# GUIDELINES FOR ADAPTING THIRD-PARTY MONITORING
## in the Context of the COVID-19 Outbreak

March 31, 2020; Revised October 1, 2021

Globally over 234 million people have been infected by COVID-19 as of October 2021. The continued public health impacts of COVID-19 impact every facet of humanitarian and development program design and implementation. With new emergency aid and modifications of ongoing aid and development programing, Third-Party Monitoring (TPM) remains critical as physical access varies based on infection rates and vaccine access. Donors and organizations use TPM to ensure both accountability in program implementation and continued learning. At the same time, TPM providers must do their part to limit human-to-human transmission of COVID-19 and ensure protection of staff and others by taking preventive measures.

This document aims to provide actionable guidelines for adapting TPM approaches in the current COVID-19 pandemic, but is applicable to any new emerging epidemic or pandemic, and is designed to be used with country- and program-level risk assessments to minimize the risk of exposure while ensuring program accountability.

Third Party Monitoring: Program management tool where third-party monitors collect independently verifiable data. Used to verify program implementation and strengthen monitoring and evaluating systems, particularly in crisis, conflict and non-permissive contexts.

## Key Considerations

1

**Information is Paramount:** Train all staff about the risk of COVID-19 transmission and self-protection measures to minimize the risk to themselves, beneficiaries and other parties. Practitioners may need a higher degree of understanding of COVID-19 risk associated with their particular work or communities they interact with in order to prepare for field work.

2

**Modify and Adapt Methodologies and Modalities:** TPM researchers and evaluation providers and practitioners may need to engage in a higher degree of communication and transparency with their partners and stakeholders, including being up-front about and describing risks and how TPM should be adjusted. When necessary, revise sample size and methodologies to ensure scientific rigor while adapting modalities to minimize risk.

3

**Continuously Coordinate and Plan to a Fluid Context:** Entities should conduct a site-specific risk assessment.[1] Planning must be iterative as no single recommendation will account for changes required due to COVID-19. It is likely that modifications will evolve over time in accordance with the stage and severity of the pandemic in a particular setting as well as national guidance.

[1] Interagency Standing Committee Guidelines Interim Guidance, Scaling Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Version 1.1. recommends a conducting a site-specific risk assessment in humanitarian situations, "based on the national risk assessment, the epidemiological situation of the area where the site is located, the travel and trade connections between the site, its host communities and areas reporting COVID-19 cases, as well as the characteristics of the site which may act as amplifiers of transmission." March 17, 2020. Available here: https://interagencystandingcommittee.org/other/interim-guidance-scaling-covid-19-outbreak-readiness-and-response-operations-camps-and-camp.

4

**Understand the Local Context:** Recognize that camp settings and urban and peri-urban centers may be particularly vulnerable to COVID-19 and will require more extensive modifications. Non-permissive and conflict settings already had existing challenges that may now be compounded by COVID-19. Access to water, sanitation and hygiene materials are critical to respond to COVID-19 and yet may be limited in settings where TPM is often used.

5

**Engage Community:** Communicate planned activities with local authorities/actors and/or community liaisons. Respect community and local authority restrictions and limitations on movement and social distancing.

## Responsible Actors

According to *Do No Harm*, "The location of the various decisions between headquarters and the field highlights who has the responsibility and power…"[2]

1. In engaging and requesting TPM services, **donors and organizations** are responsible for clearly articulating the needs and requirements of TPM services.
2. **TPM providers (organizations)** are responsible for their staff and the impact of monitoring activities. TPM providers should be empowered to recommend modifications to donors and organizations regarding activities that could put program beneficiaries, TPM staff, or the community at large at an increased risk.
3. **Field staff** [3] can be positioned to have a better understanding of the risks and opportunities at the local level.
    a. Field staff should be **provided with public health information** to be able to make their own decisions.
    b. Field staff should have the opportunity to **engage TPM institutional decision makers** and their perspectives should be included in decision making.
    c. Field staff should be **empowered to disagree and not participate** in actions that they believe could make them, their community or program participants less safe,

[2] Anderson, Mary B. Do No Harm. Lynne Rienner Publishers, 2010. Print.

[3] Field Staff include management, operations, researchers, monitors, evaluators and enumerators.

