International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

# Compliance with WHO Standards in Monitoring and Evaluating the COVID- 19 Pandemic in the Philippines and Vietnam

**Bui Le Ha Ninh**

Ph.D in Public Administration, Centro Escolar University, Manila, Philippines

**Abstract**

This research is concerned with the compliance of the Philippines and Vietnam with World Health Organization (WHO) standards in the monitoring and evaluation (M&E) of COVID-19 policies. Document analysis helps to explore the M&E plan for implementing the set of standards from WHO for COVID-19 prevention in the Philippines and Vietnam while surveys define the perception of the local health authorities on the compliance of the Philippines and Vietnam authorities with the WHO standards. Comparing the situation report shared with WHO by those countries would clarify the valuable information. As a result, compliance levels in the Philippines are perceived to be moderately high to high. Respondents in Vietnam rated compliance at a very high level. However, the two countries still have gaps in their COVID-19 M&E systems. Therefore, recommendations are then proposed for the enhancement of the M&E of COVID-19 policies and compliance with WHO.

**Keywords**: COVID-19 Pandemic, the COVID-19 M&E Framework, WHO Standards

## 1. Introduction

The COVID-19 pandemic proves that no country can prevent the COVID-19 outbreak alone. The preventions are implied by the efforts of all countries, organizations, and stakeholders. The World Health Organization (WHO) established an updated monitoring and evaluation (M&E) framework in June 2020 (World Health Organization 2020), which is a guide for countries to refer to planning, M&E, sharing internal information on prevention activities, sharing information externally, comparing, and evaluating with stakeholders. This is evidence of the transparency and effectiveness of COVID-19 prevention.

Delayed and missing data updated from countries to WHO may affect the transparency and effectiveness of M&E information, and the data may be considered of low value for WHO support activities. And those concerns become question marks for the implementation process of COVID-19 prevention activities in those countries.

This study addressed the gaps in submitting accurate and relevant data in M&E reports submitted in accordance with the WHO framework.

Understanding the M&E process of countries' activities through the standards in the WHO framework, as well as how countries were applying WHO standards (input) and comparing with the information shared through reports (output), helps us to see the current situation, the outstanding problems of the current system and partly the reason for the gaps. Philippines and Vietnam were used as the case studies. From practical experience, these examples are helpful in becoming valuable lessons in recognizing problems

and improving in the future.

The political and governance systems and institutions of each country are different. These create differences in M&E plans, processes, and activities. Therefore, this paper summarizes the main points in the political and governance systems that can support analyzing the M&E system of COVID-19 prevention activities. In addition, the role of M&E in the policy analysis process and the standards from WHO help the paper shape the activities that need to be discussed regardless of the socio-economic aspect and the importance of this chain of activities in a large and complex system.

The research predominantly employed a quantitative approach as the primary data collection tool (questionaires). Some qualitative tools, such as document analysis and interview were used to supplement the quantitative methodologies in the study. The assessment of respondents who are in charge of M&E and the internal information might help to validate the quantitative information as to how they were complying with the WHO standards and the reasons for those assessments.

The intended contribution of this study was to fill the gaps of the existing studies since there are not many in-depth studies on the M&E system in the Philippines and Vietnam such as "the Philippine evaluation policy framework: supporting evidence-based decision making" (Tungpalan 2015) defines the evaluation framework, or "Why M&E is Important in the Government Sector" (David 2019) provides the key components and tools of the M&E system to build the general M&E system that may "improve the efficiency of public policy implementation by law enforcement agencies" (Thu 2017) and also describes the role of M&E in public policy implementation process, and "developing monitoring and evaluation tools for event-based surveillance: experience from Vietnam" (Clara et al. 2020). This information leads to design and develop M&E tools such as logic models, as well as measurement of the components based on the input, activities, output and outcome of M&E.

## 2. Methodology

The study used a quantitative approach, particularly using surveys as its main method of data gathering, complemented by document analysis and interviews.

### 2.1 Respondent and Sampling Procedure

Purposive sampling was applied in identifying respondents for the survey and interview. The sample of thirty (30) respondents is considered sufficient for the quantitative method (Dovetail Editorial Team 2023).

The investigation was limited to the first year of the COVID-19 occurrence, from March 2020 (the first situation report submitted to WHO from Philippine Department of Health (DOH)) to December 2020 (when COVID-19 cases were low for both countries). This period would show the preparedness of the countries for coping with Covid-19 infectious disease.

The study selected Local Government units (LGUs) which had the most complicated Covid-19 situation with the highest number of Covid-19 infections and deaths nationwide in 2020 based on the reports from DOH, Vietnam Ministry of Health (MOH) (Vietnam Ministry of Health [MOH] & Vietnam World Health Organization [WHO] 2020; Philippine Department of Health [DOH] & Philippine World Health Organization [WHO] 2020). Survey and interview participants were those involved in M&E activities to prevent Covid-19 in selected LGUs and hospitals including city health officer, head of city epidemiology surveillance unit, surveillance officer, medical officer, nurse, medical doctor, and data manager. There are 48 participants invited, of whom 33 agreed to respond.

