and Response Plan (SPRP),[2] emphasizing the importance of a whole-of-UN response. On 14 April 2020, WHO released a Strategy Update[3] to complement the SPRP. This Strategy Update was based on the evidence the world had accumulated since the SPRP was published about how COVID-19 spreads, the severity of disease it causes, how to treat it, and how to control transmission.

The Strategy Update provides guidance to countries preparing for a phased transition from widespread transmission to a steady state of low-level or no transmission and will continue to be updated as the epidemiological situation changes. The Strategy Update translates additional practical guidance for whole-of-government and whole-of-society strategic action that can be adapted according to specific national and subnational situations and capacities. It invites national authorities to update their own COVID-19 national plans in line with guiding principles to prepare for and respond to COVID-19.

Together, the SPRP and Strategy Update are one part of three interlocking strategic plans that guide the whole-of-UN response to COVID-19. The others are the Office for the Coordination of Humanitarian Affairs (OCHA) Global Humanitarian Response Plan for COVID-19[4] (GHRP), and the United Nations Development Programme (UNDP) Framework for the immediate socio-economic response to COVID-19[5] (Annex 1).

The primary objective of the international response to the COVID-19 outbreak is to limit human-to-human transmission of the virus, care for those affected, and maintain essential health services during the outbreak.

In some cases, national authorities will be able to implement the measures needed to prepare for and respond to COVID-19 with minimal support. In other cases, partners may be called on where there are capacity gaps at national or subnational level. WHO is calling all partners to act immediately to assist all countries to rapidly detect, diagnose and prevent the further spread of the virus, and ensure the continuity of essential services and systems.

Purpose of the updated operational planning guidelines

This document was developed by WHO to provide a practical guide that may be used by national authorities to develop and update their COVID-19 national plans across the major pillars of of COVID-19 preparedness and response. It is also intended for use by the UNCTs (e.g., WHO, OCHA, UNDP, UNICEF, etc.) and key partners to develop or update their COVID-19 multiagency plans with and in support of national authorities.

Pillars

1. Country-level coordination, planning and monitoring;
2. Risk communication and community engagement;
3. Surveillance, rapid-response teams, and case investigation;
4. Points of entry, international travel and transport;
5. National laboratories;
6. Infection prevention and control;
7. Case management;
8. Operational support and logistics;
9. Maintaining essential health services and systems.

This document includes new recommendations for action aligned with recent technical guidance, including: maintaining essential health services and systems during the outbreak, and special considerations for community transmission in low-capacity and humanitarian settings. It should also be used by UNCTs and key partners to develop or update their COVID-19 multiagency plans to complement and support national authorities.

1 In this document, the word "countries" represents countries, territories, and areas.

2 https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf

3 https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_19

4 https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf

5 https://unsdg.un.org/resources/un-framework-immediate-socio-economic-response-COVID-19

COVID-19 multiagency plans should cover an 11-month period from 1 February 2020 to 31 December 2020, in alignment with the Strategy Update. The COVID-19 multiagency plan should include resource requirements with and in support of national authorities' COVID-19 national plan. The UN and its partners will implement the adapted preparedness and response actions outlined in the COVID-19 multiagency plan to ensure that the best support possible is provided to national authorities and communities affected by COVID-19.

The implementation of the multiagency plan should be monitored based on the framework with pre-defined indicators in the SPRP COVID-19 Monitoring and Evaluation Framework adapted as the situation evolves. Subsequent COVID-19 multiagency plans will be developed based on the evolving situation and needs.

This document does not supersede existing national guidance or plans. Rather, these guidelines should be used to rapidly adapt existing relevant national plans and focus the international community's support. All technical guidance by topic is available from the WHO COVID-19 website.[6]

Next steps

Using this guidance, the immediate next steps are for national authorities, UNCTs and partners to:

- Appoint a lead, if not done so already, to coordinate and oversee the development and/or update of the COVID-19 national plan and the COVID-19 multiagency plan;
- Map existing preparedness and response capacity, and identify key gaps based on the actions outlined in this document;
- Engage with national authorities and key technical and operational partners to identify appropriate coordination mechanisms, including the health cluster, and assign roles and responsibilities to address key gaps to be addressed by the COVID-19 plans;
- Engage with local donors and existing programmes to mobilize resources and capacities to implement the COVID-19 plans;
- Establish monitoring mechanisms based on key performance indicators to track progress, and review performance to adjust COVID-19 plans as needed;
- Conduct regular operational reviews, and adjust the COVID-19 response and preparedness strategies as required.

Additional resources to aid planning and monitoring include:

- COVID-19 SPRP Monitoring and Evaluation Framework;
- The COVID-19 Partnership Platform,[7] developed by WHO and launched with the UN Development Coordination Office as an online companion tool to this document.

6 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

7 https://COVID-19-response.org

PILLARS


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Pillar 1: Country-level coordination, planning, and monitoring

National public health emergency management mechanisms should be activated with the engagement of relevant ministries such as health, education, travel and tourism, public works, environment, social welfare, social protection and agriculture to provide coordinated management of COVID-19 preparedness and response. A Government and whole-of-society approach is needed for COVID-19 planning and response. Until medical countermeasures for COVID-19 are available, prevention and control strategies must be based on public health and social measures to reduce transmission. Every country must put in place comprehensive public health measures to maintain a sustainable steady state of low-level or no transmission, and have the surge capacity to rapidly control cases and clusters to prevent community transmission. If community transmission occurs, stringent measures will need to be taken to suppress transmission as quickly as possible and transition back to a steady state of low-level transmission. See Special Considerations section of this document for guidance on community transmission, and low-capacity and humanitarian settings for actions to be taken in the context of a wider humanitarian coordination system. Stringent COVID-19 control measures can have considerable social and economic costs, and should be agreed on with the participation of relevant sectors, implemented with the full understanding and participation of communities, and based on the principle of doing no harm. Potential harm from COVID-19 control measures should be mitigated through measures to protect access to food and maintain the food chain, support continuity of essential services, and to protect livelihoods. The rationale and intended public health benefits of implementing COVID-19 control measures must be effectively communicated to the affected populations, and communities engaged to own and participate in them.

