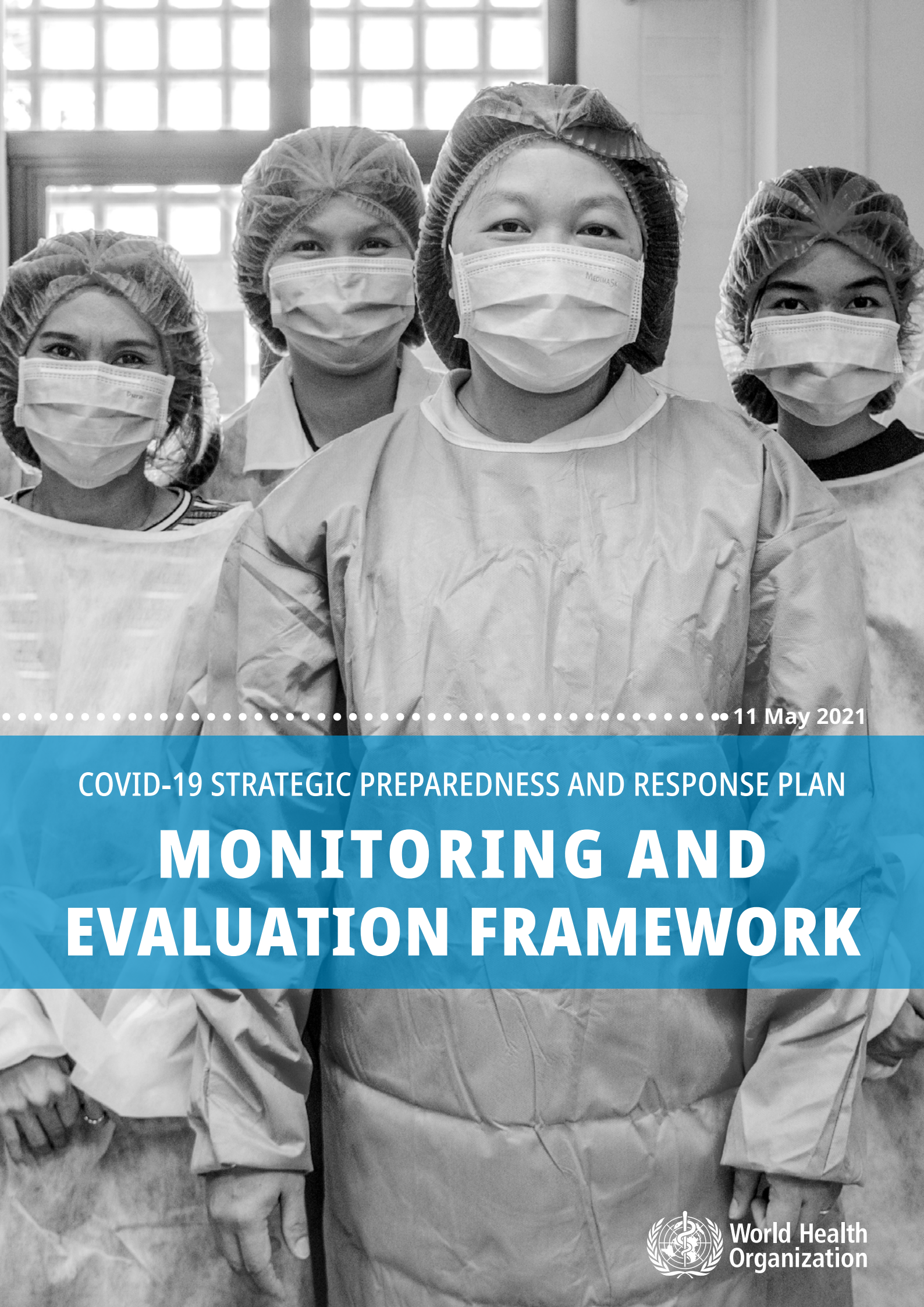

11 May 2021

COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PLAN

MONITORING AND EVALUATION FRAMEWORK

World Health Organization

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COVID-19 strategic preparedness and response plan: Monitoring and evaluation framework

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ABOUT THIS DOCUMENT

The *COVID-19 Strategic preparedness and response plan* (SPRP) 2021[1] was developed to update global strategic priorities and help guide the health response to COVID-19 as the global epidemiological situation evolved and the understanding of COVID-19 increased. The goal of the SPRP 2021 is to end the acute phase of the pandemic and build resilience and readiness for the future. The SPRP 2021 has six strategic objectives; suppress transmission, reduce exposure, counter misinformation and disinformation, protect the vulnerable, reduce deaths and illness, and accelerate equitable access to new tools. These strategic objectives are shared by the Access to COVID-19 Tools (ACT) Accelerator, which is integrated with the SPRP 2021 to ensure that access to new products is married with their safe, equitable, and effective implementation.

The *COVID-19 SPRP 2021 Operational planning guidelines*[2] were developed to accompany the SPRP 2021, providing countries with practical, high-level actions that can be adapted as appropriate and implemented at national and sub-national levels in order to achieve the six SPRP 2021 strategic objectives.

This document, the *COVID-19 SPRP 2021 Monitoring and evaluation (M&E) framework,* sets out the approach and methods for tracking and reporting on the global progress against the SPRP 2021. This document includes a short summary table of the SPRP M&E Framework's indicators (Annex 1) and the accompanying methodological notes (Annex 2). Monitoring SPRP 2021 implementation will support countries, WHO, UN agencies and partners in strategic thinking and course correction as needed, to strengthen the response to COVID-19.

1 To access the COVID-19 Strategic preparedness and response plan (SPRP 2021) (24 February 2021) see: https://www.who.int/publications/i/item/WHO-WHE-2021.02

2 To access the COVID-19 SPRP 2021 Operational planning guideline (3 March 2021) see: https://www.who.int/publications/m/item/COVID-19-strategic-preparedness-and-response-plan-operational-planning-guideline

INTRODUCTION

Background

The SPRP 2021 outlines eleven preparedness and response pillars (Figure 1). The interventions needed to break the cycles of disease transmission differ between countries and between sub-national areas within countries according to context and capacities. However, all interventions and strategic objectives are supported and enabled by multiple pillars of the response, with a need to adapt the response to changing and special contexts such as humanitarian settings.

Country response actions are supported by global and regional operations. The UN system, international partners and the private sector bring their collective complementary strengths to deliver the knowledge, resources and tools to support Member States. Together we are all working to end the acute phase of the COVID-19 pandemic, and build a safer, more resilient and better prepared world. This global dynamic system of support and response is underpinned by public health and operational intelligence to inform action.

Lessons learned from monitoring the global pandemic response in 2020 informed the development and approach taken in this M&E Framework. Lessons included the need to (1) focus on a strategic core set of indicators that drive global operations in support of regional, national and sub-national responses; (2) complement use of key performance indicators with narrative case studies to contextualize progress and lessons learned; (3) rely largely on country and regional M&E for real-time operational course corrections at national and sub-national level; (4) balance reporting requirements of stakeholders with the burden placed on reporting authorities and (5) further link with complementary monitoring frameworks to maximize reporting data as relevant to the pandemic response.

Purpose of 2021 SPRP M&E Framework

The SPRP 2021 Monitoring and Evaluation (M&E) Framework aims to monitor and report on global SPRP 2021 implementation. Timely information and analysis of the response progress and the evolving epidemiological COVID-19 situation (Annex 3), are critical to inform strategic adjustments, operational tracking, and decision-making, as well as ensuring accountability and transparency. This document sets out key reporting requirements for M&E focal points contributing to global SPRP 2021 monitoring.

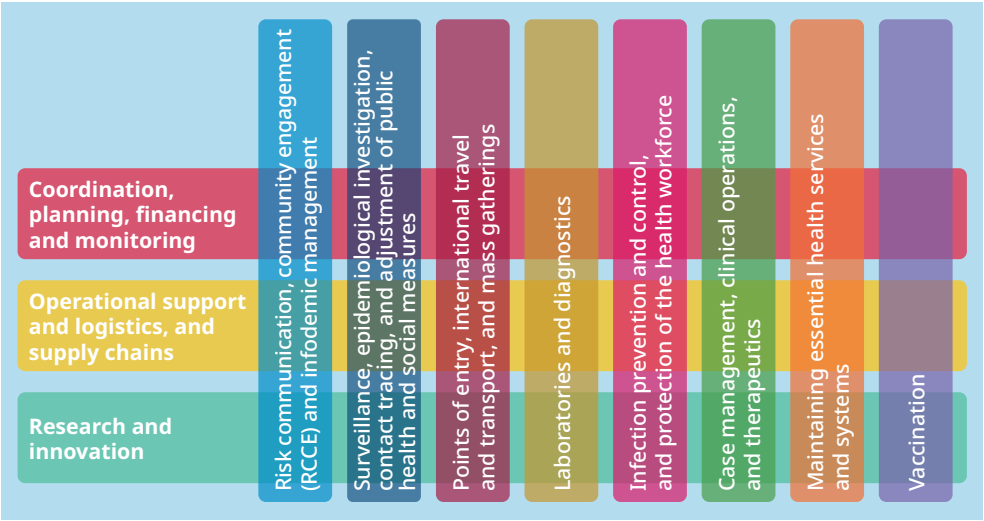
The specific objectives of the M&E Framework are to:

- monitor and report on country and global COVID-19 response actions;
- produce operational intelligence, to inform coordinated action and operational course corrections as part of an agile response;
- promote sharing of lessons learned, and promote transparency and innovation amongst countries and partners;
- set baselines and mechanisms for programmatic monitoring of COVID-19 in the long term.

Target audience

This document is primarily directed at SPRP 2021 implementing authorities and M&E focal points at national, regional and global level, including at WHO offices who are responsible for managing, monitoring and reporting on SPRP 2021 implementation.

Figure 1 Eleven pillars underpinning the national, regional and global COVID-19 response



Scope

The scope of the M&E Framework is the SPRP 2021. It is built on the ten pillars that underpin the preparedness and response structures, capacities and interventions needed in line with the SPRP goal and six strategic objectives.

The M&E Framework complements national and regional monitoring frameworks for COVID-19 that are necessary for real-time operational monitoring and response actions based on local contexts, as well as monitoring for other aspects such as the COVID-19 socio-economic response.

Within WHO, the M&E Framework interfaces with other preparedness and response frameworks such as those linked to the International Health Regulations (IHR 2005) and WHO's General Programme of Work (GPW) 13 to align contextually and maintain coherence in global and national programmatic monitoring.