### 2.2 Research Instrument

A survey employed the 10 standards from the WHO M&E framework (2020) as a list of indicators with a grading scale which 33 respondents could answer easily with precision and objectivity.

**Table 1: Rating Scale and Verbal Interpretation**

| Rating | Scale | Verbal interpretation |
|---|---|---|
| 5 | 5 | Very high level of compliance |
| 4 | 4.0 – 4.99 | High level of compliance |
| 3 | 3.0 – 3.99 | Moderately high level of compliance |
| 2 | 2.0 – 2.99 | Low level of compliance |
| 1 | 1.0 – 1.99 | Very low level of compliance |

An interview was conducted through online and offline forms. The documents were 65 Philippines' (DOH & WHO 2020) and 24 Vietnam's situation reports (MOH & WHO 2020) in 2020, as well as an official document connected to the M&E plan, process, or national plan provided by the selected departments and obtained from public sources.

### 2.3 Data Synthesis and Analysis

The mean of the rating (Mishra et al. 2019) from each indicator is used to produce the verbal interpretation for each country. For the qualitative method, the responses demonstrated the respondents' perceptions and validate information that may have been overlooked. Summarizing the problems encountered helped in determining the impact of the issues on the present M&E system's compliance with WHO.

The researcher took advantage of content analysis as a technique to quantify the use of specific words, phrases, and concepts (O'Leary 2014) that provides information about the department's M&E system and the output of compliance with WHO standards based on situation reports to compare with the respondents. The hypothesis is that there is no significant difference in the perception of respondents in the level of compliance of Philippines and Vietnam with WHO standards when they are grouped according to demographic profile.

The study followed the data privacy policy as well as the personal information policy stated in Republic Act 10173—Data Privacy Act of 2012 (Senate and House of Representatives of the Philippines 2012) of the Philippines and Article 38 of Law Number 91/2015/QH13 Civil Code in Vietnam (Vietnam National Assembly 2015) to respect the rights of the respondents and prevent the risks for respondent protection. This study might help the participants gain more knowledge about the current system and other systems in other areas and improve their performance in M&E.

## 3. Results and Discussion

### 3.1 Monitoring and Evaluation Framework of WHO for COVID-19

M&E methods have been described by Dunn (2018) as the core methods in policy analytics, namely forecasting, prescribing, monitoring, and evaluation. These methods are interdependent and connect with other factors in policy analytic. If monitoring is about observing the real data, then evaluation is concerned with defining the value data.

By this purpose, the WHO M&E framework served as the source of direction and guidance in undertaking

the study and focused on how the governments of the Philippines and Vietnam complied with it. Thus, situation reports submitted to WHO in 2020 by the Philippines and Vietnam would serve as references for explaining the monitoring and assessment data that the investigation would produce.

On June 5, 2020, WHO issued the M&E framework under COVID-19 Strategic Preparedness and Response to monitor and assess countries' progress in COVID-19 reaction and prevention. The M&E structure was created using the following ten standards.

Each standard aims at clarifying the input, outcome, and impact of the responses. Furthermore, the situation reports provided to WHO are country-level reports that updated the most current COVID-19 response. The Philippines and Vietnam have differing submission deadlines and report contents, however, the information therein aid the study in describing how the countries shared the results based on WHO M&E criteria.

**3.2 The Politico-administrative Setting**

The study is set amidst differences in the politico-administrative systems of the Philippines and Vietnam. The politico-administrative system in the country helps to provide the flow structure of M&E and the role of those department. The impact of the setting to the performance of M&E in COVID-19 of each countries. The Philippine Constitution provides for a unitary system of the government. There is but one sovereign state and one national government, unlike federal systems, which are composed of more than one autonomous or independent state. Regardless of form, all governments have at least two levels: the upper level, or government of the whole (national), and the lower-level government of the parts (local). Local governments may have varying layers due to historical and geographic factors, among others. Philippine local governments have been traditionally subdivided among provincial, city, municipal, and barangay (village) governments (Tapales 2015).

Being unitary, the national government is highly centralized and responsible for planning and implementing policies and programs and delivering public goods and services through a central bureaucracy. The central bureaucracy is the lone provider of services through central departments (DOH), which are headed by secretaries appointed by the President or head of the government. As such, the DOH was solely responsible for delivering health services through its regional and local organization, professional and administrative personnel, and the health infrastructure like hospitals and clinics, equipment, and transport facilities. The DOH laid out the policy guidelines and standards that were enforced down the hierarchy, from the national to the provincial, city, municipal, and barangay units.

In 1990, R.A 7924 implemented through Executive Order No. 7924 on January 9, 1990, created the Metropolitan Manila Development Authority (MMDA). MMDA was organized administrative mechanism to integrate the plans of 17 autonomous cities and localities in the region. The foregoing observations were true until the enactment of Republic Act No. 7160, known as an act providing for a local government code of 1991, which the Philippine legislature passed in 1991. The Code not only decentralized but also devolved the delivery of health services to the local governments. Devolution means the transfer of power and authority over functions performed by the national government to local governments. The said Code transferred a few functions, such as health, social welfare, agricultural extension, and environmental protection, to the LGUs.