Step	Actions to be taken
1	☐ Activate multi-sectoral, multi-partner coordination mechanisms to support COVID-19 emergency preparedness and response at all levels
	☐ Ensure information platform and process in Emergency Operations Center (EOC) are updated to support COVID-19 response operations **(new May 2020)**
	☐ Engage all relevant national authorities, key partners and stakeholders to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response, or adapt, where available, an existing Influenza Pandemic Preparedness Plan (IPPP)
	☐ Conduct initial risk analysis and capacity assessment, including mapping of vulnerable populations, specific to the setting, to inform the operational plan, with a focus on reducing health and social inequalities that disproportionately affect women and girls
	☐ Begin establishing metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measures
	☐ Define rationale and conduct reiterative risk assessments using a systematic approach with the participation of relevant sectors to consider introducing, adapting and lifting public health and social measures (PHSM)
	☐ Determine and monitor the adequacy of the response to be taken by transmission scenario, level of government and/or low-capacity or humanitarian setting[8] (see Special Considerations) **(new May 2020)**
	☐ Coordinate within and across sectors and other socioeconomic pillars (such as social protection and basic services, and economic response and recovery) to mitigate social and economic consequences. Coordinate with UN agencies and partners to strengthen the global food supply chain, protect food workers, properly manage food markets, and mitigate possible disruptions to the food supply, especially for vulnerable populations. **(new May 2020)**
	☐ Communicate risk assessments and planning assumptions to inform planning and actions by all sectors at all levels **(new May 2020)**
	☐ Enhance hospital and community preparedness plans; ensure that space, staffing, and supplies are adequate for a surge in patient care needs

8 https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-COVID-19
https://interagencystandingcommittee.org/health/interim-guidance-public-health-and-social-measures-COVID-19-preparedness-and-response-0

Step	Actions to be taken
2	☐ Establish an incident management support team (IMST), including rapid deployment of designated staff from national and partner organizations, within a public health emergency operation centre (PHEOC) or equivalent if available, and ensure enhancement, coordination and networking of EOCs between levels of government and across sectors
	☐ Identify and train staff for IMST functions and roles **(new May 2020)**
	☐ Identify, train, and designate spokespeople
	☐ Engage all local donors, relevant national authorities, ministries of finance, key partners, stakeholders and existing programs to mobilize/allocate resources and capacities to implement operational plans across sectors at all levels
	☐ Review regulatory requirements and legal basis of all public health measures, using the principle of doing no harm
	☐ Prepare for regulatory approval, market authorization and post-market surveillance of COVID-19 products (e.g. laboratory diagnostics, therapeutics, vaccines), when available
	☐ Implement and issue guidance on public health and social measures, including **(new May 2020)**: ☐ Personal protective measures, such as hand washing, physical distancing, and respiratory etiquette ☐ Measures that affect indviduals, such as isolation of cases and quarantine of contacts ☐ Measures to restrict movement in and out of health care facilities, long-term care facilities, institutions and camps to protect high-risk groups ☐ Measures to reduce contact between individuals, such as the suspension of mass gatherings, closure of non-essential places of work and non-essential educational establishments, and reduced public transport. These measured should be informed by an assessment of risks and benefits, including consideration of negative secondary impact on the most vulnerable ☐ Measures to reduce the risk of introduction or reintroduction of virus from high-transmission areas to low-transmission or no-transmission areas. These measures could include limits on national and international travel, enhanced screening and quarantine, but should be informed by a detailed assessment of risks and benefits
	☐ Develop initiatives to reduce financial barriers and out-of-pocket payments people may face in accessing COVID-19 health care, and non-financial initiatives to mitigate the effect of movement restriction (e.g., free or subsidised access to telecommunications, food supplies) **(new May 2020)**
	☐ Monitor the implementation of the COVID-19 national plan based on key performance indicators in the SPRP, and produce a regular situation report to be shared with WHO and partners
	☐ Consult with neighbouring countries, other countries and regional bodies on planning and management of the COVID-19 pandemic across sectors **(new May 2020)**
3	☐ Adapt and implement national cross-sectoral pandemic preparedness business continuity plans, where existing, to the COVID-19 response
	☐ Conduct regular operational reviews to assess implementation success and failures and epidemiological situation, adjust operational plans as necessary, and share lessons learned with other countries
	☐ Conduct Inter-Action Reviews (IAR) and After Action Reviews (AAR) in accordance with IHR (2005)
	☐ Use the COVID-19 outbreak to test existing plans, and document lessons learned to inform future capacity development, including for preparedness and response activities


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Pillar 2: Risk communication and community engagement (RCCE)

It is critical to regularly communicate to the public what is known about COVID-19, what is unknown, what is being done to address unknowns and to support populations, and actions that are or will be taken. RCCE plans should be based on the seven key steps developed jointly between WHO, United Nations Children's Fund (UNICEF) and International Federation of Red Cross and Red Crescent Societies (IFRC) global partnership on RCCE. Preparedness and response activities should take into consideration social science data that provide an overview of community knowledge, attitude, practices, and perceptions, and conducted in a participatory way through community engagement strategies. Community engagement strategies and the overall response should be informed and continually optimized according to community feedback to detect and respond to concerns, rumours and misinformation.

Changes to preparedness and response interventions should be announced and explained in advance and take the perspectives of affected communities into account. Public health and social measures such as movement restrictions work best when they are discussed, understood, accepted and supported by the public. Responsive, empathic, transparent, contextualised and consistent engagement in local languages through accessible and trusted channels of communication, with community-based networks and key influencers is essential to establish trust. Risk communication should minimise uncertainty, and address risk and fear. Slowing the transmission of COVID-19 and protecting communities will require the participation of every member of every community to take action and prevent infection and transmission. This requires that everyone understands and adopts individual protection measures such as washing hands, avoiding touching their face, practicing good respiratory etiquette at all times, individual level distancing, and cooperates with physical distancing measures and movement restrictions when called on to do so.

Step	Actions to be taken
1	☐ Develop/revise and implement national risk communication and community engagement plan for COVID-19, including details of anticipated public health and social measures, RCCE objectives, and key audiences, with the participation of relevant sectors, UN agencies, partners and levels of government
	☐ Conduct rapid qualitative and/or quantitative assessments to understand affected communities (knowledge, attitudes and perceptions about COVID-19, populations most at risk, communication patterns and channels, languages, religions, influencers, health-seeking behaviours)
	☐ Define community engagement and participatory processes to motivate healthy, preventative practices based on community feedback **(new May 2020)**
	☐ Prepare local messages based on the latest evidence-based messaging from WHO, and pre-test through a participatory process that specifically targets key stakeholders and is tailored to all sub-population groups (e.g., living with disability, children, women, men, and elderly people)
	☐ Identify trusted community groups (e.g., local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks to engage with (e.g., women's and youth groups, associations for people living with disabilities, business groups, traditional healers etc.)

Step	Actions to be taken
2	☐ Manage the infodemic to ensure that evidence-based factual information and guidance dispels rumours, misinformation and disinformation **(new May 2020)**
	☐ Disseminate messages and materials in local languages and via relevant communication channels
	☐ Engage with existing public health networks and community-based networks, media, local NGOs, schools, local governments and other sectors such as health care service providers, the education sector, business, travel and food/agriculture sectors, using a consistent mechanism of communication, in coordination with UN agencies and partners to ensure the efficient use of each organization's strength and audience
	☐ Use two-way communication to provide trustworthy information and discuss community actions and solutions, via channels such as hotlines (text and talk), messaging platforms where they exist, and radio shows, with systems to detect and rapidly counter misinformation
	☐ Establish large-scale community engagement for social and behaviour change to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations
	☐ Strengthen and maintain information and communication technology (ICT) infrastructure, networks and staff, and prepare for surges in demand across sectors and levels **(new May 2020)**
3	☐ Systematically establish community feedback mechanisms through: social media, community perceptions surveys, knowledge, attitude and practice surveys; and direct dialogues and consultations to ensure community feedback informs response measures, and the response is accountable to affected populations
	☐ Ensure community engagement is based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic
	☐ Monitor rumours, and track and respond to misinformation and disinformation **(new May 2020)**
	☐ Monitor the effectiveness of the RCCE plan and document lessons learned to inform future preparedness and response activities


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Pillar 3: Surveillance, rapid response teams, and case investigation

COVID-19 surveillance data are essential to calibrate appropriate and proportionate public health measures. In addition to active case finding in communities, health facilities, and at points of entry/exit, it will be necessary to enable the general population to practice self-surveillance, in which individuals are asked to self-report as a suspected case as soon as they have symptoms or signs and/or if they are a contact of a confirmed case. All countries are encouraged to adopt international R&D Blueprint efforts and research protocols such as the Unity studies to investigate additional epidemiological, virologic, and clinical characteristics.