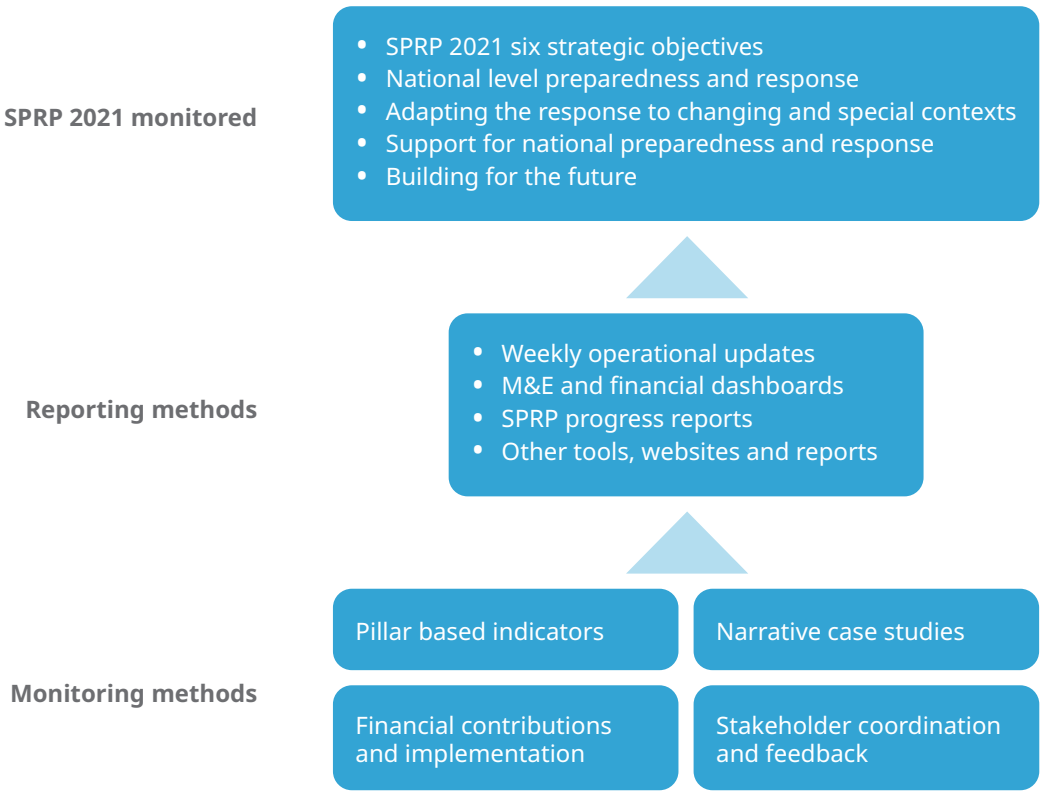
Finally, the M&E Framework interfaces with response reviews and stock takes such as the IHR Emergency Committee for COVID-19 that provide recommendations for strengthening the global response to both State Parties and the WHO Secretariat.

Approach

This M&E Framework is a collaborative initiative among stakeholders driven by WHO's global and regional incident management support teams (IMSTs). The M&E Framework uses a combination of key-performance indicators and narrative case studies to complement existing financial monitoring and stakeholder coordination and feedback mechanisms. Collectively, these form the 'operational intelligence' needed to monitor progress against the SPRP 2021 and inform strategic thinking (Figure 2).

The ten SPRP pillars excluding research and innovation are the foundation for the M&E Framework as they are the basic and comprehensive components feeding into the national, regional and global public health and social measures, as well as the SPRP 2021 strategic objectives.

Figure 2 Methods for monitoring and reporting operational intelligence against the *COVID-19 Strategic preparedness and response plan 2021*



METHODOLOGY

The methodology for monitoring using pillar-based indicators and narrative case studies is described below. Other components of SPRP operational monitoring, namely financial monitoring and stakeholder coordination, are described in Part II of the SPRP 2021.

Monitoring using pillar-based indicators

The pillar-based indicators set out in this M&E Framework (Annex 1 for Indicator Summary Table and Annex 2 for Indicator Compendium) follow the logic of the SPRP 2021 and were selected based on their utility to provide a periodic situational snapshot about country, regional or global operations and inform operational response course correction actions.

Indicators were either (a) maintained from the 2020 SPRP M&E Framework based on their continuing operational importance; (b) adapted and included from other monitoring frameworks based on their relevance to the overall global COVID-19 response; or (c) developed based on the need to have indicators that address the global evolving nature of the pandemic and response interventions.

The M&E Framework relies on proactive reporting of data and information. Completeness and geographic coverage may vary if there are delays in data sharing. To mitigate this risk, a number of indicators were selected based on data availability through global platforms and reporting tools so that data collection could be automated and timely.

Data collection: indicator data will be collected from different sources as described in Annex 2. Table 1 below shows the source of data submitted to the WHO global SPRP M&E team. Further indicator details including key terms, scope, disaggregation and targets are also detailed in Annex 2. The scope of indicators varies, with some referring to Gavi COVAX AMC-eligible countries and economies, or Humanitarian Response Plan (HRP) Countries for 2021, which are listed for reference in Annexes 4 and 5. Indicators will be collected with varying frequencies as noted in Table 1 below and in Annex 2.

Data validation: a two-step process is expected to maximize data validity. First, data will be validated by the data source responsible officer. Second, the data will be logic checked by the WHO global SPRP M&E team. All data are subject to continuous verification and may change based on retrospective updates or reviews. All data are subjected to continuous verification by WHO with the exception of those data provided by third party sites, which are not validated by the SPRP M&E team.

Indicator analysis and reporting: progress will be reported using the methods described in Figure 2. The M&E Framework indicator analysis plan will be collectively defined to respond to global and national needs for decision-making. Final aggregation, analysis, and visualization will be provided according to the agreed frequency of each indicator.

Table 1 Number of indicators by source and frequency of data collection

Frequency of indicator data collection	Sources		
	WHO headquarters	WHO regional offices	Total
Weekly	4	0	4
Fortnightly (every 2 weeks)	3	0	3
Monthly	12	3	15
Quarterly	9	1	10
Every six months	1	0	1
Annually	2	0	2
Total	31	4	35

Monitoring using narrative case studies

Narrative case studies from sub-national, national, regional or global level are critical to contextualize SPRP 2021 implementation and progress. Case studies complement indicators by providing implementers the opportunity to share their observations and lessons learnt, and to describe the enablers and challenges faced through the course of implementation. The methodology described below focuses on the global collation and reporting of case studies for the purpose of SPRP 2021; however, complementary case studies and qualitative learning are also done at country and regional level.

Case study focus: case studies will focus on sub-national, national, regional or global implementation either holistically or according to pillar-related activities or deliverables.

Case study collection: case studies will be prepared by the three levels of WHO (country, regional and headquarters) and partner agencies implementing pillar-based activities and collated by the WHO global SPRP M&E team for reporting.

Collection frequency: Frequency is dependent on the reporting method (Figure 2), with high frequency expected for the Weekly Operational Updates and lower frequency for periodic progress reports such as those for SPRP 2021.

Information validation: case studies received will be reviewed by the WHO global SPRP M&E team to confirm clarity and alignment with the SPRP 2021. Data reported in the case studies will be checked for accuracy.

Case study reporting: case studies will be reported through different methods as shown in Figure 2. This may include the Weekly Operational Updates, SPRP progress reports and pillar-specific WHO webpages or WHO COVID-19 news pages. Case studies may also be reported in documents for governing bodies or other stakeholders.

SPRP 2021 implementation evaluation

Periodic country level evaluations are expected through the conduct of intra-action reviews (IARs), post-implementation evaluations (PIEs) for vaccines, or similar exercises. WHO and partner networks supporting countries to implement SPRP 2021 will also periodically evaluate actions taken as part of the continuous learning needed to inform the response. This approach will be critical to appreciate and address the bottlenecks and challenges for effective delivery of services and interventions.

Through the ACT-A Health Systems Connector that underpins the delivery of new COVID-19 tools, emphasis will be placed on the foundational health system capacities including financing; data management, collection and analysis; workforce planning, management and development; clinical care; logistics and supply chain management. Various approaches will be used to conduct such evaluations including through Pulse Surveys and review of country response plans.

Evaluation and assessment of the global COVID-19 response, including SPRP 2021 implementation, is conducted through mechanisms such as the IHR Emergency Committee and the Independent Panel for Pandemic Preparedness and Response. These mechanisms provide recommendations for improving country-level health response, the global and regional work to support national preparedness and response, and for building future resilience.

SPRP 2021 M&E Framework review

Three months after the start of implementation of the 2021 M&E Framework, a review exercise will be done to ensure suitability of the approach and to assess the feasibility of the pillar-based indicators. Based on this review, refinements may be made to the M&E Framework as necessary. Further impact measures (such as excess mortality) may be added to the M&E Framework.

Limitations

There are limitations to monitoring SPRP 2021 technical implementation and progress globally through the approach presented in this framework. Key limitations are presented and discussed below.

- The M&E Framework has limited capacity to drive real-time response operations at the national and sub-national levels due to the differing contexts and time-lags in reporting. Therefore, regions and countries are encouraged to establish COVID-19 M&E frameworks to track operational performance and drive local response actions.
- As a framework with global coverage, it is challenging to validate data and information collated from country level. A network of WHO SPRP 2021 M&E focal points from WHO regional offices and headquarters was established to link with technical pillar teams and IMST leadership to facilitate accurate reporting and to ensure quality analyses. The network will play a critical role in collecting, validating and reporting of SPRP 2021 progress.
- For qualitative data and case studies, lessons learnt may not be generalizable across different settings and contexts. Attempts to summarize observations may obscure significant sub-national heterogeneity, particularly where there are vulnerable populations such as humanitarian contexts. This highlights the importance of regional and country level operational monitoring so that specificities are more appropriately captured and shared.
- Preparing quality case studies is a time-consuming process. WHO will work with countries and partner agencies, including ACT-A partners, to continuously identify and share implementation case studies.

ANNEXES

Annex 1: Indicator summary table[3]

Indicator	Target[4]	Reporting frequency
Pillar 1: Coordination, planning, financing, and monitoring		
Proportion of countries that have conducted at least 1 Intra-Action Review (IAR) or equivalent country-level review of the COVID-19 response	100%	Monthly
Proportion of countries that have conducted at least 1 COVID-19-related simulation exercise	N/A	Monthly
Proportion of flexible funding received by WHO for SPRP 2021	at least 30%	Quarterly
Proportion of countries that have conducted 1 or more analyses of health inequities during the COVID-19 pandemic baseline data analysis	Target to be set after	Quarterly
Pillar 2: Risk communication, community engagement (RCCE), and infodemic management		
Proportion of Advanced Market Commitment (AMC) participating economies[5] under COVAX that have a budgeted plan for vaccination acceptance and demand	100%	Monthly
Proportion of countries that have capabilities to track and address infodemics and health misinformation	70%	Quarterly
Pillar 3: Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures		
Proportion of Member States with COVID-19 detailed surveillance reporting to WHO	100%	Monthly
Proportion of countries testing for COVID-19 and reporting in a timely manner through established sentinel or non-sentinel influenza like illness (ILI), severe acute respiratory illness (SARI), acute respiratory infection (ARI) surveillance systems such as Global Influenza Surveillance and Response System (GISRS) or other WHO platforms	50%	Weekly
Proportion of countries implementing sero-epidemiological investigations or studies	40%	Quarterly
Number of countries that integrate COVID-19 surveillance into sentinel systems that monitor influenza	N/A	Quarterly
Proportion of Member States reporting COVID-19 health worker infections to WHO	100%	Monthly
Pillar 4: Points of entry, international travel and transport, and mass gatherings		
Proportion of States Parties which made timely up-to-date information about their international travel-related measures available to WHO	100%	Quarterly
Proportion of planned mass gathering events that underwent a risk assessment exercise/risk-based approach in the context of COVID-19	50%	Quarterly
Pillar 5: Laboratories and diagnostics		
Proportion of countries that publicly share SARS-CoV-2 genetic sequence data	75%	Monthly
Proportion of countries participating in WHO External Quality Assessment Program 2021	100%	Annually
Proportion of countries with 100% performance across laboratories participating in a SARS-CoV-2 EQA scheme	75%	Annually

3 For details on indicator targets (including details on scope the target refers to) and frequency, refer to Annex 2. Some indicators may change reporting frequency.