As a result of devolution, the LGUs have taken over the delivery of health services. The DOH, which used to be the sole health provider, became an enabler, standard-setter, and "national technical authority in health" (Cuenca 2018).

The above-cited political-administrative change may have implications for the study. The participants or

respondents in the Metro Manila area come from city governments that are politically and administratively autonomous of the DOH. Besides, the city administration's capacity may vary in complying with WHO and DOH standards because they vary in population, land area, and budgetary resources.

Vietnam, while similarly a unitary state, is socialist in ideological orientation, characterized by central planning. As such, it has a highly centralized system from central to local levels, headed by the Government, responsible for exercising executive power (National Academy of Public Administration 2018). In terms of health service delivery, MOH (Central Government) is solely responsible for planning and implementing health policies and programs. City Health Department which is a specialized agency under People's Committees (local state administrative agencies) prepares and developes plans to ensure the implementation working well in local government (Department of Preventive Medicine 2021). The local governments follow the national guidance (MOH & Ministry of International Ministry 2015***)*** that their Philippine counterparts possess.

Pursuant to decision number 2268/QD-BYT dated April 5, 2018 of MOH about functions, tasks, powers and organizational structure of the General Department of Preventive Medicine under the MOH, the General Department of Preventive Medicine is a specialized agency with the state management, organization and implementation of the provisions of the law on preventive medicine nationwide included infectious disease prevention and control. It is also the only agency authorized by the MOH for international notification and infectious diseases (MOH 2018).

The role of this department has been announced in the national plan number 237/QD-BYT (MOH 2020) who was the lead of M&E prevention activities. Also, the preventive medicine system would help to monitor and evaluate the COVID-19 situation and preventive activities.

In terms of conformity with WHO and MOH standards, Vietnamese LGUs may be expected to exhibit higher levels of compliance with centrally planned and authorized standards.

### 3.3 The M&E Plan to Implement the Set of Standards From WHO

To understand what are the organization structure, who are in charge of M&E functions, how the countries monitor and evaluate the information, especially based on the WHO standards, and the data were monitored and evaluated comparing with the data shared in situation report, the M&E would be the one playing this role. Before looking for the M&E plan to implement the set of standards from WHO, the study would summarize the COVID-19 situation, and explore the existing M&E plan in the Philippines and Vietnam which were used for COVID-19 to recognize the challenges of each system.

#### 3.3.1 Philippines

The COVID-19 case transmission was confirmed in the Philippines in the early period. The first COVID-19 case was confirmed in January 2020, and the first case in the Philippines of local transmission was found in March 2020 (DOH & WHO 2020). A national contingency plan was completed in March 2020. Thus, the general community quarantine was applied on March 15, 2020, in the NCR, along with other actions to prevent the spread of COVID-19. During 2020, the highest cases were reported in August, and the cases decreased at the end of the year. The NCR was the area with the highest cases in the Philippines. As of December 22, 2020, a total of 462,815 confirmed cases had been reported.

Before the COVID-19 epidemic occurred, the Philippines seemed to be well prepared to build a complete process of combining disease surveillance and response. The Philippine Integrated Disease Surveillance and Response (PIDSR) was deployed to improve existing systems and was integrated into a unified system to make anti-epidemic activities more effective, accurate, and faster (Philippine National Epidemiology

Center 2014).

PIDSR was the foundation of the national disease surveillance and response module, from communities to the local, regional, and national levels. In the local disease surveillance and response module, the municipal epidemiology and surveillance unit (MESU) or CESU receives and monitors the data of emerging disease cases from health facilities (hospitals, clinics, ports, communities, etc.). The unit then provides or coordinates the information for the local government to respond to the health action, while the provincial epidemiology and surveillance unit (PESU) manages the information to support preventive activities. In the national module, the regional epidemiology and surveillance unit (RESU) manages the consolidated information from the local level and from national health facilities to provide support at the local level, as well as updating the information from the region to the central government as the NEC (now the Epidemiology Bureau (EB)). The information would help the central government evaluate the situation as well as the activities to prevent COVID-19.

During 2020, the Inter-Agency Task Force issued a guideline and national strategy called the National Action Plan (NAP), which was executed by the national, regional, and local task forces against COVID-19. Its content was about financial requirements, the role, function, and performance of the implementing parties in COVID prevention, and the organizational structure from the central government to the local government. The NAP had been adjusted 3 times: NAP I (March-June 2020), NAP II (July-September 2020), and NAP III (October 2020-March 2021). However, NAP I, II, and III appeared to have no separate M&E plan mentioned, even though the central government established the M&E support group from NAP II (July 2020) onwards. Also, the connection between the standards and WHO was not shown in the plan, except for the mention of global coordination. The role of DOH in NAP was to share the data with WHO as the country participated in and supported global research (NAP I) and update a range of information from WHO. There were some major activities that matched the standards of the WHO. However, there was no indicator or clear expectation of results.

While the situation reports started to adopt the WHO M&E categories in March 2020, out of the 10 elements that this study addressed, the reports included 9 elements. And also, the PIDSR was just mentioned in NAP III while the process was released in 2014. Through document analysis, the M&E plan lacked coordination, unification, and transparency.