In a scenario in which community transmission is occurring, it is essential to monitor the geographical spread of the virus, transmission intensity, disease trends, characterize virological features, and assess impacts on health-care services. See Special Considerations for more information on surveillance considerations in settings with community transmission.

Step	Actions to be taken
1	☐ Disseminate case definition and investigation protocols to health workers (public and private sectors) in line with WHO guidance
	☐ Activate and/or enhance case finding using case definitions and event-based surveillance, and continue influenza-like illness (ILI) and severe acute respiratory infection (SARI) surveillance and/or other syndromic surveillance
	☐ Assess gaps in active case finding, mortality surveillance, and event-based surveillance systems

Step	Actions to be taken
2	☐ Train and equip multidisciplinary rapid (community-based) response teams to immediately investigate cases and clusters, scale up case management, and conduct individual isolation of cases, scale up contact tracing and quarantine of contacts
	☐ Enhance surveillance to detect suspect cases within 48 hours of symptom onset, with testing of suspect cases within 24 hours of detection[9] **(new May 2020)**
	☐ Identify, follow up, and whenever possible quarantine contacts for the 14-day incubation period of the virus; actively engage communities for contact tracing, with a focus on high-risk areas **(new May 2020)**
	☐ Establish a national system of contact tracing (including contact database) through a whole-of-society approach **(new May 2020)**
	☐ Enhance existing surveillance systems to enable monitoring of COVID-19 transmission (using qualitative and quantitative indicators), and adapt tools and protocols for contact tracing and monitoring to COVID-19
	☐ Undertake case-based reporting to WHO within 24 hours in accordance with IHR (2005)
	☐ Implement surveillance strategies to actively monitor and report disease trends, impacts, and population perspectives to global laboratory/epidemiology systems, such as the Global Influenza Surveillance and Response System. Share with WHO all data necessary to conduct global risk assessments, including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children.
3	☐ Continue conducting risk assessments as appropriate. Use global, regional and/or national and local risk assessments to guide actions or changes to the response strategy
	☐ Provide robust and timely epidemiological and social science data analysis to relevant stakeholders to continuously inform risk assessment and support operational decision making for the response
	☐ Test and document the performance of the existing surveillance system, through actual experience and/or table-top or simulation exercises and use the findings to inform future preparedness and response activities
	☐ Produce weekly epidemiological and social science reports, and disseminate to all levels and international partners

9 https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(COVID-19)

Pillar 4: Points of entry, international travel, and transport

Efforts and resources at points of entry should focus on supporting surveillance and risk communication activities. Appropriate public health measures at points of entry may include: entry and exit screening; education of travellers on responsible travel behaviours before, during, and after travel; case finding; contact tracing; isolation; and quarantine. Risk of imported cases can be managed through: an analysis of the likely origin and routes of importations; measures put in place at points of entry to rapidly detect and manage suspected cases among travellers, including the capacity to quarantine individuals arriving from areas with community transmission; and cleaning and disinfection of the environment at points of entry and onboard conveyance. It is critical that countries enable essential travel needed for pandemic response, humanitarian relief, repatriation, and cargo operations.

Step	Actions to be taken
1	☐ Develop, adjust and implement a points of entry public health emergency plan
2	☐ Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s) and carry out cleaning and disinfection; prepare for novel public health approaches at points of entry for resumption of international traffic
	☐ Prepare rapid health assessment and isolation facilities to manage ill passenger(s) and identified contacts, and make provisions to safely transport patients or contacts to designated health facilities
	☐ Communicate information about COVID-19 to travellers, including travellers to mass gatherings
	☐ Prepare activities for active case finding at points of entry in coordination with stakeholders, including point of entry and conveyance operators **(new May 2020)**
3	☐ Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust readiness and response plans as appropriate
	☐ Regularly report COVID-19-related alerts detected at points of entry or on-board conveyances to the national health surveillance system **(new May 2020)**

Pillar 5: National laboratories

Countries should prepare laboratory capacity to manage large-scale testing for COVID-19 domestically, through public, private and academic laboratories. If this is not possible, testing should be organized through arrangements with international reference laboratories. In the event of community transmission, surge plans should be activated to manage the increased volume of samples from suspected cases. See the Special Considerations section in this document for actions to adapt laboratory capacity to meet surge demand during community transmission, low-capacity, and humanitarian settings. WHO can support access to relevant reference laboratories and protocols, reagents, and other supplies through the interagency COVID-19 Supply Chain System (CSCS).

Step	Actions to be taken
1	☐ Establish access to designated domestic COVID-19 diagnostic laboratory(ies) through public, private and academic systems, and consider use of veterinary laboratories
	☐ Adopt and disseminate SOPs (as part of disease outbreak investigation protocols) for collection, management, and transport of COVID-19 diagnostic specimens
	☐ Identify hazards and perform a biosafety risk assessment at designated laboratories; use appropriate biosafety measures to mitigate risks
	☐ Laboratories should adopt systems for molecular (PCR) testing, supported by timely access to reagents, testing kits, and a trained workforce
2	☐ Ensure specimen collection, management, referral network and procedures are functional
	☐ Share genetic sequence data and virus materials according to established protocols for COVID-19
	☐ Develop and implement plans to link laboratory data with other key epidemiological data for timely data analysis
	☐ Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission
3	☐ Monitor and evaluate diagnostics, data quality and staff performance, including use of and performance with different platforms, and incorporate findings into a strategic review of national laboratory capacity; share lessons learned
	☐ Develop a quality assurance mechanism for laboratory testing, including quality indicators

Pillar 6: Infection prevention and control

Infection prevention and control (IPC) practices in health facilities and communities should be reviewed and enhanced to prepare for the treatment of patients infected with COVID-19, and prevent transmission to staff, between staff, between staff and patients/visitors, and in the community. Ensure community awareness of public health preventive measures, including physical distancing, frequent hand washing, and respiratory etiquette. In the event of shortages of critical personal protective equipment (PPE), it may be necessary consider PPE alternatives. Enabling these IPC measures is dependent on access to safely managed water, sanitation and hygiene (WASH), particularly for vulnerable communities and those populations affected by humanitarian crisis.