4 N/A or not applicable: These are monitoring indicators to inform situational assessment with no targets defined.

5 Note: Refer to Annex 4 for the full list of participating economies.

Indicator	Target	Reporting frequency
Pillar 6: Infection prevention and control, and protection of the health workforce		
Proportion of countries with a national IPC programme	100% of countries with WHO country offices	Every 6 months
Number of users who completed OpenWHO IPC modules	N/A	Monthly
Proportion of countries supported by COVID-19 SPRP 2021 investments for Infection Prevention and Control (IPC)	60%	Quarterly
Pillar 7: Case management, clinical operations, and therapeutics		
WHO dashboard updates on therapeutics/oxygen utilization amongst hospitalized patients published monthly	Monthly update published	Monthly
Proportion of supplies requested (biomedical equipment) through WHO supply mechanism that are delivered within 10 weeks of request validation (shared indicator with Pillar 8)	85%	Fortnightly
Pillar 8: Operational support and logistics, and supply chain		
Proportion of supplies requested (PPE) through WHO supply mechanism that are delivered within **6–8** weeks of request validation	85%	Fortnightly
Proportion of supplies requested (diagnostics) through WHO supply mechanism that are delivered within **6 weeks** of request validation	85%	Fortnightly
Proportion of requested COVID-19 supply volume that has been shipped to countries through WHO supply mechanisms	85%	Monthly
Evolution monitoring of global demand trends within WHO supply mechanisms	One analysis per month	Monthly
Pillar 9: Maintaining essential health services and systems		
Number of countries reporting disruption to essential health services during COVID-19 pandemic	Target to be set after baseline data analysis	Quarterly
Proportion of countries where at least one vaccine preventable disease (VPD)-immunization campaign was affected by COVID 19 that has since been reinstated using risk mitigation strategies	N/A	Monthly
Pillar 10: Vaccination		
Proportion of AMC participating economies that have granted timely regulatory approval OR import-only authorization for one or more COVID-19 vaccines granted WHO Emergency Use Listing (EUL)	100%	Monthly
Proportion of Member States that have reported COVID-19 vaccine-related serious adverse event/s following immunization (AEFI) to WHO	100%	Monthly
Number of countries that have started administration of COVID-19 vaccination	100%	Weekly
Number of COVID-19 vaccine doses administered globally	N/A	Weekly
Proportion of global population with at least one vaccine dose administered	N/A	Weekly

Indicator	Target	Reporting frequency
Adapting the response to changing and special contexts		
Proportion of countries in humanitarian settings with a functioning multi-sectoral mental health and psychosocial support (MHPSS) coordination group	100%	Monthly
Proportion of countries within fragile, conflict-affected and vulnerable settings (FCV) reporting unusual all-cause mortality trends	N/A	Monthly
Proportion of countries within FCV reporting unusual pressure on hospital services	N/A	Monthly

Annex 2: Indicator compendium

The following compendium contains detailed methodological notes for all global indicators included in the SPRP 2021 M&E Framework. The method notes include each indicator's rationale for use, associated key terms defined, the numerator and denominator, scope and target, data source and reporting frequency.

Most indicators reference the International Health Regulations (2005) Emergency Committee regarding the outbreak of the COVID-19 statements, which are available in the maintained Committee website.[6]

Pillar 1 Coordination, planning, financing and monitoring	
Indicator: Proportion of countries that have conducted at least one Intra-Action Review (IAR) or equivalent country-level review of the COVID-19 response	
Rationale for use	This indicator aims to support the monitoring of the IHR Emergency Committee's fourth meeting temporary recommendation issued by the WHO Director-General for States Parties to "share best practices, including from intra-action reviews, with WHO, to apply lessons learned from countries and mitigating resurgence of COVID-19." Findings from evaluations, review exercises and intra-action reviews can inform in-country decision-making, adjust COVID-19 operational response plans, improve capabilities for preparedness and response actions across the 10 SPRP pillars, as well as to link to dissemination of best practices across Member States. Countries may choose to conduct more than 1 IAR or equivalent review exercise, inclusive of conducting exercises at the **sub-national level.**
Definition of key terms	An IAR[7]is a country-led, facilitated discussion bringing together a small group of COVID-19 responders, including decision makers with knowledge of the public health response pillars under review, such as multisectoral coordination, surveillance, and diagnostic testing. The objective of the IAR is collective learning, in which responders can share experiences and identify current challenges and bottlenecks, as well as what actions are working to further improve the response to COVID-19 and contribute to the health system strengthening in the long term. This may also include IARs completed at the subnational level. The guidance and tools for COVID-19 intra-action reviews can be found here. An equivalent country-level review refers to any country-driven process that brought together multi-sectoral stakeholders to review the COVID-19 response and identify challenges and lessons learned to inform future actions. These may also include reviews conducted at the subnational level.
Measurement	
Numerator	Number of countries completing at least 1 IAR or equivalent review exercise within the country
Denominator	All countries
Disaggregation	N/A
Scope	All countries
Target	100%
Data collection and reporting	
Data source	The WHO Regional M&E Focal Points will liaise with the Regional AAR/Simulation Exercise focal points to consolidate reporting for this indicator (country/subnational). The M&E Regional focal point will share available reporting for the indicator with the HQ SPRP M&E Team. In some instances, a country will conduct multiple IAR or equivalent review exercises; these countries should continue reporting subsequent reviews at the specified frequency to the established WHO IHR Focal Points.[8]
Reporting start date	January 2021
Reporting frequency	Monthly

6 To access all Statements from the International Health Regulations (2005) Emergency Committee regarding the outbreak of the coronavirus disease (COVID-19), see here: https://www.who.int/groups/COVID-19-ihr-emergency-committee

7 To access the Guidance for conducting a country COVID-19 intra-action review (IAR) (23 July 2020) see here: https://www.who.int/publications/i/item/WHO-2019-nCoV-Country_IAR-2020.1

8 Note: It is possible that a country will conduct more than one IAR or equivalent review during the course of one calendar year. Countries may also prioritize to conduct multiple subnational-level IARs.

Pillar 1 Coordination, planning, financing and monitoring	
Indicator: Proportion of countries that have conducted at least one COVID-19-related simulation exercise	
Rationale for use	Findings from simulation exercises can inform decision-making for the improvement of response and preparedness capacities of countries, as well as strategic and operational planning, such as updating national and sub-national COVID-19 response plans, vaccination plans and actions.
Definition of key terms	An exercise that simulates an emergency situation to which a described or simulated response is made. The purpose is to validate and enhance preparedness, operational readiness and response plans, procedures and systems. WHO defines different types of exercises, including discussion-based table-top exercises as well as operations-based exercises such as drills, functional exercises and field/full scale exercises.[9] WHO has developed various COVID-19 tabletop exercise (TTX) packages.
Measurement	
Numerator	Number of countries completing COVID-19 related simulation exercise
Denominator	All countries
Disaggregation	This indicator reporting will be disaggregated by focus of simulation exercises: • vaccine roll-out • other COVID-19 related topics
Target	There is no set target for this indicator
Data collection and reporting	
Data source	The WHO HQ Simulation Exercise focal point will consolidate data from the WHO Regional IHR Focal Points and then report results to WHO HQ SPRP M&E Team
Reporting start date	January 2021
Reporting frequency	Monthly

9 To access Coronavirus disease (COVID-19) training: Simulation exercise packages see here: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise

Pillar 1 Coordination, planning, financing and monitoring	
Indicator: Proportion of flexible funding received by WHO for SPRP 2021	
Rationale for use	In order for WHO to make operational decisions based on epidemiological situation and on-the-ground needs, partners have been encouraged to fund SPRP 2021 with flexible funding. This allows WHO to direct resources where they are most needed and enables WHO to be agile and strategic in achieving the objectives in the SPRP 2021. To track and bring visibility to the proportion of funding that is flexible, the following indicator was developed.
Definition of key terms	**Flexible funds:** Funding donated to the SPRP 2021 but no further functional or geographic specifications/requirements specified. Official Development Assistance (ODA) countries are also included under this category. **Designated:** Funding donated to the SPRP 2021 and designated to some degree of geographical specifications/requirements. This specification may include a regional designation or as focused as a specific country. For geographical specifications, usually these funds become flexible once they have reached their geographical destination. **Specified:** Funding dedicated to the SPRP 2021 with geographical and/or programmatic earmarking together with some form of functional earmarking against outcomes, outputs, and activities with a budget.
Measurement	
Numerator	Total flexible funds received under SPRP 2021
Denominator	Total funds received under SPRP 2021
Scope	All funding received under SPRP 2021 in WHO (Headquarters, Regional Office, Country Offices)
Target	At least 30%
Data collection and reporting	
Data source	The data for funding received under SPRP 2021 at all levels of WHO is managed by the WHO HQ team for Finance and Management within a Power BI Dashboard. This data will be shared with the HQ SPRP M&E team on a quarterly basis.
Reporting start date	February 2021, launch date of SPRP 2021
Reporting frequency	Quarterly

Pillar 1 Coordination, planning, financing and monitoring	
Indicator: Proportion of countries that have conducted 1 or more analyses of health inequities during the COVID-19 pandemic	
Rationale for use	Given the significant inequities revealed and exacerbated by the pandemic, this indicator aims to monitor progress of countries in addressing gender, equity, human rights, and Social Determinants of Health (SDH) within COVID-19 responses. It is based upon the understanding that evidence-based equitable interventions require disaggregated data and related analysis and research that identifies barriers to access health services faced by specific population groups during the COVID-19 pandemic. To meet this indicator, countries should have produced at least one qualitative or quantitative analysis of health inequities (including, but not limited to a report, paper, and/or research). The analysis/es should link to at least one of the COVID-19 health services for any of the 10 SPRP response pillars. Analysis/es can include: • analyses using data disaggregated by sex, age, and at least two of the following inequality dimensions: income/wealth, race, ethnicity, migratory status, disability, geographic location, and other SDH and characteristics relevant in national contexts;[10] or • analyses on barriers to access to COVID-19 health services related to situations of vulnerability and/or gender, ethnic, or other forms of inequality and/or discrimination affecting their rights. The indicator will be considered as met by a country with a "Yes" response to either of the above criteria (either related to reports or research produced by the Ministry of Health or another ministry).
Definition of key terms	**COVID-19 health services** include all those services related to the 10 SPRP response pillars, including vaccines. **Health inequities** are differences in health status or in the distribution of health resources between different population groups, that can be characterized as 'unfair' and which could be reduced by the right mix of government equity sensitive policies and interventions. **Gender equality** in health means that women and men* have equal conditions for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results. (*Gender also refers to expressions and identities of women, men, boys, girls, and gender-diverse people.) **Ethnic inequalities** are inequalities driven and perpetuated by discrimination against, and/or the marginalization of, diverse ethnic groups. Ethnicity is a purely social concept that refers to cultural practices, language, history, or ancestry transmitted through learning that begins in childhood. **Human rights** are interdependent, indivisible, and interrelated. This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa. **Social Determinants of Health (SDH)** are the non-medical conditions or factors that influence health outcomes and wellbeing They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
Measurement	
Numerator	# Member States that indicate have conducted 1 or more analyses of health inequities during the COVID-19 pandemic
Denominator	All Member States that responded to WHO Pulse Survey
Scope	All Member States
Target	The target will be set during the first quarter of M&E Framework based on its initial 2021 Pulse Survey results.
Data collection and reporting	
Data source	WHO Pulse Survey
Reporting start date	May 2021
Reporting frequency	This indicator is aimed for reporting on a quarterly basis and will be adjusted based on the number of times the Pulse Survey is administered during 2021.