**3.3.2 Vietnam**

In Vietnam, the first case was reported on January 20, 2020. However, the first national response plan was conducted at the beginning of January, when the COVID-19 cases in China were announced and before the first case was found. After that, the government suspended border crossings with China around January 29, 2020. The school closure started in January 2020. Also, all international flights were suspended around March 18, 2020. Early activation and response from the government and effective multiple coordination helped Vietnam in COVID-19 prevention, detection, and control (MOH & WHO 2020). In 2020, the highest cases were reported in July 2020, when the pandemic attacked Da Nang city. As of December 31, 2020, Viet Nam has reported a total of 1,465 laboratory-confirmed cases of COVID-19, of which 55% were imported. 90.5% of cases were recovered (MOH & WHO 2020).

However, the documents about the M&E process were still lacking and not unifying among the sources. Especially, the documents were about the M&E process for COVID-19.

In the national plan number 237/QD-BYT (MOH 2020), the content was about the activities needed to prevent COVID-19 and the roles of each department and office from central to local government who were responsible for COVID-19 preparedness and prevention. Monitoring and provision were one of the

activities listed, along with information about monitoring the cases in local health centers, hospitals, points of entry, and all health facilities; investigation; access to the situation; and reporting even to international organizations. Although monitoring and evaluation were mentioned as one of the roles of the department listed in the plan, how those departments communicated and the chart, map, or structure built for the whole process were not presented in the plan. And the national plan highlighted that the local plan would be based on the province and cities. There was no information about standards from WHO; even one task of MOH was information sharing globally. Like the Philippines, the Vietnamese government plan lacked M&E information and was not in compliance with WHO.

Going back to the COVID-19 period, the organizational structure of the preventive medicine system was updated in 2021 (Department of Preventive Medicine 2021) for all diseases. The government has two kinds of management, consisting of state management (which is carried out in the legislative, executive, and judicial fields to perform functions for state management activities) and professional management (only in the health field). All functional units listed under the MOH belong to the preventive medicine system. Those agencies have both state management and professional management for the non-business units that perform or provide public services, such as medical institutes. The functional agencies have professional management with the city health department under the people's committee of the province /city only for cities/provinces level since state management belongs to state agencies down to the people's committee of the province /city.

This management is the same at the city level when the city health department has state management and professional management with public non-business units under the city health department, as well as professional management at the lower local level as the health committee division under the people's committee of the district.

The district health center is still one of the public non-business units under the management of the city health department in terms of organization, human resources (appointment of a director and deputy director of the district health center), operations, finance, and facilities. Therefore, the city health department still has both state management and professional management with the district health center, while the health committee division has state management with the district health center in terms of appointment, transfer, rotation, commendation, discipline, dismissal, resignation, and implementation of regimes and policies towards the heads and deputy heads of the district health center. On the professional side, the district health center is also managed by another public non- business unit of the city health department.

The community health center is the lowest level of local government under the state management of the health committee division and the professional management of the district health center.

In other sources from the HCM Pasteur Institute (2014), the organizational system of preventive medicine included the preventive medicine system and the medical service administration system. On the preventive medicine system side, there were direct connections among departments and units from the General Department of Preventive Medicine to public non-business units under the ministry, provinces/cities and districts down to the commune health center. The differences with the preventive medicine system of the Department of Preventive Medicine were that there was no city health department, no health committee division, and no connection between the public non-business units under the ministry and the public non-business units under the city health department. On the medical service administration system side, there were connections between the preventive medicine units and hospitals, respectively, at each level. On the vertical side of the hospital, the management is from the Department of Medical Service Administration

down to the national hospital, the general hospital of provinces/ cities, and the general hospital of the district.

Circular number 54/2015/TT-BYT "Guiding the Regime of Information, Reporting, and Declaration of Infectious Diseases and Epidemics," was the report that flows from central government to local government for both sides, such as the preventive medicine system and the medical service administration system. There were two ways of reporting a virtual report and an offline report. If medical facilities and departments of all levels could directly update data in the virtual report system, then the offline report flow would be followed by the organizational structure. The structure of the offline reporting system was the same as the preventive medicine system of the HCM Pasteur Institute for vertical and horizontal connections.

The process captured by the respondents shows that there was a connection between the public non-business units under the ministry and the public non-business units under the city health department, as this is the actual process. Meaning the process was closer to the process from HCM Pasteur Institute 2014. In short, the national government has developed the organizational structure, tools, and processes for M&E generally already. However, all had not been given due attention. That was why the information in the system was not unified. This could lead to problems arising at all stages, making management ineffective and affecting those involved in health issues. The system also lacked transparency, updating regularly, and creating trust for people.

Also, the system was not used in COVID-19 M&E. Based on the answers to the questionnaire, the MOH had created a new Google Drive so that all levels could update data directly through it to meet the complex situation as well as the requirements of the speed of measurement. Although the MOH had the flexibility to adjust the process to make epidemic prevention more effective, it also showed that the MOH had not been well prepared for arising problems. This rapid change might also lead to risks in the fact that officers and employees were not trained, well prepared, and involved in handling M&E information. The new process was not legally regulated, and there was no clear specific sanction to apply to the units or localities. This might affect the efficiency of implementation. The non-compliance or incorrect implementation was possible and sets bad precedents among implementing units.