## Phase 1: Desk Review

**Introduction:** The ability to perform a desk review remains the same, but reliance on desk review will become more important as TPM providers continue to adapt to COVID-19. For example, if the desk review normally accounts for 10% of the overall process or data collection, TPM providers may need to rely more heavily on desk review (e.g. 20-30%) during COVID-19.

| Action | Pre-COVID-19 | COVID-19 Adaptions |
|---|---|---|
| Desk Review | Define purpose and goals | Maximize use of desk research by relying on published and grey literature from local, national and international partners; context reports published by country-level media |
| | Review all means of verification, indicator tracking and reporting | Focus on what data is needed that you do not already have and then determine what is possible to collect immediately or what can be delayed until a later date when risk is reduced |
| Methodology Development | Source of evidence | Revise based on:<br>• Site-specific risk assessment [4]<br>• Physical access<br>• Local authorities<br>• Identify sources of evidence and contacts needed: phone numbers of beneficiaries; social media outreach for surveys<br>• Responder characteristics: who will respond to the survey/ interview? How convenient must the data request be to the respondent?<br>• Can social distancing be implemented for data collection to minimize risk?<br>• Do these data require human or in-person contact? If so, can data be delayed or collected by alternative methodologies due to local health recommendations? |
| | Methods for data collection (qualitative and quantitative) | |
| | Sample size | |
| | Method of analysis | |
| Staff Training | Basics of TPM training (safety and security, field operations, data collection methods) and program-specific training | Add World Health Organization guidelines for personal protection to staff training and national/local guidance |
| | | No physical contact between TPM monitor and beneficiaries |
| | | Consider possible fever checks/hand washing/PPE [5] if local law/ policy permits and procurement is possible |
| | | Follow social distancing local guidelines |

[4] *Idib.*

[5] Personal protective equipment.

## Phase 2: Inception

**Introduction:** Inception and work planning may need to change from on-site to remote (web-based meetings, video and/or audio calls).

| Action | Pre-COVID-19 | COVID-19 Adaptions |
|---|---|---|
| Inception and Work Planning | Standard operating procedures (in-country meetings) | Revise based on:<br>• Site-specific risk assessment [6] to determine feasibility of in-country work planning based on infection and vaccine rates<br>• Physical access (ability to travel to and within country)<br>• Local authorities<br>• Identify sources of evidence and contacts needed: phone numbers of stakeholders; social media outreach for work planning<br>• Consider on-line work planning<br>• Consistent with WHO guidelines, encourage vaccination for all staff if available in country, and wear properly fitting mask if social distancing is not possible<br>• Follow WHO and local social distancing guidelines (maintain meter distance) [7]<br>• Develop plans for how to manage possible infection and exposure, including isolation, based on local law and guidance |
| | What is the learning agenda/questions that should guide data collection? | What is the learning agenda/questions that should guide data collection? |

[6] Interagency Standing Committee Guidelines Interim Guidance, Scaling Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Version 1.1. March 17, 2020. Available here: https://interagencystandingcommittee.org/other/interim-guidance-scaling-covid-19-outbreak-readiness-and-response-operations-camps-and-camp.

[7] Advice for the Public: Coronovirus Disease (COVID-19) Updated October 2021, World Health Organization. October 1, 2021. Available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

## Phase 3: Methodologies and Modalities

**Introduction:** COVID-19 may require changes in how interviews are conducted, such as moving to outside venues where social distancing can be implemented and potentially coupled with fever checks and hand washing. Some methodologies may need to be suspended or delayed and sample sizes may need revisions to adjust for changes in planned methodologies.

### Decision making in a new crisis:

| New Context (i.e. arrival of global COVID-19 pandemic) | | | | |
|---|---|---|---|---|
| **Options** | **Dividers** | **Intervention** | **Connectors** | **Options** |
| Redesign | Systems | Targeting? | Systems | Redesign |
| | Values | Resources? | Values | |
| | Experiences | Staffing? | Experiences | |
| | Attitudes | Partnering? | Attitudes | |
| | Actions | | Actions | |
| | ⇅ | | ⇅ | |

| Action | Pre-COVID-19 | COVID-19 Adaptions |
|---|---|---|
| Survey | Conduct surveys of beneficiaries using statistically relevant sample; often conducted in-person | Revise length and sample size, recognizing there will be reduced power and/or data availability for conclusions |
| | | Make environment as safe as possible by masking, conducting survey outside/well ventilated place and maintain distance. |
| | | Phone |
| | | SMS/Text with defined questions (short) via mobile data collection software/apps |
| | | Web link (longer) |
| | | Local social isolation requirements may make in-person surveys impossible. |
| | | Consider delay in planned methodology or change methods (e.g., conduct survey outside of the home for household survey) |
| | | Consider possible fever checks/hand washing/PPE if local law/policy permits and procurement is possible |
| | | Follow social distancing local guidelines [8] |