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Pillar 2 Risk communication, community engagement and infodemic management	
Indicator: Proportion of Advanced Market Commitment (AMC) participating economies[11] under COVAX that have a budgeted plan for vaccination acceptance and demand	
Rationale for use	From its meeting on 14 January 2021, the IHR Emergency Committee advised WHO to support State Parties to "encourage and facilitate vaccine acceptance and uptake by providing credible information on vaccine safety and the benefits of vaccination to address concerns." To meet this recommendation, countries need to have a good communication plan in place to provide accurate and up-to-date information to families and communities about the COVID-19 vaccines, eligible segments of the population and continuation of recommended behaviours by all community members to prevent infection and transmission. Vaccination acceptance and demand communication will need to address and engage various intended audiences, as per the phases of vaccine delivery and to ensure acceptance and uptake. To implement the communication plan, countries need a budget that accounts for the different activities both nationally and at sub-national level.[12] This indicator monitors progress in AMC participating economies, which are comprised of 92 low and middle-income economies.
Definition of key terms	**Vaccine acceptance,** as shown by research, is driven by people's behaviour including an enabling environment, social influencers and motivations. **COVAX** is the vaccines pillar of the Access to COVID-19 (ACT) Accelerator. COVAX is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi and the World Health Organization (WHO), alongside key delivery partner UNICEF. Its aim is to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world. This involves the COVAX Facility, a global risk-sharing mechanism for pooled procurement and equitable distribution of COVID-19 vaccines. **The COVAX AMC** is the financing instrument that supports the participation of 92 low- and middle-income participating economies in the COVAX Facility – enabling access to donor-funded doses of safe and effective COVID-19 vaccines.
Measurement	
Numerator	Number of AMC participating economies with budgeted communication plans for vaccine acceptance and demand[13]
Denominator	Total AMC participating economies
Disaggregation	N/A
Scope	This indicator will focus on the 92 AMC-eligible economies
Target	100%
Data collection and reporting	
Data source	WHO HQ Information Network for Epidemics (EPI-WIN) team will review and analyse National Deployment of Vaccine Plans (NDVP) submissions from AMC economies within the COVID-19 Partners Platform.[14] The WHO HQ Information network for Epidemics (EPI-WIN) team will also use the WHO/UNICEF Joint Reporting Process (eJRF)[15] as an additional source of complementary information to support reporting for this indicator. The HQ IM-RCCE team will then report data to the HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Monthly

11 Note: Refer to Annex 4 for the full list of participating economies.

12 To access Communicating risk in public health emergencies (10 January 2018) see here: https://www.who.int/publications/i/item/9789241550208

To see Acceptance and demand for COVID-19 vaccines: Interim guidance (31 January 2021) see here: https://www.who.int/publications/i/item/WHO-2019-nCoV-vaccination-demand_planning-tool-2021.1 https://www.who.int/publications/i/item/WHO-2019-nCoV-vaccination-demand_planning-tool-2021.1

13 To access the Acceptance and demand for COVID-19 vaccines: communications plan template (31 January 2021) see here: https://www.who.int/publications/i/item/WHO-2019-nCoV-vaccination-demand_planning-template-2021.1

14 To access the COVID-19 Partners Platform see here: https://covid19partnersplatform.who.int/en/

15 To access the WHO/UNICEF Joint Reporting Process (eJRF) see here: https://www.who.int/immunization/monitoring_surveillance/routine/reporting/en/

Pillar 2 Risk communication, community engagement and infodemic management	
Indicator: Proportion of countries that have capabilities to track and address infodemics and health misinformation	
Rationale for use	This indicator aims to monitor progress against the IHR (2005) Emergency Committee's advice to WHO to work with partners to counter mis/disinformation and infodemics and the committee's temporary recommendation issued by the WHO Director-General for State Parties to "engage communities to address rumours and misinformation and keep the public informed, with a focus on vulnerable populations." An infodemic can intensify or lengthen outbreaks when people are unsure about what they need to do to protect their health and the health of people around them. With growing digitization – an expansion of social media and internet use – information can spread more rapidly, which can help to more quickly fill information voids but can also amplify harmful messages.[16] To monitor the progress of this indicator, the WHO Pulse Survey tool which assesses essential health services will be used. The Pulse Survey will disaggregate the current capability of the country to track and address infodemic and health misinformation.
Definition of key terms[17]	**An infodemic** is an overabundance of information, both online and offline. It includes deliberate attempts to disseminate wrong information to undermine the public health response and advance alternative agendas of groups or individuals. **Infodemic management** is the systematic use of risk- and evidence-based analyses and approaches to manage the infodemic and reduce its impact on health behaviors during health emergencies. It aims to ensure people have access to factual information in a timely manner that is easily understood; so that they may rapidly adopt behaviours to protect health and the health of others during an epidemic. Infodemic management must be backed up by science, rely on evidence-based interventions, and make use of best practices, including sharing experiences and continuous learning.
Measurement	
Numerator	Number of countries self-reporting to have capability to track and address infodemic and health misinformation either within the Ministry of Health or within another governmental Ministry
Denominator	All Member States that responded to WHO Pulse Survey
Disaggregation	Responses will be disaggregated by: • Yes, capability present within Ministry of Health or equivalent • Yes, capability within government but in another Ministry • Not yet, but planning on setting up a unit • No unit, but we have staff completing these tasks • No • Don't know
Scope	Global
Target	70%
Data collection and reporting	
Data source	WHO HQ Information network for Epidemics (EPI-WIN) Team will compile all results from the administered WHO National Pulse Survey on continuity of essential health services during the COVID-19 pandemic and will report this to the WHO HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	This indicator is aimed for reporting on a quarterly basis and will be adjusted based on the number of times the Pulse Survey is administered during 2021.

16 To access An ad hoc WHO technical consultation managing the COVID-19 infodemic: call for action (7–8 April 2020) see here: https://www.who.int/publications/i/item/9789240010314

17 To access the WHO infodemic health topic page see here: https://www.who.int/health-topics/infodemic#tab=tab_1

Pillar 3 Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures	
Indicator: Proportion of Member States with COVID-19 detailed surveillance reporting to WHO	
Rationale for use	On 29 October 2020, the IHR (2005) Emergency Committee advised WHO to "encourage and support countries to understand and report on their epidemiological situation and relevant indicators" as well as provide support to strengthen countries' robust public health surveillance. The WHO Public health surveillance for COVID-19 interim guidance (16 December 2020) asks for national authorities to include "COVID-19 as a mandatory notifiable disease with requirements for immediate reporting." This indicator aims to provide a global assessment of country reporting to WHO on COVID-19 cases, deaths, and related epidemiological information on a monthly basis.
Definition of key terms	A Member State is considered to have reported COVID-19 cases[18] to WHO in the past month if it has provided either: • at least one weekly aggregate surveillance reporting submission providing at least age and sex data of cases; or • for countries maintaining case-based surveillance, has provided Case Reporting Forms (CRFs) for at least 50% of incident cases reported in first week of past month, providing at least age and sex of cases.
Measurement	
Numerator	Number of Member States reporting detailed COVID-19 surveillance data to WHO
Denominator	All Member States
Disaggregation	There is no disaggregation for this indicator
Scope	All Member States
Target	100%
Data collection and reporting	
Data source	WHO HQ Surveillance Pillar will consolidate the data reporting from Member States and share main findings with the HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Monthly

18 Note: The case definition of COVID-19 in humans caused by SARS-CoV-2 infection should be aligned with the latest updated case definition as issued by WHO.

Pillar 3 Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures	
Indicator: Proportion of countries testing for COVID 19 and timely reporting through established sentinel or non-sentinel ILI, SARI, ARI surveillance systems such as GISRS or other WHO platforms	
Rationale for use	This indicator aims to monitor progress against the IHR (2005) Emergency Committee's temporary recommendation issued by the WHO Director-General for State Parties to "continue timely and consistent reporting to WHO, including through platforms such as GISRS…to enhance global understanding of the pandemic's evolution" by looking at consistent reporting through GISRS and established WHO platforms. Routine surveillance systems are key to monitoring trends in transmission. 125 countries participate in routine respiratory disease surveillance through the Global Influenza Surveillance and Response System (GISRS). Many of these systems are now being adapted to monitor for COVID-19. Countries with limited resources for identifying and reporting on COVID-19 cases may prioritize monitoring trends through routine sentinel or non-sentinel surveillance systems.
Definition of key terms[17]	**A surveillance system** aims to monitor trends of cases, rapidly detect new cases in countries with sporadic transmissions. WHO recommends that countries consider using existing surveillance systems to report COVID 19 cases. These systems can include: hospital-based SARIs, primary care ILIs, GISRS, or other syndromic respiratory disease systems.
Measurement	
Numerator	Number of countries testing for COVID 19 and reporting routinely through established sentinel or non-sentinel ILI, SARI, ARI surveillance systems such as GISRS or another WHO platform
Denominator	Countries participating to GISRS and expected to conduct ILI, SARI, ARI surveillance during the specific time of the year: • Week 1 to 17: 116 countries; • Week 18 to 20: 126 countries; • Week 21 to 39: 69 countries; • Week 40: 126 countries; • Week 41 to 52: 116 countries.
Disaggregation	N/A
Scope	All countries
Target	50%
Data collection and reporting	
Data source	WHO HQ Global Influenza Programme will be responsible for the data collection of this indicator and will share data with the HQ SPRP M&E Team for indicator reporting.
Reporting start date	January 2021
Reporting frequency	Weekly

Pillar 3 Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures	
Indicator: Proportion of countries implementing sero-epidemiological investigations or studies	
Rationale for use	The emergence of a new virus means that understanding transmission patterns, severity, clinical features and risk factors for infection will be limited at the start of the epidemic. To address these unknowns, WHO has provided Early Investigation Master Protocols (branded the WHO Unity Studies) to countries. This indicator aims to support the IHR Emergency Committee's temporary recommendation issued by the WHO Director-General for States Parties on research and development to "support and conduct COVID-19 research, in line with the WHO Research and Development Blueprint." These protocols are designed to rapidly and systematically collect and share data in a format that facilitates aggregation, tabulation and analysis across different settings globally. Data collected using these investigation protocols will be critical to refine recommendations for case definitions and surveillance, characterize key epidemiological features of COVID-19, help understand spread, severity, spectrum of disease, and impact on the community and to inform guidance for application of public health and social countermeasures.
Definition of key terms	**Sero-epidemiological:** epidemiological investigations involving the identification of antibodies to specific antigens in populations of individuals.
Measurement	
Numerator	Number of countries which have implemented at least one sero-epidemiological investigation using WHO Unity Studies master protocols
Denominator	All countries
Disaggregation[19]	WHO Unity studies master protocols will be disaggregated by individual protocols: • Population-based age-stratified sero-epidemiological investigation protocol for COVID-19 infection; • Household transmission investigation protocol for COVID-19 infection AND the First Few X (FFX) cases and contact investigation protocol for COVID-19 infection; • Assessment of risk factors for COVID-19 in health workers protocols (cohort AND case control designs); • Schools and other educational institutions transmission investigation protocol for coronavirus disease 2019 (COVID-19); • A prospective cohort study investigating maternal, pregnancy and neonatal outcomes for women and neonates infected with SARS-CoV-2; • COVID-19 vaccine effectiveness protocols.
Scope	All countries
Target	40%
Data collection and reporting	
Data source	WHO HQ Health Operations/Unity Study focal point will consolidate regional Unity Study focal point reporting. The consolidated data will then be shared with HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Quarterly

19 Note: If further research protocols are added to the Unity Studies master protocol list, they will also be included in the indicator analysis.