Step	Actions to be taken
1	☐ Assess IPC capacity at all levels of healthcare system, including public, private, traditional practices and pharmacies. Minimum requirements include functional triage system and isolation rooms, trained staff (for early detection and standard principles for IPC); and sufficient IPC materials, including PPE and WASH services/hand hygiene stations
	☐ Assess IPC capacity in public places and community spaces where risk of community transmission is considered high
	☐ Review and update existing national IPC guidance. Health guidance should include defined patient-referral pathways, including an IPC focal point, in collaboration with case management. Community guidance should include specific recommendations on IPC measures and referral systems for public places such as schools, markets and public transport, as well as community, household, and family practices
	☐ Increase public awareness/education on preventative public health measures, including physical distancing, frequent hand hygiene and respiratory etiquette through media, signage in public places, and through whole-of-society awareness and engagement approaches, including with national and local governments and private sector actors **(new May 2020)**
	☐ Develop and implement a plan for the management and monitoring for respiratory illness of health workers exposed to confirmed cases of COVID-19
	☐ Develop a national plan to manage PPE supply (stockpile, distribution), and to identify IPC surge capacity needs (personnel numbers and competencies)
	☐ Advocate for water utilities and small-scale providers to provide sufficient safe water to allow for IPC measures in healthcare facilities, hand hygiene in homes, public and collective settings **(new May 2020)**
	☐ Ensure critical WASH products are prioritized in global and regional supply chain support initiatives; support local production of critical hygiene and prevention items **(new May 2020)**
	☐ Advocate for the inclusion of WASH services in economic response packages to support vulnerable crisis-affected households **(new May 2020)**

Step	Actions to be taken
2	☐ Identify and engage trained staff with the authority and technical expertise to implement IPC activities that are prioritized based on risk assessment and local care-seeking patterns
	☐ Record, report, and investigate all cases of healthcare-associated infections **(new May 2020)**
	☐ Disseminate IPC guidance for home and community care providers
	☐ Implement triage, early recognition, source controls, and administrative controls; use visual alerts (educational material in appropriate language) to inform family members and patients to inform triage personnel of respiratory symptoms, and to practice respiratory etiquette
	☐ Apply standard precautions for all patients at all times, as well as administrative, environmental and engineering controls; implement empiric additional precautions (droplet and contact and, whenever applicable, airborne precautions) for suspected or confirmed COVID-19 cases **(new May 2020)**
	☐ Support access to WASH services in public places and community spaces most at risk, with special considerations for vulnerable collective sites (including for homeless people, migrants, and long-term care populations) and community isolation centres
	☐ Ensure hand hygiene stations are available, supplied and functioning at all gathering places (markets, clinics, places of worship, public facilities and transport stations) in COVID-19 affected areas, high-risk areas and humanitarian settings **(new May 2020)**
	☐ Develop mortuary plans to manage increased numbers of corpses due to COVID-19 deaths, and ensure safe burial measures are supported **(new May 2020)**
3	☐ Monitor IPC and WASH implementation in selected healthcare facilities and public spaces using the Infection Prevention and Control Assessment Framework, the Hand Hygiene Self-Assessment Framework, hand hygiene compliance observation tools, and the WASH Facilities Improvement Tool
	☐ Monitor the continuity of WASH services, supplies, prices and financial sustainability, analyse trends, estimate gaps, and propose corrective actions when needed **(new May 2020)**
	☐ Provide prioritized tailored support to health facilities based on IPC risk assessment and local care-seeking patterns, including for supplies, human resources and training
	☐ Carry out training for all health workers to address any skills and performance deficits, with emphasis on how to put on and remove PPE, and environmental cleaning


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Pillar 7: Case management

Health facilities should prepare for large increases in the number of patients with suspected COVID-19. Staff should be familiar with the suspected COVID-19 case definitions, and must be able to deliver the appropriate care pathway; ensuring that patients with, or at risk of, severe illness are treated and/or referred immediately. A high volume of cases will put staff, facilities and supplies under pressure. A COVID-19 referral pathway that designates appropriate care settings for mild COVID-19 patients may allow for care in the community, a facility for respiratory support, or at home. Guidance should be made available on how to manage mild cases in self-isolation, when appropriate. Plans to provide business continuity and provision of other essential healthcare services should be reviewed and adapted as needed. Special considerations and programs should be implemented for vulnerable populations (elderly patients; patients with chronic diseases; pregnant and lactating women; children; and residents of long-term facilities).

Step	Actions to be taken
1	☐ Map vulnerable populations and map public and private health facilities and workforce (including traditional healers, pharmacies, long-term living facilities, and other providers), and identify alternative facilities that may be used to provide treatment
	☐ Identify oxygen capacity and mechanical ventilation capacity
	☐ Continuously assess the burden on the local health system, and capacity to safely deliver primary health care services and other essential health services
	☐ Ensure that guidance is made available for the care of all patients with COVID-19, including self-care for those with mild COVID-19 (if self-isolation is the correct care pathway) and acute care for those with severe disease

Step	Actions to be taken
2	☐ Disseminate regularly updated information, train, and refresh the health work force (including community health workers, medical, nursing, respiratory therapists, physical therapists, ambulatory teams) in the management of COVID-19, using specific protocols based on international standards and WHO clinical guidance
	☐ Set up screening and triage areas at all health care facilities; set up screening capacities in the community **(new May 2020)**
	☐ Surge clinical care capacity according to the epidemiological scenario; establish dedicated COVID-19 treatment areas to effectively isolate and treat all COVID-19 cases **(new May 2020)**
	☐ Deliver optimized standard of care for all patients, including those with severe and critical COVID-19 **(new May 2020)**
	☐ Establish dedicated pre-hospital COVID-19 care pathways, with equipped teams and ambulances to safely transport suspected and confirmed cases (including safe transfer of severe and critically ill patients) to designated treatment areas
	☐ Ensure comprehensive medical, nutritional, psycho-social, and palliative care for those with COVID-19
	☐ Participate in the WHO global clinical network knowledge exchange platform to aid in the clinical characterization of COVID-19, address challenges and share best practices in clinical care, and foster global collaboration (optional based on country capacity)
	☐ Maintain routine and emergency health service provision for the population
3	☐ Assess diagnostics, therapeutics, and vaccines for compassionate use and clinical trials, regulatory approval, market authorization, and/or post-market surveillance, as appropriate
	☐ Adopt international R&D Blueprint efforts and research protocols, such as: Monitored Emergency Use of Unregistered and Investigational Intervention protocol; the Solidarity trial for therapeutics; Unity studies to investigate additional epidemiological, virological, and clinical characteristics. Contribute clinical data on hospitalized COVID-19 patients to the WHO Global COVID-19 Clinical Platform
	☐ Evaluate implementation and effectiveness of case management procedures and protocols (including for pregnant women, children, elderly patients, and immunocompromised patients), and adjust guidance and/or address implementation gaps as necessary

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Pillar 8: Operational support and logistics

Logistical arrangements to support incident management and operations should be reviewed. Expediated procedures may be required in key areas (e.g., surge staff deployments, procurement of essential supplies, staff payments, staff trained in the use of the Essential Supplies Forecasting Tool). Due to the acute shortage of essential supplies to respond to the outbreak, a COVID-19 supply chain system (CSCS) has been established to provide countries with essential supplies for their COVID-19 response. The CSCS is led by the Supply Chain Task Force, which is co-chaired by WHO and WFP, and includes representation from all participating agencies (WHO, WFP, UNICEF, United Nations Office for Project Services (UNOPS), UNDP, United Nations Population Fund (UNFPA), Office of the United Nations High Commissioner for Refugees (UNHCR). The CSCS will identify, certify, source, allocate, and deliver essential supplies to where they are needed most.