### 3.4 Perception of Local Respondents in Compliance with the WHO M&E Standards

Through the official documents, the study understood that there was missed information or inconnection between the M&E plan of the national government (input data) and the situation report (output data) and the insufficient, unifying information in the M&E plan. Those gaps would impact the valuable data shared. To have a sign from another perspective on how the data was shared in the situation, comparing the actual performance of the local unit based on the WHO standards and the data shared in the situation report, the studies observed the perception of the local respondents through their rating of compliance with the WHO M&E standards.

#### 3.4.1 Philippines

Overall, the compliance level of the Philippines got moderately high to very high. Also there are three unrated standards. This research shows the difficulties of each standard which the respondents are facing.

*Country-level coordination, planning, and monitoring.* Although the Philippines got a very high level of compliance generally, there were some gaps based on the interview and document analysis.

The CESU systems under PIDSR were built up although variably for all cities. Each city had a different

structure, workflow, and capacity. Thus, the performances were different also. CESU in 3 cities was invested in, and focused on development when the COVID-19 epidemic occurred, while CESU was established and operated before COVID-19 in 5 cities. There were 2 cities that not only operated CESU but also created a separate command center for COVID-19 so that all heads of units can work together. Information was centralized in a system, so the management was unified and controlled better.

The structures of 2 cities were more different when CESU was not integrated into any center, but a new center was established under CESU such as the contact tracing command center and the mega contract tracing center. The staff in those centers still held other tasks at CESU but was in charge of the center at the same time, which was at an equal level with CESU.

The quality and quantity of manpower had differed among cities. Since each city has independence in COVID-19 management, there were inequal capacities to handle the COVID-19.

The differences in organizational structure in each city affected the creation of an M&E plan and coordination mechanism not only in the city health department but also in the selected hospital. They had different processes, functions, and structures for collecting and tracking information.

The coordination would not only be within the government, private organization, or non-government organization but also among all related participants. Based on the repondent, the NAPs for the most part failed to involve the community, which has most of the human resources and could track the situation in real time and in the right place. The measurement of engineering and personal protective equipment was inadequate and a risk assessment exercise was not disseminated in the NAPs I, II, and III (National Task Force on COVID19 Implementer 2020a, 2020b, 2020c). This showed the incomplete mechanism and plan from the national government, especially from health workers and community levels, to deal with the actual situation.

Compared with the information in the situation report submitted to WHO, country-level coordination was shared from March 9 to June 4, 2020, and mass gatherings under Non-Pharmaceutical Interventions were shared from June 9 to December 22, 2020 (DOH & WHO 2020). However, the information was about the plan, not about the performance. Hence, the details from the respondents explained other perspectives on the actual activities.

There was no connection between the national plan, actual performance and output from the situation report. The M&E was missed.

*Risk communication and community engagement.* Although the compliance level was high overall, the diversity was also high. According to the repondent, there was no communication plan in the community, and they were capacitated in RCCE. There was no clear mechanism to take care of the feedback from the city, and there was a lack of a health education and promotion officer to manage the community engagement, including the community feedback. With limited human and other resources, the connection with the community was not continuous. The relatively low score for *community feedback* is due to the absence of mechanisms for community meetings, hotlines, surveys, etc. in some cities in Metro Manila. While situation reports from March 9 to June 4, 2020 (DOH & WHO 2020) mentioned Non-Government Organization (NGO) engaged in community engagement under risk communication, LGUs still lacked the mechanism to do so.

*Surveillance, rapid response teams, and case investigation. Contact tracing implementation and training,* and *implementing seroepidemiological investigations or studies* were just for the national government (regional epidemiology surveillance unit/Epidemiology Bureau) and the Technical Education and Skills Development Authority. There was a lack of official training for the local government. Also, the work

was too large for the LGUs to make the investment, according to 3 cities. The situation reports submitted to the WHO proved the weakness of monitoring Rapid Response Teams as well (DOH & WHO 2020).

*Points of entry, international travel, and transport.* Based on the city that had an international transportation, the terms of points of entry were not available from 2020 to 2021, which parallels the period of this study. The health units were not tracking the information because the Bureau of Quarantine handled it mainly. According to the situation report (DOH & WHO 2020), information on points of entry, international travel, and transport was shared only twice and nothing was further shared from the third report onward.

*National laboratories. COVID19 laboratory test capacity* and *scoring 100% on external quality assessment project (EQAP))* apply only to the national level and the LGUs in the NCR did not have information on the matter. In the practice, some cities couldn't keep up with the demand as there was no local molecular lab from March 2020 until November 2020. No EQAP system was established by DOH. In 2021 onward, this index was available.

The information shared in the situation report for the period of March 9 to May 11, 2020 (DOH & WHO 2020) showed the capacity at the country level and the number of tests per day. Not following the standard indicator from M&E framework.