Pillar 3 Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures	
Indicator: Number of countries that integrate COVID-19 surveillance into sentinel systems that monitor influenza	
Rationale for use	Despite its great challenges, the COVID-19 pandemic provides an opportunity for countries to strengthen core surveillance capacities and public health system resilience to respond more effectively to future threats. As noted by the IHR Emergency Committee in October 2020, existing influenza surveillance systems, coordinated through the Global Influenza Surveillance and Response System (GISRS), are in a unique position to contribute to COVID-19 surveillance. Considering the likely co-circulation of influenza, SARS-CoV-2 viruses and other respiratory viruses (ORVs), influenza sentinel surveillance systems are the global platform to efficiently monitor the potential long-term community transmission and evolution of SARS-CoV-2 viruses, and to detect and monitor the co-circulation of these viruses. Countries are encouraged and have started integrating SARS-CoV-2 surveillance into existing influenza sentinel systems complemented with outbreak/ pandemic surveillance of SARS-CoV-2 for case detection, contact tracing and containment as part of COVID-19 pandemic response. This indicator will help identify countries to be targeted for integrating SARS-CoV-2 surveillance into existing influenza sentinel systems or for establishing such systems, and for sustainable global surveillance of relative co-circulation of SARS-CoV-2 and other respiratory viruses of public health importance.
Limitations	The strengths and limitations of primary care-based (ILI/ARI) and hospital-based (SARI) sentinel surveillance systems for addressing COVID-19 objectives have been described previously.[20] Integrating SARS-CoV-2 testing into influenza surveillance systems is not intended to detect **all** COVID-19 infections or replace SARS-CoV-2 testing for contact tracing, outbreak investigation or containment response. Therefore, the priority of such integration varies as the pandemic evolves and depends on national and global response/control strategies.
Measurement	
Numerator	Number of countries (Member States) using sentinel surveillance systems to monitor influenza and SARS-CoV-2 at the same time
Denominator	There is no denominator specified for this indicator
Disaggregation	Countries will have met this indicator if: • They integrated SARS-CoV-2 surveillance into existing influenza sentinel surveillance systems; or • They established a sentinel surveillance system for the joint monitoring of SARS-CoV-2 and influenza.
Scope	135 Member States (to exclude the 59 Member States that have already met this indicator in 2020)
Target	No target has been established, and progress will be reviewed within the 3-month SPRP M&E Framework review period
Data collection and reporting	
Data source	WHO FluNet/FluMart or regional reporting platforms complemented with data from regional office influenza/PIP focal points; WHO HQ Global Influenza Programme for collation and submission to HQ SPRP M&E team
Reporting start date	January 2021
Reporting frequency	Quarterly (report updates/changes as of 1 January 2021)

20 To access Maintaining surveillance of influenza and monitoring SARS-CoV-2: adapting Global Influenza Surveillance and Response System (GISRS) and sentinel systems during the COVID-19 pandemic: interim guidance (8 November 2020) see here: https://apps.who.int/iris/handle/10665/336689?locale-attribute=de&

Pillar 3 Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures	
Indicator: Proportion of Member States reporting COVID-19 health worker infections to WHO	
Rationale for use	On 29 October 2020, the IHR (2005) Emergency Committee advised WHO to "encourage and support countries to understand and report on their epidemiological situation and relevant indicators" as well as provide support to strengthen countries' robust public health surveillance. The WHO Public health surveillance for COVID-19 interim guidance (16 December 2020) asks for national authorities to include "COVID-19 as a mandatory notifiable disease with requirements for immediate reporting." This indicator aims to provide an overview on health worker infections reporting completeness of Member State reporting to WHO. A more detailed analysis of health worker infections is expected as part of the epidemiological intelligence provided by WHO through periodic reports and the COVID-19 detailed surveillance data dashboard.[21]
Definition of key terms	A Member State is considered to have reported COVID-19 health worker infections[22] to WHO in the past month if it has provided either: • at least one weekly aggregate surveillance reporting submission providing cases or deaths of health worker cases; or • for countries maintaining case-based surveillance, has provided Case Reporting Forms (CRFs) for at least 50% of incident cases reported in first week of past month, providing health worker status for the recorded cases.
Measurement	
Numerator	Number of Member States reporting COVID-19 health worker infections
Denominator	All Member States
Disaggregation	COVID-19 health worker death reporting may be shown as a disaggregation to provide more detailed analysis of available data reporting
Scope	All Member States
Target	100%
Data collection and reporting	
Data source	WHO HQ Surveillance Pillar will consolidate the data reporting from Member States and share main findings with the HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Monthly

21 To access the detailed surveillance data dashboard see her: https://app.powerbi.com/view?r=eyJrIjoiYWRiZWVkNWUtNmM0Ni00MDAwLTljYWMtN2EwNTM3YjQzYmRmIiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9

22 Note: The case definition of COVID-19 in humans caused by SARS-CoV-2 infection should be aligned with the latest updated case definition as issued by WHO.

Pillar 4 Points of entry, international travel and transport, and mass gatherings	
Indicator: Proportion of States Parties which made timely up-to-date information about their international travel-related measures available to WHO	
Rationale for use	As per article 43 of the International Health Regulations (2005), State Parties implementing additional health measures referred to in paragraph 1 of this Article which significantly interfere (i.e. the refusal of entry or departure of international travelers or their delay within 48 hours) with international traffic shall within 48 hours provide to WHO the public health rationale and relevant scientific information for it. These additional health measures shall be reviewed within three months. To assist countries in implementing a risk-based approach to international travel-related measures, WHO published in December 2020 an interim guidance document on this subject (which is subject to further updates in 2021).[23] This indicator aims to assess the extent to which States Parties conduct risk assessments to inform their decision-making processes on the implementation of international travel-related measures to mitigate the risk of importation and/or onwards transmission, and exportation of SARS-CoV-2 virus. This is in line with the IHR's Emergency Committee's temporary recommendation issued by the WHO Director-General for States Parties (15 April 2021) to "implement coordinated, time-limited, risk-based, and evidence-based approaches for health measures in relation to international traffic in line with WHO guidance and IHR provisions. If States Parties implement quarantine measures for international travellers on arrival at their destination, these measures should be based on risk assessments and consider local circumstances."
Definition of key terms	Relevant definitions are provided in Part I of the IHR (2005). In addition, further details on the risk-based approach to international travel are available in WHO's technical interim guidance "Considerations for implementing a risk-based approach to international travel in the context of COVID-19."[24] WHO's current position with regards to the use of COVID-19 vaccination in the context of international travel is available in the interim position paper "Considerations regarding proof of COVID-19 vaccination for international travelers."[25] **Government website** is an official website of a country's ministry (e.g. Ministry of Health Ministry of Foreign Affairs), Prime Minister Office, or Office of the President that would communicate travel measures in-country
Measurement	
Numerator	Number of States Parties which have shared information on their travel-related measures with WHO as per the criteria stated in the indicator
Denominator	196 States Parties to IHR (2005)
Disaggregation	The IHR Secretariat based within WHO Headquarters and Regional Offices will track the availability of travel measures to WHO, disaggregated by: • Yes, State Party communicated travel measures officially either via IHR Focal Point at the regional or HQ level, including a public health rationale; • Yes, State Party communicated travel measures via government website (and not via official channels) either with or without a public health rationale; • No, travel measures have not been communicated either via official channels or government website; • Do not know/No information is available.
Scope	Global
Target	100%

23 To access the Considerations for implementing a risk-based approach to international travel in the context of COVID-19 (16 December 2020) see here: https://www.who.int/publications/i/item/WHO-2019-nCoV-Risk-based-international-travel-2020.1

24 Ibid.

25 To access the Interim position paper: considerations regarding proof of COVID-19 vaccination for international travelers (5 February 2021) see here: https://www.who.int/news-room/articles-detail/interim-position-paper-considerations-regarding-proof-of-COVID-19-vaccination-for-international-travellers

Data collection and reporting	
Data source	The IHR Secretariat will consolidate available information (official State Parties' notifications and official government website reporting) with Regional Office IHR focal points. The IHR Secretariat will then share the indicator reporting with HQ SPRP M&E team for reporting on this indicator.
Reporting start date	January 2021
Reporting frequency	Quarterly

Pillar 4 Points of entry, international travel and transport, and mass gatherings	
Indicator: Proportion of planned mass gathering events that underwent a risk assessment exercise/risk-based approach in the context of COVID-19	
Rationale for use	In the context of the COVID-19 pandemic, WHO recommends that any decision related to holding a mass gathering should be based on a rigorous appraisal of the associated risks, and of the organizers' capacity to mitigate them through the implementation of a defined set of precautionary measures and communicate any relevant information to the prospective participants. For the purpose of SPRP 2021 monitoring, WHO HQ and Regional Offices will identify a list of planned mass gathering events that are potentially high risk as the scope for this indicator. High risk refers to events which are highly visible or during which transmission of SARS-CoV-2 is likely to occur due to size (large events), duration (multi-day events), location (indoors) or other criteria that are relevant for the country context (such as significant cultural, social or political events with high country reputational risk). Where feasible, WHO will validate the list of events identified with Member States. Both single and multi-country events will be considered for inclusion in the list, with the aim to strengthen the application and monitoring of the risk assessment exercise/risk-based approach at international, national and sub-national level, and to bring the attention of relevant authorities and mass gathering event organizers to the importance of this process. The list of events will be reviewed on a quarterly basis and updated as required. The application of the risk assessment exercise/risk-based approach for these listed mass gathering events will be tracked over time and reported cumulatively on a quarterly basis.
Definition of key terms	A COVID-19 risk assessment exercise/risk-based approach relies: (1) on the use of one of the tools developed by WHO for this purpose or of any of their derivative adaptations, or (2) on the adoption of any risk-based approach to support the decision-making process related to the organization of a mass gathering in the context of COVID-19. The process should be based on the three steps of risk evaluation, risk mitigation and risk communication, and should be jointly undertaken by relevant health authorities and event organizers.
Measurement	
Numerator	Number of planned mass gathering events from the pre-identified list that underwent a risk assessment exercise/risk-based approach.
Denominator	Number of pre-identified mass gathering events
Disaggregation	N/A
Scope	**Geographic:** all countries, territories and areas **Temporal:** the numerator and denominator reported each quarter will reflect the number of events planned for that quarter plus previous quarters (i.e. cumulative). The basis for the calculation will be the scheduled date of the event.
Target	50% of all events in the list
Data collection and reporting	
Data source	WHO HQ Mass Gathering Team and regional office Mass Gathering Focal Points will develop the mass gathering event list at the beginning of the monitoring period, as relevant to regional contexts. This list will include information provided by event organizers to WHO/HQ Mass Gathering team. This pre-identified list will serve as the basis for all monitoring activities associated with mass gatherings and the usage of a risk assessment/risk-based approach under the SPRP 2021 M&E Framework. This list will be updated on a quarterly basis by the Mass Gathering focal points at the HQ and Regional levels. The list of events will be managed by the WHO Collaborating Centre for Global Health Security, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA in collaboration with WHO/HQ Mass Gathering team. Information on the application of risk assessment/risk-based approaches for each event in the list will be based on inputs from WHO RO Mass Gathering focal points. WHO HQ Mass Gathering team will provide data for the indicator each quarter to the WHO HQ SPRP M&E Team.
Reporting start date	31 January 2021
Reporting frequency	Quarterly