Step	Actions to be taken
1	☐ Map available resources and supply systems in health and other sectors; conduct in-country inventory review of supplies based on WHO's: a) Disease Commodity Package (DCP); b) COVID-19 patient kit; and c) the COVID-19 Supply Chain System (CSCS) catalogue. Identify central stock reserves, if available, for COVID-19 case management
2	☐ Implement supply chain control and management system (stockpiling, storage, security, transportation and distribution arrangements) for medical and other essential supplies, including COVID-19 DCP and patient kit reserve ☐ Review procurement processes (including importation and customs) for medical and other essential supplies, and encourage local sourcing of high-quality products to increase timely access to supplies ☐ Assess the capacity of the local market to meet increased demand for medical and other essential supplies, and coordinate requests for critical items to the CSCS through the COVID-19 Supply Portal on the COVID-19 Partners Platform ☐ Conduct regular review of supplies; develop a central stock reserve for case management of COVID-19 ☐ Prepare staff surge capacity and deployment mechanisms; health advisories (guidelines and SOPS); pre-deployment and post-deployment packages (briefings, recommended/mandatory vaccinations, enhanced medical travel kits, psychosocial and psychological support including peer support groups) to ensure staff wellbeing
3	☐ Identify and support critical functions that must continue during a widespread outbreak of COVID-19, such as: water and sanitation; fuel and energy; food; telecommunications/internet; finance; law and order; education; and transportation; and essential workforce

Pillar 9: Maintaining essential health services and systems

When health systems are overwhelmed, both direct mortality from an outbreak and indirect mortality from preventable and treatable conditions increase dramatically. Countries will need to make difficult decisions to balance the demands of responding directly to COVID-19, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of system collapse. See associated operational guidance: COVID-19: Operational guidance for maintaining essential health services during an outbreak.[10]

Step	Actions to be taken
1	**Establish simplified purpose-designed governance, finance and coordination mechanisms to complement response protocols**
	☐ Establish (or adapt) simplified mechanisms and protocols to govern essential health service delivery in coordination with response protocols
	☐ Establish triggers/thresholds that activate a prioritization process and phased reallocation of routine comprehensive service capacity towards essential services
	☐ Assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways
	☐ Set up coordination mechanism between finance and health authorities for financing essential health services **(new May 2020)**
	☐ Introduce more flexible budget allocations and spending authority for frontline service providers **(new May 2020)**
	☐ Suspend co-payments/user fees at the point of care for essential health services for all patients, regardless of insurance or citizenship status **(new May 2020)**
	Identify context-relevant essential services
	☐ Generate a country-specific list of essential services (based on context and supported by WHO guidance and tools)
	☐ Identify routine and elective services that can be delayed or relocated to non-affected areas
	☐ Create a roadmap for progressive phased reduction of services

10 See associated operational guidance: https://www.who.int/publications-detail/COVID-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak

Step	Actions to be taken
2	**Optimize service delivery settings and platforms**
	☐ Conduct a functional mapping of health facilities, including those in public, private, and military systems (shared action with Pillar 7: Case management)
	☐ Taking into account re-purposed facilities, concentrate 24-hour acute care services at designated first-level hospital emergency units (or similar) and ensure public awareness
	☐ Redirect chronic disease management to focus on maintaining supply chains for medications and needed supplies, with a reduction in provider encounters
	☐ Establish outreach mechanisms as needed to ensure delivery of essential services
	☐ Disseminate information to prepare the public for changes in service delivery platforms (including outreach), and to guide safe care-seeking behaviour **(new May 2020)**
	Establish effective patient flow (screening, triage, and targeted referral) at all levels
	☐ Disseminate information to prepare the public and guide safe care-seeking behaviour
	☐ Establish screening of all patients on arrival and mechanisms for isolation at all sites using the most up-to-date COVID-19 guidance and case definitions
	☐ Ensure acuity-based triage at all sites providing acute care
	☐ Establish clear criteria and protocols for targeted referral (and counter-referral) pathways
3	**Rapidly re-distribute health workforce capacity, including re-assignment and task sharing**
	☐ Maximize occupational health and staff safety measures in all categories listed in the associated guidance
	☐ Map health worker requirements (including critical tasks and time expenditures) in the four COVID-19 transmission scenarios
	☐ Create a roadmap for phased implementation and timely scale-up of a workforce redistribution strategy
	☐ Allocate finances for timely payment of salaries, overtime, sick leave, and incentives or hazard pay, including for temporary workers
	☐ Initiate rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management, and essential infection prevention and control
	Identify mechanisms to maintain availability of essential medications, equipment, and supplies For details, see Pillar 8: Operational support and logistics of the Operational planning guidelines to support country preparedness and response
	☐ Map essential services list to resource requirements
	☐ Map public and private pharmacies and suppliers
	☐ Create a platform for reporting inventory and stockouts, and for the coordination of re-distribution of supplies


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Special considerations for community transmission settings

Community transmission is defined as an outbreak or outbreaks in which a large number of confirmed cases are detected from unknown chains of transmission, or by increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories).

Pillar, step, and action to be taken	Adjustment for community transmission settings
Pillar 1, Step 2: Country-level coordination, planning and monitoring	
☐ Establish an incident management team, including rapid deployment of designated staff from national and partner organizations, within a public health emergency operation centre (PHEOC) or equivalent if available	☐ Implement all-of-society resilience, repurpose government, business continuity, and community services plans
Pillar 3, Step 2: Surveillance, rapid response teams, and case investigation	
☐ Enhance surveillance to detect suspect cases within 48 hours of symptom onset, with testing of suspect cases within 24 hours of detection[11]	☐ Adapt existing surveillance systems to monitor transmission intensity and spatial distribution (e.g. through sentinel sites)
☐ Identify, follow up, and whenever possible quarantine contacts for the 14-day incubation period of the virus; actively engage communities for contact tracing, with a focus on high-risk areas	☐ Continue active case finding and contact tracing where possible, especially in newly infected areas
☐ Establish a national system of contact tracing (including contact database) through a whole-of-society approach	☐ Quarantine contacts and isolate cases; apply self-initiated isolation for symptomatic individuals
☐ Enhance existing surveillance systems to enable monitoring of COVID-19 transmission (using qualitative and quantitative indicators), and adapt tools and protocols for contact tracing and monitoring to COVID-19	
☐ Actively monitor and report disease trends, impacts, and population perspectives to global laboratory/epidemiology systems, such as the Global Influenza Surveillance and Response System. Share with WHO all data necessary to conduct global risk assessments, including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children.	