*Infection prevention and control*. There was no *national infection prevention and control (IPC) program*, and the cities used water, sanitation and hygiene (WASH) emergencies instead, according to the respondents from the selected cities. Furthermore, this standard was not disseminated to all LGUs. While the IPC training was just for hospitals, as the DOH shared in the situation reports under infection prevention and control subject during March 9 - June 4, 2020 (DOH & WHO 2020) without the actual data, NGOs were the ones to conduct the training moving forward with the number of workers.

Summarily, not all healthcare facilities had triage and isolation capacity, and not all health workers were trained formally. There was no case management training for health workers, no monitoring for Intensive Care Unit (ICU) beds, and no confirmed hospitalized COVID19 cases that were discharged. The Long Term Care Facility had a national policy (home testing was not taken into consideration), and guidelines on IPC for the Long Term Care Facility were not updated, for example at the Quezon city level. This was a reason why the ratings were moderate to high.

*Case management.* The number of ICU beds provided to priority countries through Emergency Medical Teams or similar surge mechanism depended on the private hospital system as 1 of respondent commented. Compliance with the WHO M&E standard, *case management* was rated by Philippine respondents as moderately high due to lack of ICU beds and the training of health workers was just very specific to COVID-19 cases only.

The data in the situation report expressed the opposite aspect when the number of ICU beds and number of health workers trained in case management of COVID19 cases in the previous week were updated (DOH & WHO 2020).

*Operational support and logistics.* The Operational Support and Logistics was unrated because this was managed by the national government with authorization and document support, as well as the strict implementation of the Data Privacy Act and the support sent to patients directly.

However, this standard was covered in the situation report since the Philippines was a priority country (DOH & WHO 2020).

*Maintaining essential health services and systems.* Overall, the WHO M&E standard, maintaining essential health services and systems was rated as having a moderately high level of compliance because

of lack of monitoring infor mation availability.

*Cross-cutting issues.* Multi-sectoral mental health and psychosocial support technical working groups, and national occupational safety and health plans or programmes for health workers are unavailable.

**3.4.2 Vietnam**

Although several aspects of information were rated at a very high level of compliance, Risk communication and community engagement, Surveillance, rapid response teams, and case investigation, Infection prevention and control, and Case management were given an overall rating of high level of compliance.

The respondents provided more information to support clarifying the meaning of the rates. Also the information is captured from the document was contributing to the insight.

*Country-level coordination, planning, and monitoring.* Vietnam had a coordination plan to prevent the COVID-19 case transmission inside the country (the COVID-19 virus is transmitted between people living in the community, not from outside of the country) early and quickly. Vietnam had a strict and close monitoring of the case, tracing all travel histories of the patient and blocking the area that was doubtful to have the COVID-19 case. The coordination came from all of the departments, such as the health unit, national police, transportation, local government, and even the citizens nearby. Those information were mentioned in the situation report under Strategic approach and best practice/Lessons learned (MOH & WHO 2020). This is the reason why the level of compliance is very high.

*Risk communication and community engagement. Community feedback* had an average score because the channels to communicate were not applied to high-information technology. The risk communication was mentioned in the situation report number (MOH & WHO 2020). However, until October 2020, the details of the risk communication training or working group would only be shared.

*Surveillance, rapid response teams, and case investigation.* According to the respondent, there was a contact tracing application for the city; however, the implementation was not effective because there was no unification of organization, and the department lacked expense and manpower. Those might be reasons that there were no information of some standards in the situation reports.

*Points of entry, international travel, and transport.* The ratings showed that the city had no information to monitor, and this was not under their scope. Although the information about incoming travelers and how to detect them was updated in the situation report (MOH & WHO 2020), however, the guidance and procedures were just issued in September 2020 and shared with the report by October 2020. This standard was not rated due to a lack of coordination with the proper government agencies as transportation facilities.

*National laboratories.* The COVID-19 laboratory test capacity of the city was more than WHO expected since WHO just monitored the test capacity within 72 hours. From the beginning until November 2020, the City had nine COVID-19 laboratories using the reverse transcription polymerase chain reaction method and released the results within 6-8 hours. However, in the situation report (MOH & WHO 2020), there was no data showing the test capacity of the laboratory or the diagnostic capacity of countries, as well as the number of tests divided by age and sex.

*Infection prevention and control.* For a national IPC program and WASH standards within all health care facilities, the city has popularized and directed the local health units to follow the IPC program and WASH standards; however, there was no performance assessment, just monitoring the IPC. With *the number of health workers trained in IPC in the previous week*, all of the health workers were trained once per year, and there was no update per week as per WHO standards. By then, there was no data about how many health workers were trained per week in the situation report (MOH & WHO 2020). There was an update

about IPC training and details of infection prevention and control only.

*Case management.* A clinical referral system was in place to care COVID19 cases in the city. Although there were only 27 hospitals compared with the number of national hospitals, it was still a big number to manage the population, including the COVID-19 referral center. However, it was hard to manage the COVID-19 cases up to 50,000/week. The clinical referral system can care for certain cases and has plans to arrange and classify the level of the cases to follow up at home or in the health center. The situation reports (MOH & WHO 2020) presented that the health workers in most national hospitals were trained in COVID-19 case management. However, there were no actual numbers for that. Although confirmed hospitalized COVID 19 cases were discharged and a clinical referral system in place to care for COVID 19 cases had a high rating, those were not reported in the situation report.