Pillar 5 Laboratories and diagnostics	
Indicator: Proportion of countries that publicly share SARS-CoV-2 genetic sequence data	
Rationale for use	This indicator aims to support the International Health Regulations (IHR, 2005) Emergency Committee's temporary recommendation issued by the WHO Director-General for States Parties (14 January 2021) to "increase molecular testing and genetic sequencing and share sequences and meta-data with WHO and through publicly accessible databases to enhance global understanding of the virus evolution and inform response efforts" and to "utilize the WHO SARS-CoV-2 global laboratory network, leverage GISRS and other laboratory networks for timely reporting and sharing of samples; support other State Parties, where needed, in timely sequencing of SARS-CoV-2 virus specimens." Genetic sequence data are important to track the ongoing outbreak and monitor the evolution of the virus, in order to detect SARS-CoV-2 variants and understand implications for public health and social measures, diagnostics, therapeutics and vaccines. By monitoring the proportion of countries that publicly share SARS-CoV-2 genetic sequence data, transparency and capacity to generate sequence data can be investigated. There are publicly accessible databases that promote the rapid sharing of SARS-CoV-2 sequences to help researchers understand how viruses evolve and spread during the pandemic. Uploading sequence data to one of these databases indicates transparency and willingness to share data. In addition, it can show which countries have in country capacity for sequencing or are able to refer samples internationally.
Definition of key terms	**"Share"** means that country has uploaded SARS-CoV-2 sequences to a publicly accessible database. **"Genetic sequence data"** is the genetic composition of SARS-CoV-2 and its variants that has been determined by sequencing. It includes both whole genomes and partial sequences.
Measurement	
Numerator	Number of countries sharing virus sequence data on a publicly accessible database each month
Denominator	All countries
Disaggregation	N/A
Scope	All countries
Target	75%
Data collection and reporting	
Data source	WHO HQ Laboratory Pillar will consolidate data reporting for this indicator, including using publicly accessible sequence databases and share results with the WHO HQ SPRP M&E Team
Reporting start date	January 2021
Reporting frequency	Monthly

Pillar 5 Laboratories and diagnostics	
Indicator: Proportion of countries participating in WHO External Quality Assessment Program 2021	
Rationale for use	External Quality Assessments (EQAs) are used to monitor the quality of laboratory testing. WHO used existing capacity in the Global influenza laboratory network and established a new SARS-CoV-2 molecular EQA scheme in 2020 to assess and promote global testing capacity for SARS-CoV-2. All laboratories testing for SARS-CoV-2 are encouraged to enrol in a national or international recognized EQA scheme where available to assess testing quality.
Definition of key terms[17]	**EQAP** stands for External Quality Assessment Project (EQAP). Laboratories performing molecular testing for SARS-CoV-2 are participating in the EQA scheme to monitor quality.
Measurement	
Numerator	Number of countries that participate in the WHO EQAP 2021.
Denominator	All countries with PCR capacity for SARS-CoV-2 detection
Disaggregation	This indicator will be disaggregated to report: • countries participating in WHO EQA national programme; • countries participating in the subnational laboratory EQA programme.
Scope	All national laboratories conducting SARS-CoV-2 molecular testing
Target	National: 100% Subnational: 50%
Data collection and reporting	
Data source	**National:** HQ Global Influenza Programme will collect this data and report it to the WHO HQ SPRP M&E Team for national-level information. **Subnational:** For sub-national laboratory participation in EQAP, the HQ Laboratory Pillar team will consolidate available information from the Regional Laboratory Focal Points and share with the HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Annually

Pillar 5 Laboratories and diagnostics	
Indicator: Proportion of countries with 100% performance across laboratories participating in a SARS-CoV-2 EQA scheme	
Rationale for use	All laboratories testing for SARS-CoV-2 are encouraged to enrol in a national or international recognized External Quality Assessment (EQA) scheme where available, particularly those at the national level, to assess testing quality. The score given to laboratories is based on the proportion of samples correctly identified (i.e. number of samples correctly identified over the total number of samples). It is important to monitor the quality of testing of all laboratories reporting testing results for SARS-CoV-2 To focus on subnational laboratory performance, WHO has rolled out a subnational EQA scheme to support Member States. In total, 101 countries are participating in this EQA scheme in 2021
Definition of key terms	**EQA** stands for External Quality Assessment. Laboratories performing molecular testing for SARS-CoV-2 are participating in EQAs to assess and monitor testing quality.
Measurement	
Numerator	**National:** Number of countries scoring 100% on the WHO EQA Project 2021 (average across all National laboratories used in case more than one National laboratory in the country participating) **Subnational:** Number of countries participating in the subnational EQA scheme scoring the maximum possible score
Denominator	**National:** All countries participating in the WHO EQAP (SARS-CoV-2) 2021 **Subnational:** All countries participating in the WHO subnational EQA scheme for SARS-CoV-2 in the country (N=101 countries)
Disaggregation	This indicator will be disaggregated to report: • national laboratory EQA reporting; and • subnational laboratory EQA reporting.
Scope	**National:** All countries **Subnational:** 101 countries have participated in the subnational laboratory EQA scheme
Target	**National:** 95% **Subnational:** 75%
Data collection and reporting	
Data source	For national-level information and laboratory performance reporting in the WHO EQAP 2021, HQ Global Influenza Programme, in collaboration with Regional Offices, will collect this data and report it to the WHO HQ SPRP M&E Team. For sub-national laboratory performance reporting in EQAP, the HQ Laboratory Pillar team will consolidate available information from the Regional Laboratory Focal Points and share with the HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Annually

Pillar 6 Infection prevention and control, and protection of the health workforce	
Indicator: Proportion of countries with a national infection, prevention and control (IPC) programme	
Rationale for use	Threats posed by epidemics, pandemics and antimicrobial resistance (AMR) have become increasingly evident as ongoing universal challenges and they are now recognized as a top priority for action on the global health agenda. Effective IPC is the cornerstone of such action. The International Health Regulations (IHR) position effective IPC as a key strategy for dealing with public health threats of international concern.[26]
Definition of key terms	A national IPC programme is defined at a minimum as having:[27] • a dedicated Ministry of Health budget for implementing IPC strategies and plans; and • one full-time focal point trained in IPC.
Measurement	
Numerator	Number of countries that report a national IPC programme
Denominator	All countries with a WHO country office
Disaggregation	N/A
Scope	All countries
Target	All countries with WHO country offices
Data collection and reporting	
Data source	The data will be based on reporting from the regional IPC focal points. Regional IPC focal points will collate data from country office focal points or through country use of the national IPCAT2 tool that is expected to be launched in mid-2021. WHO HQ Pillar 6 M&E Focal Point will consolidate data as received from WHO regional IPC focal points to share with the WHO HQ SPRP M&E Team.
Reporting start date	April 2021
Reporting frequency	Every 6 months

26 To access Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level (November 2016) see here: https://www.who.int/gpsc/ipc-components-guidelines/en/

27 To access Minimum requirements for IPC programmes, Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level (2019) see here: https://www.who.int/infection-prevention/publications/min-req-IPC-manual/en/
To access Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level (November 2016) see here: https://www.who.int/gpsc/ipc-components-guidelines/en/

Pillar 6 Infection prevention and control, and protection of the health workforce	
Indicator: Number of users who completed OpenWHO IPC modules	
Rationale for use	One global investment in expanding IPC capacity has been IPC training through the OpenWHO platform. As of 22 March, there are 13 IPC-related courses of which 3 are COVID-19 specific (IPC general course, Protective equipment and Long-term care) and 10 that are part of the IPC series. More are expected to be added over time, while others will be updated based on need. OpenWHO has served a critical role during the COVID-19 emergency to expand the reach of training and knowledge transfer, especially in light of travel measures restricting the movement of experts and the need for materials to be available in multiple languages. This indicator will monitor the uptake and use of IPC related OpenWHO courses, while recognizing the limitations of mass training platforms for knowledge transfer or practice change.
Definition of key terms	**OpenWHO** is WHO's interactive, web-based, knowledge-transfer platform offering online courses to improve the response to health emergencies. OpenWHO enables the Organization and its key partners to transfer life-saving knowledge to large numbers of frontline responders.
Measurement	
Numerator	Number of users who completed IPC related OpenWHO modules and filled the self-reporting demographic information survey
Denominator	Not applicable
Disaggregation	The indicator will be disaggregated by: • users for each course (including any additional courses added during the SPRP 2021 timeframe); • by country (geographic); • by language; • by participant category (self-reported, e.g. student, Ministry of Health, health worker, etc.).
Scope	All countries
Target	Not applicable
Data collection and reporting	
Data source	The WHO HQ SPRP M&E Team will link with the OpenWHO HQ Team to consolidate available user analytics for reporting of this indicator.
Reporting start date	January 2021
Reporting frequency	Monthly

Pillar 6 Infection prevention and control, and protection of the health workforce	
Indicator: Proportion of countries supported by COVID-19 SPRP 2021 investments for Infection Prevention and Control (IPC)	
Rationale for use	This indicator will support the programmatic objectives by monitoring WHO's country-level financial and technical support investments for IPC capacity building during the COVID-19 emergency response. It provides the opportunity for more dynamic real-time assessment of inputs available for implementation, and it can trigger strategic and operational decisions at the global level and with partners on further needs to achieve programmatic goals.
Measurement	
Numerator	Number of WHO country offices with COVID-19 Pillar 6 IPC financing (award budget)
Denominator	All countries with a WHO country office
Disaggregation[19]	N/A
Scope	All countries with WHO country offices
Target	60% (based on the 2020 baseline that 50% of WCOs had Pillar 6 financing)
Data collection and reporting	
Data source	The WHO HQ Pillar 6 M&E Focal Point will coordinate with the WHO HQ WHE Finance and WHO HQ SPRP M&E Teams to consolidate and report this indicator.
Reporting start date	January 2021
Reporting frequency	Quarterly