11 https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(COVID-19)

Pillar, step, and action to be taken	Adjustment for community transmission settings
Pillar 5, Step 2: National laboratories	
☐ Ensure specimen collection, management, referral network and procedures are functional	☐ If diagnostic capacity is insufficient, implement prioritized testing and measures that can reduce spread (e.g. isolation), including priority testing of: • People who are at risk of developing severe disease and vulnerable populations, who will require hospitalization and advanced care for COVID-19 (see Clinical management of severe acute respiratory infections when novel coronavirus is suspected). • Health workers (including emergency services and non-clinical staff) regardless of whether they are a contact of a confirmed case (to protect health workers and reduce the risk of nosocomial transmission) • The first symptomatic individuals in a closed setting (e.g. schools, long-term living facilities, prisons, hospitals) to quickly identify outbreaks and ensure containment measures
☐ Share genetic sequence data and virus materials according to established protocols for COVID-19	
☐ Develop and implement plans to link laboratory data with other key epidemiological data for timely data analysis	
☐ Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission	
Pillar 7, Step 2: Case management	
☐ Disseminate regularly updated information, train, and refresh the health work force (including community health workers, medical, nursing, respiratory therapists, physical therapists, ambulatory teams) in the management of COVID-19, using specific protocols based on international standards and WHO clinical guidance	☐ Screen and triage patients at all points of access to the health system
☐ Set up screening and triage areas at all health care facilities; set up screening capacities in the community	☐ Care for all suspected and confirmed patients according to disease severity and acute care needs
☐ Surge clinical care capacity according to the epidemiological scenario; establish dedicated COVID-19 treatment areas to effectively isolate and treat all COVID-19 cases	☐ Scale-up surge plans for health facilities and ad-hoc community facilities, including enhancement of COVID-19 referral system


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Special considerations for low-capacity and humanitarian settings

People affected by humanitarian crises and those living in low capacity settings are especially vulnerable to the impacts of the COVID-19 outbreak. In these settings, critical measures for COVID-19 prevention and control that have been a feature of the response in higher resource settings, such as physical distancing, movement restrictions and home confinement, hand washing with water and soap, and closure of schools and workplaces, may be more difficult to implement and potentially more harmful to the survival of many community members. In these settings, it is critical to consider measures to protect access to food supply and essential services, and to protect livelihoods. In addition, capacities for testing, isolating and treating those who develop the disease, and tracing and quarantining contacts, may be severely lacking owing to weaker health systems.

Preparedness and response actions in communities in low-capacity settings are supported by UN agencies, regional and international partners and networks, and in humanitarian settings with additional support through the UN Resident/Humanitarian Coordinator.

Considerations are referenced from the Interagency Standing Committee (IASC) Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness and Response Operations in Low Capacity and Humanitarian Settings.[12]

Pillar, step, and action to be taken	Adjustment for Low-Capacity and Humanitarian Settings
Pillar 1, Step 1: Country-level coordination, planning, and monitoring	
☐ Engage all relevant national authorities, key partners and stakeholders to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response, or adapt, where available, an existing Influenza Pandemic Preparedness Plan	☐ Engage communities and local Civil Society Organizations (CSOs) to assess the risks of COVID-19 introduction and/or spread in their community, to enable an appropriate and contextualized response ☐ Empower leadership of communities and local authorities to develop a site-specific plan ☐ Map community measures for community health workers and community actors to implement and monitor ☐ Map resources that are available, and identify remaining gaps to prioritize external support

12 https://interagencystandingcommittee.org/system/files/2020-05/IASC%20Interim%20Guidance%20on%20Public%20Health%20and%20Social%20Measures%20for%20COVID-19%20Preparedness%20and%20Response%20Operations%20in%20Low%20Capacity%20and%20Humanitarian%20Settings.pdf

Pillar, step, and action to be taken	Adjustment for Low-Capacity and Humanitarian Settings
Pillar 1, Step 2: Country-level coordination, planning, and monitoring	
☐ Implement and issue guidance on public health and social measures, including: ☐ Personal protective measures, such as hand washing, physical distancing, and respiratory etiquette ☐ Measures that affect individuals, such as isolation of cases and quarantine of contacts ☐ Measures to restrict movement in and out of health care facilities, long-term care facilities, institutions and camps to protect high-risk groups ☐ Measures to reduce contact between individuals, such as the suspension of mass gatherings, closure of non-essential places of work and non-essential educational establishments, and reduced public transport. These measured should be informed by an assessment of risks and benefits, including consideration of negative secondary impact on the most vulnerable ☐ Measures to reduce the risk of introduction or reintroduction of virus from high-transmission areas to low-transmission or no-transmission areas. These measures could include limits on national and international travel, enhanced screening and quarantine, but should be informed by a detailed assessment of risks and benefits	☐ Restrict or ban mass gatherings; permit smaller gatherings where physical distancing and hand hygiene can be ensured to reduce the potential for spread, including market attendance, humanitarian distributions and other assistance, and religious events. Plan for the continuation of daily essential activities in the community (trade, public services) and functioning community governance structures and mechanisms that respect physical distancing and hand hygiene to the extent possible. If not possible, establish one-way circulation system for pedestrians, with ground markings and physical barriers in communal facilities to support physical distancing ☐ Reduce the use of non-essential workspaces and ensure essential services. If not possible, explore the feasibility of staggered work times ☐ Reduce non-essential movement. If not possible, explore the feasibility of staggered timings for movements outside the home ☐ Work with UN agencies and partners to strengthen the global food supply chain, protect food workers, properly manage food markets, and mitigate possible disruptions to the food supply, especially for vulnerable populations. Where possible, local markets and food systems should be supported throughout containment measures and humanitarian interventions ☐ Should widespread transmission occur, and stricter movement restrictions be needed, ensure that basic necessities and protection of communities can be fulfilled ☐ Consider quarantine of travellers from high-risk countries or areas, and ensure the basic needs and protection of quarantined individuals and their families ☐ Provide socio-economic support (including cash-based and voucher assistance) for COVID-19-affected families to cover basic needs and access to essential services, and address inequities ☐ Strengthen national social protection schemes through horizontal and/or vertical expansion to address the socio-economic impact of COVID-19 and support the continuation of essential services and community functions ☐ Ensure the homeless and most marginalized are not left behind as systems and programs adapt to the outbreak

Pillar, step, and action to be taken	Adjustment for Low-Capacity and Humanitarian Settings
Pillar 2, Step 1: Risk communication and community engagement	
☐ Develop/revise and implement national risk communication and community engagement plan for COVID-19, including details of anticipated public health and social measures, RCCE objectives, and key audiences, with the participation of relevant sectors, UN agencies, partners and levels of government	☐ Work with local influencers, national and international partners including the IFRC, UNICEF and WHO to develop social mobilization and community engagement plans based on existing response mechanisms, and contextualized to the setting and its community.
☐ Conduct rapid qualitative and/or quantitative assessments to understand affected communities (knowledge, attitudes and perceptions about COVID-19, populations most at risk, communication patterns and channels, languages, religions, influencers, health-seeking behaviours)	☐ Provide timely, accurate and trusted information that responds to community needs and that is focused on what individuals and communities can do to halt the spread of the outbreak
☐ Define community engagement and participatory processes to motivate healthy, preventative practices based on community feedback	☐ Address social stigma through capacity building and provision of support to individuals facing stigmatization
☐ Prepare local messages based on the latest evidence-based messaging from WHO, and pre-test through a participatory process that specifically targets key stakeholders and is tailored to all sub-population groups (e.g., living with disability, children, women, men, and elderly people)	☐ Establish collective (interagency) feedback mechanisms to track and respond to community perception of the response, other key perceptions and concerns, fears, rumours, and misinformation
☐ Identify trusted community groups (e.g., local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks to engage with (e.g., women's and youth groups, associations for people living with disabilities, business groups, traditional healers etc.)	
Pillar 3, Step 1: Surveillance, rapid response teams, and case investigation	
☐ Disseminate case definition and investigation protocols to health workers (public and private sectors) in line with WHO guidance	☐ Enhance early warning, case-detection and reporting capacities in health care facilities and the community
☐ Activate and/or enhance case finding using case definitions and event-based surveillance, and continue influenza-like illness (ILI) and severe acute respiratory infection (SARI) surveillance and/or other syndromic surveillance	☐ Work with support through regional or international networks as needed
☐ Assess gaps in active case finding, mortality surveillance, and event-based surveillance systems	☐ Adapt community case definition from the WHO COVID-19 suspected case definition, and train community health workers to report back to supervisors and health authorities for further investigation and follow-up.