*Operational support and logistics.* Based on the guidelines from the WHO framework (WHO 2020), this standard was used for priority countries. During 2020, Vietnam was not a priority country. The information aspects from this standard were not presented in the report submitted to WHO. There was no indicator monitoring at the local and hospital levels either.

*Maintaining essential health services and systems*. All safety conditions were met through measurement weekly. Therefore, no campaign was affected. Meaning the M&E system did not monitor this object. Also there was no data of maintaining essential health services and systems in the situation report (MOH & WHO 2020). It is evident that there was difficulty in monitoring at all levels.

*Cross-cutting issues.* Respondents believe that multi-sectoral mental health and psychosocial support technical working groups, and national occupational safety and health plans or programmes for health workers are unavailable. Thus, no rating for this object.

## 4. Conclusion

This study sought to answer how the governments of the Philippines and Vietnam produced the existing M&E plan, especially based on WHO standards, to prevent COVID-19. The concerns were relating to organization structure and the national plan, and how those gaps impacted the valuable information sharing to internal and international stakeholders.

Also, the study presented how the local respondents assessed each country's compliance with the WHO monitoring and evaluation standards. Those proved and showed the challenges that the national government could not get the data and shared the data, even on time.

From the survey results, it appears that there was only partial compliance, where there was relatively high compliance perceived in the Philippines and very high compliance perceived in Vietnam with only seven standards, while three standards were not rated at all. Compliance was deemed essential to contributing to the prevention and control of the COVID-19 pandemic.

An authoritarian and centralized system of governance in Vietnam may partly explain the relatively higher levels of compliance and uniformity in the responses. Although the devolution of health services in the Philippines aimed at a reliable program of decentralized and responsible health systems, this was not helpful in achieving a coherent and unified monitoring of the pandemic due to the variations in the organization, staffing, and resources of the antonomized cities in the NCR.

Both Philippine and Vietnamese respondents reported the lack of a national plan at the beginning of the COVID-19 outbreak, although they recognized some form of epidemiological plan designed to address epidemics via 2014.

## 5. Recommendations

In order to budge the gaps in levels of compliance with WHO M&E standards, the following steps are humbly offered, which governments of the Philippines and Vietnam may undertake:

- The Philippines and Vietnam may, for future preparedness adopt the WHO scheme in combination with the lessons of COVID-19. For its part, WHO may, for greater compliance, issue protocols or enter into agreements with various governments to adopt the Standards.
- Intergovernmental coordination between the DOH/MOH and LGUs to include a common organizational pattern, responsibilities, accountabilities, and manpower training.
- To resolve the limited human resources, the involvement of the community should be considered. This helps to get more manpower and trust with what to do in the government. Also they can reach people/citizens easily since they are the one representing for those people and located in the area. Therefore, the response would be faster. In this case, the national government should come up with the communication plan and train the community volunteers, groups and the health education to manage the community engagement.
- The DOH or the central government should have an official guideline for LGUs with specific support and guidance to ensure monitoring and consistency across cities. The documents should have a common and high application, and uniformity among all LGUs to ensure the quality of information and avoid incorrect information as much as possible. Beside it, there should be regular training about case management, contact tracer as well as specific training in terms of health field so health workers have full knowledge about it to prepare and treat better and faster for patients.
- Those preparedness should be completed before the actual disaster happening. Therefore, the Government has time to monitor the situation and tackle the shortage of human resources, supply or time.
- The national government should invest more for M&E system across the local level by fund, training and full of M&E framework with details about the guideline, standard, process and procedure officially.

## References

1. Clara A., Dao A.T.P., Mounts A.W., Bernadotte C., Nguyen H.T., Tran Q.M., Tran Q.D., Dang T.Q., Merali S., Balajee S.A., & Do T.T, 2020, "Developing monitoring and evaluation tools for event-based surveillance: experience from Vietnam.", Global Health 16,38 (2020). https://doi.org/10.1186/s12992-020-00567-2
2. Cuenca Janet S, 2018, "Health Devolution in the Philippines: Lessons and Insights", Discussion Paper Series No. 2018-36, Philippine Institute for Development Studies.
3. David J.T, 2019, "Why M&E is Important in the Government Sector?", Climate Change Commission, National Economic and Development Authority. https://designingresilience.ph/wp-content/uploads/Why-ME-is-Important-in-the-Government-Sector-NEDA.pdf
4. Department of Preventive Medicine, 2021, "Organizational System of Preventive Medicine". https://vncdc.gov.vn/he-thong-to-chuc-y-te-du-phong-pde4114.html
5. Dovetail Editorial Team, 2023, "What is purposive sampling?". https://dovetail.com/research/purposive-sampling/
6. Vietnam National Assembly, 2015, "Law number 91/2015/QH13 Civil Code (Article 38) (VN)". https://thuvienphapluat.vn/van-ban/Quyen-dan-su/Bo-luat-dan-su-2015-296215.aspx