Pillar 7 Case management, clinical operations and therapeutics	
Indicator: WHO dashboard updates on therapeutics/oxygen utilization amongst hospitalized patients published monthly	
Rationale for use	WHO collects detailed clinical information on patients from countries through the Clinical Platform. It is important to monitor the proportional use of therapeutics and oxygen among the patients captured in this system. Despite biases in reporting, the data can shed light on clinical management practices, the need for optimizing country and health provider protocols and support in addressing bottlenecks. While the platform will host available clinical data on hospitalized patients, there are acknowledged limitations to the Clinical Platform dashboard and analysis is dependent on Member States sharing case eporting forms with WHO.
Definition of key terms	**Clinical Platform:**[28] The platform is a secure, limited-access, password-protected platform hosted on OpenClinica. WHO will use the anonymized COVID-19 data solely for the permitted purpose(s) for which it is provided to WHO, and will protect the confidentiality and security of the Anonymized Data, in each case, in accordance with the Terms of Use[29] applicable to the Global COVID-19 Clinical Data Platform.
Measurement	
Numerator	Dashboard updates published monthly
Denominator	N/A
Disaggregation	N/A
Scope	The number of countries participating each month (share data) will be reported within the dashboard. **Global Clinical Data Platform: clinical characteristics** • % of hospitalized patients with severe/critical oxygen (stratified by severity); • % of patients on severe/critical disease on corticosteroids (stratified by severity); • % of patients treated with unproven therapies (all severities); • The scope of the dashboard and the key areas for analysis will be updated periodically to align with clinical guidelines.
Target	One clinical dashboard update per month
Data collection and reporting	
Data source	The WHO HQ SPRP M&E Team will check the online dashboard for frequency of updates and scope of information available.
Reporting start date	After dashboard launch expected in May 2021
Reporting frequency	Monthly

28 To access the Global COVID-19 Clinical Data Platform for clinical characterization and management of patients with suspected or confirmed COVID-19 see here: https://www.who.int/teams/health-care-readiness-clinical-unit/COVID-19/data-platform

29 To access the Terms of Use for Global COVID-19 Clinical Data Platform for Clinical Characterization and Management if Hospitalized Patients see here: https://cdn.who.int/media/docs/default-source/documents/emergencies/terms-of-use-global-covid19-data-platform.pdf?sfvrsn=d0a440c1_2

Pillar 7 Case management, clinical operations and therapeutics	
Indicator: Proportion of supplies requested (biomedical equipment) through WHO supply mechanisms that are delivered within 10 weeks of request validation[30]	
Rationale for use	In order to ensure timeliness of WHO supply mechanisms, WHO will measure key products and track the end-to-end lead time, beginning from the request validation by the country supply coordinator to the delivery of the supplies requested (biomedical equipment) in-country. Further detailed analysis of the entire end to end lead time from order validation to supply delivery (biomedical equipment) processes will be analyzed by the WHO-OSL Headquarters team to identify and address bottlenecks as well as improve performance of the Supply Portal.
Definition of key terms	**Request validation:** Approval of the country supply coordinator and endorsed by WHO-HQ/OSL. **End-to-end lead time:** Refers to the time period from order validation to country delivery. **Country delivery:** The delivery of the request to the consignee in-country. **WHO supply mechanism:** This refers to either the WHO Supply Portal managed by WHO/HQ or a regional supply procurement mechanism such as in the Regional of the Americas.
Measurement	
Numerator	Number of supplies requested (biomedical equipment) delivered within 10 weeks of request validation
Denominator	Number of supplies requested (biomedical equipment) total that were delivered
Disaggregation	N/A
Scope	This indicator focuses on orders placed through WHO Supply Portal or regional procurement mechanism
Target	85%
Data collection and reporting	
Data source	WHO HQ OSL will source from existing databases managing the request status indication and share with WHO HQ SPRP M&E Team. WHO Regional M&E Focal Points will consolidate any additional inputs from regional procurement mechanisms and share with WHO HQ SPRP M&E Team.
Reporting start date	2021
Reporting frequency	Fortnightly

30 This indicator is a shared indicator under both Pillar 7 (Case Management, clinical operations and therapeutics) and Pillar 8 (Operational support and logistics and supply chain).

Pillar 8 Operational support and logistics and supply chain	
Indicator: Proportion of supplies requested (PPE) through WHO supply mechanisms that are delivered within 6–8 weeks of request validation	
Rationale for use	In order to ensure timeliness of the WHO Supply Portal, WHO-HQ will measure key products and track the end-to-end lead time, beginning from the request validation by the country supply coordinator to the delivery of the supplies requested (PPE) in-country. Further detailed analysis of the entire end to end lead time from request validation to supply delivery (PPE) processes will be analyzed by the WHO OSL Headquarters team to identify and address bottlenecks as well as improve performance of the Supply Portal.
Definition of key terms	**Request validation:** Approval of the country supply coordinator and endorsed by WHO-HQ/OSL. **End-to-end lead time:** refers to the time period from order validation to country delivery. **Country delivery:** The delivery of the request to the consignee in-country. **WHO supply mechanism:** This refers to the WHO Supply Portal managed by WHO/HQ or a regional supply procurement mechanism such as in the Regional of the Americas.
Measurement	
Numerator	Number of supplies requested (PPE) delivered within 6–8 weeks of request validation
Denominator	Number of supplies requested (PPE) total that were delivered
Disaggregation	N/A
Scope	This indicator focuses on orders placed through the WHO Supply Portal or a regional procurement mechanism
Target	85%
Data collection and reporting	
Data source	WHO HQ OSL will source from existing databases managing the request status indication and share with WHO HQ SPRP M&E Team. WHO Regional M&E Focal Points will consolidate any additional inputs and relevant data from regional procurement mechanisms and share with WHO HQ SPRP M&E Team.
Reporting start date	2021
Reporting frequency	Fortnightly

Pillar 8 Operational support and logistics and supply chain	
Indicator: Proportion of supplies requested (diagnostics) through WHO supply mechanisms that are delivered within 6 weeks of request validation	
Rationale for use	In order to ensure timeliness of the WHO Supply Portal, WHO-HQ will measure key products and track the end-to-end lead time, beginning from the supply order validation by the country supply coordinator to the delivery of the supply orders (diagnostics) in-country. Further detailed analysis of the entire end to end lead time from order validation to supply delivery (diagnostics) processes will be analyzed by the WHO-OSL Headquarters team to identify and address bottlenecks as well as improve performance of the Supply Portal.
Definition of key terms	**Request validation:** Approval of the country supply coordinator and endorsed by WHO-HQ/Operations Supply and Logistics. **End-to-end lead time:** refers to the time period from order validation to country delivery. **Country delivery:** The delivery of the request to the consignee in-country. **WHO supply mechanism:** This refers to the WHO Supply Portal managed by WHO/HQ or a regional supply procurement mechanism such as in the Regional of the Americas.
Measurement	
Numerator	Number of supplies requested (diagnostics) delivered within 6 weeks of order validation
Denominator	Number of supplies requested (diagnostics) total that were delivered
Disaggregation	N/A
Scope	This indicator focuses on orders placed through WHO Supply Portal or the PAHO PMIS System (ERP)
Target	85%
Data collection and reporting	
Data source	WHO HQ OSL will source from existing databases managing the request status indication and share with WHO HQ SPRP M&E Team. WHO Regional M&E Focal Points will consolidate any additional inputs and relevant data from regional procurement mechanisms and share with WHO HQ SPRP M&E Team.
Reporting start date	2021
Reporting frequency	Fortnightly

Pillar 8 Operational support and logistics and supply chain	
Indicator: Proportion of requested COVID-19 supply volume that has been shipped to countries through WHO supply mechanisms	
Rationale for use	This indicator aims to provide a global overview of the supply volume disaggregated by type and will serve as a monitoring of supply services within the WHO Supply Portal or a regional procurement mechanism
Definition of key terms	**Shipped:** Supply within the transport process. **Supply volume:** refers to the quantity of items (by type of disaggregation) requested that have been shipped.
Measurement	
Numerator	Units shipped/value shipped
Denominator	Units requested/value requested
Disaggregation	This indicator will be disaggregated by type of supply volume: • PPE • biomedical equipment • diagnostics.
Scope	Global volume
Target	85%
Data collection and reporting	
Data source	WHO HQ OSL will review the shipment status updates and shipment dates and share available information analysis with the WHO HQ SPRP M&E Team on a monthly basis. WHO Regional M&E Focal Points will consolidate any additional inputs and relevant data from regional procurement mechanisms and share with WHO HQ SPRP M&E Team.
Reporting start date	To date since January 2021
Reporting frequency	Monthly

Pillar 8 Operational support and logistics and supply chain	
Indicator: Completion of monthly evolution monitoring of global demand trends through WHO supply mechanisms	
Rationale for use	This indicator aims to support WHO-OSL based in Headquarters to monitor the evolution of the demand trends for PPE, diagnostics and biomedical equipment over time. By monitoring the adjustment of country demands over time, WHO can then adjust planning to anticipate an uptick or downward trend of demand and make strategic decisions on workforce and procurement with an evidence-base.
Measurement	
Numerator	Units requested, current month [Value requested – current month]
Denominator	Average of units requested (6 months) [Average value requested (6 months)]
Disaggregation	This indicator will be disaggregated by: • PPE • biomedical equipment • diagnostics.
Scope	The measurements will look at 6-months recall of data as well as the current month.
Target	No target has been set
Data collection and reporting	
Data source	WHO HQ OSL will review their Demand Tracker and provide updates to the WHO HQ SPRP M&E team on a monthly basis. WHO Regional M&E Focal Points will consolidate any additional inputs and relevant data from regional procurement mechanisms and share with WHO HQ SPRP M&E Team.
Reporting start date	The first reporting month of January 2021 will then include averages inclusive of July 2020 onward. This will be adjusted over time.
Reporting frequency	Monthly

Pillar 9 Maintaining essential health services and systems	
Indicator: Proportion of countries reporting disruption to essential health services during COVID-19 pandemic	
Rationale for use	This indicator aims to monitor progress against the IHR (2005) Emergency Committee's advice to WHO to "support countries to monitor their ability to provide and strengthen essential health services throughout a likely extended COVID-19 response…including but not limited to, essential prevention for communicable diseases, particularly vaccination, services related to reproductive health, care of vulnerable populations, such as young infants and older adults, provision of medications and supplies…, etc." The tracking of essential health services during the pandemic is critical in order to achieve the optimal balance between fighting the COVID-19 pandemic and maintaining other essential services to prevent excess morbidity and mortality of all-causes. In order to rapidly understand the extent of service disruptions across the health system, the Pulse Survey seeks to assess how services are being affected by the COVID-19 pandemic and to track any changes that may be occurring as the outbreak progresses along its various stages. The Pulse Survey consists of questions related to current national policies, plans and structures, disruptions to health services, reasons for disruptions, mitigation approaches, information tracking, and priority needs. It includes sections that target different key informants in the country, including a section on cross-cutting health system functions and services, and focused sections on disruptions to service-specific areas. Based on the Pulse Survey results and in triangulation with other key data sources, the Ministry of Health and WHO can organize policy dialogues with key stakeholders to jointly review results, discuss implications in programmes, flag critical challenges and bottlenecks and identify mitigation strategies for maintaining essential health services.
Definition of key terms	For the definition of essential health services, access guidance on COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak.[31]
Measurement	
Numerator	Number of Member States reporting disruption of core essential health services during the COVID-19 pandemic
Denominator	All Member States that responded to WHO Pulse Survey
Disaggregation	This will be disaggregated by type of essential health service: • primary care services • emergency care services • additional services • auxiliary services.
Scope	All Member States
Target	The target will be set during the first quarter of M&E Framework based on the initial 2021 Pulse Survey results.
Data collection and reporting	
Data source	WHO HQ Pillar 10 team will compile all results from the administered WHO national Pulse Survey on continuity of essential health services during the COVID-19 pandemic. The HQ Pillar 10 team will then share results with the HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	This indicator is aimed for reporting on a quarterly basis and will be adjusted based on the number of times the Pulse Survey is administered during 2021.