Pillar, step, and action to be taken	Adjustment for Low-Capacity and Humanitarian Settings
Pillar 3, Step 2: Surveillance, rapid response teams, and case investigation	
☐ Train and equip multidisciplinary rapid (community-based) response teams to immediately investigate cases and clusters, scale up case management, and conduct individual isolation of cases, scale up contact tracing and quarantine of contacts	☐ Increase screening capacities inside the community, at entrance of setting and important communal facilities
☐ Enhance surveillance to detect suspect cases within 48 hours of symptom onset, with testing of suspect cases within 24 hours of detection[12]	☐ Establish a referral system and safe pathway for suspected cases to designated local isolation facilities; in conflict situations this should be through cross-line coordination
☐ Identify, follow up, and whenever possible quarantine contacts for the 14-day incubation period of the virus; actively engage communities for contact tracing, with a focus on high-risk areas	☐ Test all suspected cases according to testing strategy and capacities
☐ Enhance existing surveillance systems to enable monitoring of COVID-19 transmission (using qualitative and quantitative indicators), and adapt tools and protocols for contact tracing and monitoring to COVID-19	☐ In settings where testing suspected cases is not possible, monitor overall trends; undertake early detection through laboratory confirmation of a limited number of cases with a focus on health workers, those with severe disease, and closest contacts (e.g. six to 12 per case)
	☐ Use syndromic surveillance and diagnosis of exclusion for isolation and clinical care decision making; ensure other morbidities can be detected and treated, especially those with more readily available tests
	☐ Add strict daily monitoring of contacts when they cannot remain in quarantine
	☐ Share with WHO all data necessary to conduct global risk assessments through data platforms, such as the Global Influenza Surveillance and Response System and the IHR mechanism. These data should include SARI and ILI where available
Pillar 4, Step 2: Points of entry, international travel, and transport	
☐ Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s) and carry out cleaning and disinfection; prepare for novel public health approaches at points of entry for resumption of international traffic	☐ Conduct risk assessments and guide preparedness and response measures in COVID-19 outbreaks in refugee and migrant settings around ground crossings, and introduce systematic health screening for migrants and refugees in camps and other collective settlements

13 https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(COVID-19)

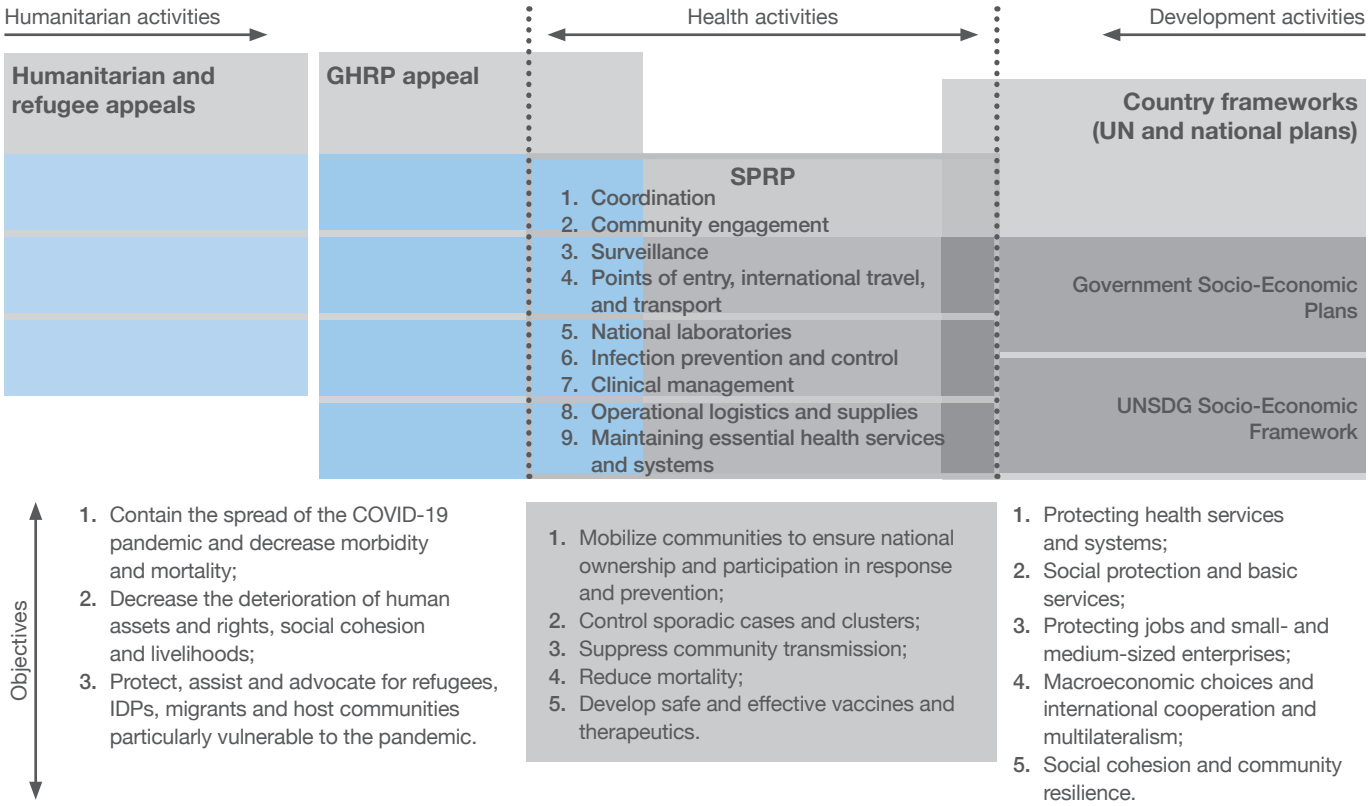
Pillar, step, and action to be taken	Adjustment for Low-Capacity and Humanitarian Settings
Pillar 6, Step2: Infection prevention and control	
☐ Apply standard precautions for all patients at all times, as well as administrative, environmental and engineering controls; implement empiric additional precautions (droplet and contact and, whenever applicable, airborne precautions) for suspected or confirmed COVID-19 cases	☐ In scenarios of critical PPE shortages consider PPE alternatives and temporary measures such as extended use, reprocessing, or use of alternative PPE.
☐ Support access to WASH services in public places and community spaces most at risk, with special considerations for vulnerable collective sites (including for homeless people, migrants, and long-term care populations) and community isolation centres	☐ Ensure hand hygiene stations are available, supplied and functioning at all gathering places (markets, clinics, places of worship, public facilities and transport stations) in COVID-19 affected areas, high-risk areas and humanitarian settings
	☐ Ensure provision of hygiene supplies to targeted households in vulnerable communities, COVID-19 affected households living in low-income settings, and humanitarian setting
	☐ Ensure WASH services and IPC kits including soap and clean water in health care facilities
	☐ Identify and put in place additional prevention measures for individuals at risk of complications at the household level supported by the family, such as physical barrier if a separate room is not available, the proper wearing of masks, environmental cleaning, etc
Pillar 7, Step 1: Case management	
☐ Map vulnerable populations	☐ Work with support from WHO, humanitarian and health organizations such as MSF, IFRC, Save the Children and other partners on case management measures
☐ Map public and private health facilities and workforce (including traditional healers, pharmacies, long-term living facilities, and other providers), and identify alternative facilities that may be used to provide treatment	☐ Consider health care facilities, other facilities and home based on hierarchy of isolation and treatment priority
	☐ Mobilize resources and establish community structures and/or construct additional (temporary) structures for isolation of cases based on their level of clinical severity
Pillar 7, Step 2: Case management	
☐ Disseminate regularly updated information, train, and refresh the health work force (including community health workers, medical, nursing, respiratory therapists, physical therapists, ambulatory teams) in the management of COVID-19, using specific protocols based on international standards and WHO clinical guidance	☐ solation and treatment of mild/moderate cases should be prioritized in community facilities; severe and critical cases should be isolated and treated in designated community facilities that have appropriate clinical care capacity if there is insufficient hospital bed capacity
☐ Set up screening and triage areas at all health care facilities; set up screening capacities in the community	☐ Support the implementation of case management measures at household level
☐ Surge clinical care capacity according to the epidemiological scenario; establish dedicated COVID-19 treatment areas to effectively isolate and treat all COVID-19 cases	☐ Work with international partnerships to support the delivery of essential clinical supplies, including oxygen supply systems, as needed through the activation of the IASC protocols