7. Dunn W.N, 2018, "Public Policy Analysis: an Integrated Approach" (6th ed.), New York: Routledge.
8. Mishra P., Singh U., Pandey CM., Mishra P., & Pandey G, 2019, "Application of student's *t*-test, analysis of variance, and covariance." Ann Card Anaesth, 22(4):407-411. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6813708/#:~:text=The%20Student's%20t%20test%20is,mean%20difference%20was%20statistically%20significant.
9. National Academy of Public Administration, 2018, "Course materials for major specialists", Ha Noi. https://hocvientuphap.edu.vn/boiduong/Lists/ThongBaoNhapHoc/Attachments/203/Tai%20lieu%20BD%20ngach%20CVC%20ban%20hanh%20theo%20Q%C4%90%20so%202720-%2028.12.2018%20cua%20BNV.pdf
10. National Task Force on COVID19 Implementer, 2020a, "The National Action Plan against COVID 19 III". https://iatf.doh.gov.ph/wp-content/uploads/2022/09/Signed-NAPCOVID19-Phase-III_1612953014.pdf
11. National Task Force on COVID19 Implementer, 2020b, "The National Action Plan against COVID 19 II". https://iatf.doh.gov.ph/wp-content/uploads/2022/09/NAP-Phase-II-Reportv2.pdf
12. National Task Force on COVID19 Implementer, 2020c, "The National Action Plan against COVID 19 I". https://iatf.doh.gov.ph/wp-content/uploads/2022/09/NationalAction-Plan-against-COVID-19-1.pdf
13. O'Leary Z, 2014, "The essential guide to doing your research project" (2nd ed.), Thousand Oaks, CA: SAGE Publications, Inc.
14. Philippine Department of Health & Philippine World Health Organization, 2020, "Philippines COVID-19 situation reports". https://www.who.int/philippines/emergencies/COVID-19-response-in-the-philippines/situation-reports
15. Philippine National Epidemiology Center, 2014, "Manual of Procedures for Philippine Integrated Disease Surveillance and Response" (3rd Ed.), Philippine Department of Health. https://doh.gov.ph/sites/default/files/publications/PIDSRMOP3ED_VOL1_2014.pdf
16. Tapales Proserpina D, 2015, "The Nature and State of Local Government." In Reyes Danilo R., Tapales Proserpina D., Domingo Ma. Oliva Z., & Mendoza Maria Fe V. (Ed.), Introduction to Public Administration in the Philippines: A Reader (3rd ed., Vol. 1), Quezon City: UP-NCPAG.
17. The Philippine government, 1991, "An act providing for a local government code of 1991, Republic Act No. 7160." https://www.officialgazette.gov.ph/1991/10/10/republic-act-no-7160/
18. Thu T. L, 2017, "Improve the efficiency of public policy implementation by law enforcement agencies.", State Organization Magazine, ISSN 2815-6439. https://tcnn.vn/news/detail/38920/Nang_cao_hieu_qua_thuc_thi_chinh_sach_cong_cua_co_quan_hanh_phapall.html
19. Tungpalan R.G, 2015, "The Philippine Evaluation Policy Framework: Supporting Evidence-based Decision Making", 13th ODA Evaluation Workshop Tokyo, Japan. https://www.mofa.go.jp/policy/oda/evaluation/seminars_and_workshops/evaluation_workshops/13_02.pdf
20. Senate and House of Representatives of the Philippines, 2012, "Republic Act 10173 – Data Privacy Act of 2012 (PH)". https://www.privacy.gov.ph/data-privacy-act/
21. Vietnam Ministry of Health, 2020, "Decision number 237/QD-BYT on the promulgated plan to respond to each level of acute respiratory infection caused by a new strain of Corona virus (nCoV)". https://moh.gov.vn/web/dich-benh/huong-dan-chuyen-mon/-

/asset_publisher/NxZAa8ST2KXb/content/quyet-inh-so-237-q-byt-ngay-31-01-2020-ve-viec-ban-hanh-ke-hoach-ap-ung-voi-tung-cap-o-dich-benh-viem-uong-ho-hap-cap-do-chung-moi-cua-vi-rut-corona-n

22. Vietnam Ministry of Health, 2018, "Pursuant to decision number 2268/QD-BYT of the Minister of Health about functions, tasks, powers and organizational structure of the General Department of Preventive Medicine under the Ministry of Health". https://thuvienphapluat.vn/van-ban/Bo-may-hanh-chinh/Quyet-dinh-2268-QD-BYT-2018-chuc-nang-quyen-han-co-cau-to-chuc-cua-Cuc-Y-te-du-phong-378962.aspx
23. Vietnam Ministry of Health & Vietnam World Health Organization, 2020, "Vietnam COVID-19 situation reports". https://www.who.int/vietnam/emergencies/COVID-19-in-vietnam/situation-reports
24. World Health Organization, 2020, "Monitoring and Evaluation Framework: COVID-19 Strategic Preparedness and Response (SPRP)". https://www.who.int/publications/i/item/monitoring-and-evaluation-framework