[8] As of October 1, 2021, WHO recommends a 1-meter distance.

| Action | Pre-COVID-19 | COVID-19 Adaptions |
|---|---|---|
| **Key Informant Interview (KII)** | Conduct key informant interviews as per standard operating procedures | Phone |
| | | SMS/Text with defined questions (short) via mobile data collection software/apps |
| | | Web link (longer) |
| | | Community contributor/liaison as proxy who conducts interviews outside of home/office |
| | | Make KII as safe as possible by masking, conducting KII outside/well ventilated place and maintain 1 meter distance from key informant |
| | | Consider possible fever checks/hand washing/PPE if local law/policy permits |
| **Focus Group Discussion (FGD)** | Conduct FGDs of beneficiaries or other stakeholders; often in groups of 8-12 people conducted indoors in closed settings | Local social isolation requirements may make FGDs impossible, or limited to fewer people with sufficient distancing |
| | | Conduct FGDs via three-way or multi person audio/video call if technology permits |
| | | *If a community contributor/ liaison as proxy is able to conduct FGDs:*<br>• Consider possible fever checks/hand washing/PPE if local law/ policy permits<br>• Make FGD as safe as possible by masking, conducting FGDs outside/well ventilated place and maintain 1 meter distance |
| **Observation/ Monitoring** | Observation and monitoring of activity, usually conducted on-site | Maintain social distancing minimum 1 meter from activity points |
| | | Utilize long-range cameras to maintain physical distance and/or phone camera zoom feature |
| | | Remote sensing geospatial technologies |
| | | Consider delaying study and/or consider possible fever checks/hand washing/masks if local law/policy permits and procurement is possible; and/or encourage vaccination and masking based on WHO guidelines and local law/availability |
| **Post-Activity Monitoring** | Monitoring and verification, usually conducted on-site or via beneficiary engagement | Maintain social distancing minimum 1 meter or more from activity points or key informant |
| | | Consider possible fever checks/hand washing/PPE if local law/policy permits and procurement is possible; and/or encourage vaccination and masking based on WHO guidelines and local law/availability |
| | | Utilize long-range cameras to maintain physical distance and/or phone camera zoom feature |
| **Remote Sensing** | Use of satellite imagery or drones and other geospatial technology | Use of satellite imagery or drones and other geospatial technology |
| **Trend Analysis** | Statistical analysis to determine patterns of behavior over time; assumes remote access to data and requires a time-series | Statistical analysis to determine patterns of behavior over time; assumes remote access to data and requires a time-series |

## Phase 4: Data Validation and Reporting

**Introduction:** In the COVID-19 context, in-country data mining from data not easily accessed remotely will require a risk assessment. Data may only be available if accessed remotely and will inform data quality checks. Reporting may require discussion of how COVID-19 has impacted or will impact the report.

| Action | Pre-COVID-19 | COVID-19 Adaptions |
|---|---|---|
| Data Quality Checks | Purpose and goals | Maximize use of desk research by relying on published and grey literature from local, national and international partners; context reports published by country-level media |
| | | Focus on what data is needed that you do not already have access and then determine what is possible to collect |
| | Review all means of verification, indicator tracking and reporting | Revise based on:<br>• Site-specific risk assessment [8] to determine feasibility of in-country work data mining or availability of remote access to data<br>• Physical access<br>• Local authorities<br>• Assess access (ability to travel)<br>• Consider possible fever checks/hand washing/masks if local law/policy permits<br>• Follow social distancing local guidelines<br>• Consider remote data access only |
| **Reporting** | Tailored to client and program request | Explain methodology and changes based on COVID-19 and resulting limitations |

[8] Interagency Standing Committee Guidelines Interim Guidance, Scaling Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Version 1.1. March 17, 2020.

**Not business as usual:** While TPM has many advantages in being able to provide independent and verifiable data collection in complex, conflict and proacted humanitarian crises, TPM must be adapted to the continued presence of COVID-19. Re-evaluate data collection methods prior to sending monitors to the field and recognize that adapted methods will require changes in staffing, resources and additional time.

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