ANNEX 1: ALIGNMENT WITH OTHER UN PLANS

There are currently three UN global plans: the WHO Strategy Update of the COVID-19 Strategic Preparedness and Response Plan (SPRP), the Office for the Coordination of Humanitarian Affairs (OCHA) Global Humanitarian Response Plan for COVID-19 (GHRP), and the United Nations Development Programme (UNDP) framework for the immediate socio-economic response to COVID-19.

At country-level, there is also the wider Cooperation Framework overseen by the United Nations Resident Coordinator (RC). GHRP settings will have a Humanitarian Response Plan and other agencies and non-governmental organizations may also have their own plans.

Three complementary components to the UN multilateral response



Summary

Global Humanitarian Response Plan (GHRP)
OCHA

Purpose: Strategic plan and resource mobilisation vehicle.

Objective and scope: Respond to immediate health and multi-sectoral humanitarian needs in especially vulnerable countries.

Who benefits: The most vulnerable people in 63 countries already facing a humanitarian or refugee crisis, or with high levels of vulnerability.

Who implements: Humanitarian Country Teams (HCTs), UN agencies and national and international NGOS.

Who is responsible for developing and monitoring the plan: OCHA, in coordination with HCTs, UN agencies and NGOs.

Strategic Preparedness and Response Plan (SPRP)
WHO

Purpose: Strategic plan and resource mobilisation vehicle.

Objective and scope: Support public health measures to limit human-to-human transmission of the virus, care for those affected, and maintain essential health services and systems during the outbreak.

Who benefits: Globally, people in countries affected by the pandemic or at risk.

Who implements: WHO and all national and international partners supporting national governments.

Who is responsible for developing and monitoring the plan: WHO, in collaboration with national governments, HCTs and UN Country Teams.

UN Socio-Economic Framework
(and other country socio-economic plans/frameworks)
UNDP/DCO

Purpose: Programming framework.

Objective and scope: Mitigate the social and economic impacts of COVID-19.

Who benefits: Vulnerable people in 162 countries covered by 129 UN Resident Coordinators.

Who implements: The UN Development System and all national and international partners supporting national governments, though country teams led by UN Resident Coordinators.

Who is response for develop the plans: UN Development Cooperation Office, UN Country Teams under the leadership of UN Resident Coordinators and UNDP as technical lead, in support of national governments.

ANNEX 2: ACRONYM LIST

AAR	–	After Action Reviews
CHW	–	Community Health Worker
CMT	–	Crisis Management Team
COVID-19	–	Coronavirus Disease of 2019
CSCS	–	Interagency Supply Chain Systems
DCP	–	Disease Commodity Package
EOC	–	Emergency Operations Center
GHRP	–	Global Humanitarian Response Plans for COVID-19, released by the Office for the Coordination of Humanitarian Affairs (OCHA)
GISRS	–	Global Influenza Surveillance and Response System
IAR	–	Inter-Action Reviews
IASC	–	Inter-Agency Standing Committee
ICAO	–	International Civil Aviation Organization
ICT	–	Information and Communication Technology
IFRC	–	International Federation of Red Cross and Red Crescent Societies
IHR 2005	–	International Health Regulations
ILI	–	Influenza-Like Illness
IMO	–	International Maritime Organization
IMST	–	Incident Management Support Team
Infodemics	–	Excessive amount of information about a problem, which makes it difficult to identify a solution
IOM	–	United Nations International Organization for Migration
IPC	–	Infection Prevention and Control (Pillar 6)
IPPP	–	Influenza Pandemic Preparedness Plan
MSF	–	Médecins Sans Frontières
NGO	–	Non-Governmental Organization
OCHA	–	Office for the Coordination of Humanitarian Affairs
PCR	–	Polymerase Chain Reaction (molecular COVID-19 testing)
PHEIC	–	Public Health Emergency of International Concern
PHEOC	–	Public Health Emergency Operation Centre
PHSM	–	Public Health and Social Measures
PoE	–	Points of Entry
PPE	–	Personal Protective Equipment
R&D	–	Research & Development
RC	–	United Nations Resident Coordinator

RCCE	–	Risk Communication and Community Engagement (Pillar 2)
SARI	–	Severe Acute Respiratory Infection
SOP	–	Standard Operating Procedures
SPRP	–	COVID-19 Strategic Preparedness and Response Plan, released by the World Health Organization on 3 February 2020
'Strategy Update'	–	Strategy Update of the Strategic Preparedness and Response Plan (SPRP), released by the World Health Organization on 14 April 2020
UN	–	United Nations
UNCT	–	United Nations Country Teams
UNDCO	–	United Nations Development Coordination Office
UNDP	–	United Nations Development Programme
UNFPA	–	United Nations Population Fund
UNHCR	–	United Nations High Commissioner for Refugees
UNICEF	–	United Nations Children's Fund
UNOPS	–	United Nations Office for Project Services
WASH	–	Water, Sanitation and Hygiene
WHO	–	World Health Organization

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