31 To access COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak (1 June 2020) see here: https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1

Pillar 9 Maintaining essential health services and systems	
Indicator: Proportion of countries where at least one vaccine preventable disease (VPD)-immunization campaign was affected by COVID 19 that has since been reinstated using risk mitigation strategies	
Rationale for use	This indicator aims to monitor progress against the IHR (2005) Emergency Committee's advice to WHO to support countries to support countries to monitor their ability to provide and strengthen essential health services (including [non-COVID-19] vaccination) and assess and manage the unintended consequences of public health measures. Mass immunization campaigns complement routine immunization services and contribute to increased coverage of the most common childhood vaccinations. To reduce the risk of further spreading COVID-19, mass gatherings have been suspended in several countries, compromising the national capacity to protect children from vaccine preventable diseases (VPDs).
Measurement	
Numerator	Number of countries where at least one planned VPD campaign that was previously postponed or suspended, either fully or partially, due to COVID-19 has been reinstated
Denominator	Number of countries where at least one planned VPD vaccination campaign was postponed or suspended, either fully or partially, because of COVID 19
Disaggregation	N/A
Scope	Member States, inclusive of sub-analysis of strategies used to reduce risk associated with VPD campaigns. VPD mass campaigns include the following: measles and rubella, Tetanus-Diphtheria, bivalent oral polio vaccine (bOPV), monovalent oral polio vaccine 2 (mOPV2), Yellow Fever, Typhoid vaccine, oral cholera vaccine (OCV), and Meningitis A.
Target	N/A
Data collection and reporting	
Data source	WHO/IVB HQ team maintain the Immunization Repository, which includes inputs from partners. This database will be shared every month with the HQ SPRP M&E Team. The Immunization Repository is updated regularly by WHO, UNICEF and other key immunization partners as information becomes available. In addition to rolling updates by stakeholders, WHO at all-levels review and update the repository on a quarterly basis.
Reporting start date	January 2021
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Pillar 10 Vaccination	
Indicator: Proportion of AMC participating economies with timely regulatory approval OR import-only authorization for COVID-19 vaccines that have been granted WHO Emergency Use Listing (EUL)	
Rationale for use	The EUL is used during public health emergencies. When products are not licensed yet (still in development), WHO will assess the quality, safety and efficacy (or performance) data generated during development and conduct a risk-benefit assessment to decide if they can be used outside clinical trials.[32] Emergency regulatory procedures for a COVID-19 vaccine should ensure: an expedited assessment of available data and evidence that supports best regulatory decision-making on COVID-19 vaccine approval during the processes of registration and strain changes/variations and other post-approval changes. The expedited assessment could be based on reliance approaches to facilitate approval. Recognition and/or reliance on the WHO prequalification/Emergency Use Listing (EUL) programme, the decisions of stringent regulatory authorities (SRA) or WHO-Listed Authority (WLA), are regulatory options available for NRAs. In addition, resources, i.e. human, financial and infrastructure, that enable emergency regulatory procedures to be developed and implemented should be made available to NRAs.[33] To facilitate timely and quality use of vaccines during an emergency, countries need to rapidly review products for regulatory authorization. During emergencies, countries are encouraged to review and authorize/ approve or issue an import permit for vaccines within 15 days. Reporting from this indicator will be used to support defining challenges and potential bottlenecks to scaling up COVID-19 vaccine roll-out in AMC economies over time. In addition, this indicator will inform retrospective analysis for future investment, corrective actions and policy decisions.
Limitations	As part of this indicator, there should be certain limitations that should be acknowledged as related to interpretation. They include the following limitations: • Select AMC participating economies have not accepted certain vaccines under the COVAX Facility; • some countries took decisions to authorize a COVID-19 vaccine(s) in advance of WHO-EUL listing with direct liaison with the vaccine manufacturer(s).
Definition of key terms	**WHO Emergency Use Listing (EUL)** is a procedure for assessing unlicensed vaccines, therapeutics and in vitro diagnostics during public health emergencies with the ultimate goal of expediting the availability of these products to people who need them. **Timely regulatory approval** of COVID-19 vaccine granted WHO EUL is defined as less than or equal to 15 days. Import authorization is also has been considered.

32 To access Considerations for the Assessment of COVID-19 Vaccines for Listing by WHO (25 November 2020) see here: https://www.who.int/publications/m/item/considerations-for-the-assessment-of-COVID-19-vaccines-for-listing-by-who

33 To access the Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines (16 November 2020) see here: https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccine_deployment-2020.1

Measurement	
Numerator	Proportion of AMC participating economies approved vaccines for use within 15 days **including** authorization
Denominator	Total AMC participating economies

Disaggregation	Reporting will be disaggregated (per vaccine type that has been given Emergency Use Listing):
	• Approved for use within _____ days of EUL:
	  • ≤ 15 days
	  • 15 days to 1 month
	  • More than 1 month
	• Import Only
	  • ≤ 5 days
	  • 6–15 days
	  • More than 15 days
	• Ongoing process/not completed
	• Non-applicable

Scope	AMC participating economies
Target	100% of AMC participating economies approved WHO EUL COVID-19 vaccines for use within 15 days including import authorization
Data collection and reporting	
Data source	COVAX SCO Tracker; maintained by WHO, Gavi and partners
Reporting start date	Since January 2021
Reporting frequency	Monthly

Pillar 10 Vaccination	
Indicator: Proportion of Member States that have reported COVID-19 vaccine-related serious adverse event/s following immunization (AEFI) to WHO	
Rationale for use	In line with the IHR Emergency Committee's advice to WHO to increase countries' capacities for COVID-19 vaccine introduction, including "monitoring uptake and vaccine safety", this indicator seeks to characterize the current country capacities for AEFI monitoring and reporting globally as related to any administered COVID-19 vaccine. WHO is carefully monitoring the rollout of all COVID-19 vaccines and will continue to work closely with countries to manage potential risks, and to use science and data to drive response and recommendations. Based on any gaps in data reporting to the global system, WHO and partners can then take action to support Member States.
Definition of key terms	**Adverse event following immunization (AEFI):** is any untoward medical occurrence which follows immunization, and which does not necessarily have a causal relationship with the usage of the vaccine. The adverse event may be any unfavourable or unintended sign, abnormal laboratory finding, symptom or disease.[34] These are grouped in five types: • vaccine product-related reaction • vaccine quality defect-related reaction • immunization error-related reaction • immunization anxiety-related reaction • coincidental event. **Serious adverse event following immunization** is inclusive of hospitalization, disability, prolongation of hospitalization, death, congenital anomaly or any other medically significant condition. **VigiBase**[35] is the unique WHO global pharmacovigilance database, which gathers reports of suspected adverse events of medicines and vaccines, inclusive of AEFIs potentially linked to COVID-19 vaccines.
Measurement	
Numerator	Number of Member States that have reported **at least one** COVID-19 serious vaccine-related adverse event following immunization (AEFI) to the WHO-supported global system, VigiBase
Denominator	Number of total Member States that have administered at least 100 000 COVID-19 vaccines
Disaggregation	N/A
Scope	All Member States
Target	90% of Member States should have reported at least one serious AEFI case following COVID-19 vaccine
Data collection and reporting	
Data source	WHO HQ Pharmacovigilance team, sourcing from VigiBase
Reporting start date	Since January 2021
Reporting frequency	Monthly

34 To access more information on WHO Vaccine Safety Basics e-learning course on AEFIS, see here: https://www.who.int/vaccine_safety/initiative/tech_support/ebasic/en/

35 For further information on the WHO global pharmacovigilance database, see here: UMC | VigiBase (who-umc.org)

Pillar 10 Vaccination	
Indicator: Number of countries that have started administration of COVID-19 vaccination	
Rationale for use	This indicator aims to monitor progress against the IHR (2005) Emergency Committee's advice to WHO to support "equitable access" to vaccines through the ACT Accelerator and promote global solidarity and equitable vaccine access. This is in line with the International Health Regulations (IHR, 2005) Emergency Committee's (14 January 2021) advice to WHO to "promote global solidarity and equitable vaccine access by encouraging States Parties and manufacturers to donate resources and provide support to the COVAX Facility" whose aim is to guarantee fair and equitable access for every country in the world. Global equitable access to a vaccine, particularly protecting health care workers and those most-at-risk is then only way to mitigate the public health and economic impact of the pandemic. This indicator will track the start-time of all COVID-19 vaccine roll-out amongst Member States.
Definition of key terms	Where multiple vaccines are used in a country, the start date of the COVID-19 vaccine is equivalent to start date of the first vaccine introduced (non-clinical trial). Suspensions (temporary or otherwise) of vaccination rollout are not taken into consideration.
Measurement	
Numerator	Number of Member States started vaccination of COVID-19 vaccine
Denominator	Number of total Member States
Disaggregation	N/A
Scope	All Member States
Target	All Member States
Data collection and reporting	
Data source	WHO HQ SPRP M&E Team will source reporting from the WHO Coronavirus (COVID-19) Dashboard[36] in collaboration with the HQ Pillar 10 M&E focal point.
Reporting start date	As of December 2020, or start of COVID-19 vaccination
Reporting frequency	Weekly

36 To access the WHO Coronavirus (COVID-19) dashboard see here: https://covid19.who.int/

Pillar 10 Vaccination	
Indicator: Number of COVID-19 vaccine doses administered globally	
Rationale for use	This indicator aims to track and transparently report the number of COVID-19 doses worldwide. Further to this indicator, there will be further analysis of the number doses administered with support from the COVAX Facility.
Definition of key terms	**Total administered doses** are cumulative totals since the start of the vaccination, in the respective country, through the latest data update. This refers to single doses and may not equal the total number of people vaccinated, depending on the specific dose regime (individuals receive multiple doses).
Measurement	
Numerator	Number of total doses administered globally
Denominator	None
Disaggregation	This indicator will be disaggregated by: • total doses administered globally; • COVAX-supported doses administered globally.
Scope	This dose distribution will be measured globally within all countries, territories and areas.
Target	Target varies by country.
Data collection and reporting	
Data source	WHO HQ SPRP M&E Team will source reporting information through the WHO Coronavirus (COVID-19) Dashboard[37] in collaboration with the HQ Pillar 10 M&E focal point. These data are pooled from numerous sources, including direct reports from Member States, WHO review of publicly available official data, or data collated and published by third-party sites such as Our World in Data.[38] Data published by third-party sites have not been validated by WHO, and WHO cannot comment on accuracy or completeness. Differences in counts are expected compared to other sources due to different inclusion criteria and data cut-off times.
Reporting start date	Time since first dose was administered (December 2020)
Reporting frequency	Weekly

37 To access the WHO Coronavirus (COVID-19) dashboard see here: https://covid19.who.int/

38 To access Coronavirus (COVID-19) Vaccinations on Our World in Data see here: https://ourworldindata.org/covid-vaccinations

Pillar 10 Vaccination	
Indicator: Proportion of global population with at least one COVID-19 vaccine dose administered	
Rationale for use	As WHO and partners work together on the response – tracking the pandemic and roll-out of COVID-19 vaccine administration is critical. This indicator aims to monitor the global uptake of COVID-19 vaccines and vaccination coverage and monitor global equitable access to vaccines.
Definition of key terms	Global population is inclusive of all countries, territories and areas.
Measurement	
Numerator	Number of persons with at least one vaccine dose administered
Denominator	Global population
Disaggregation	N/A
Scope	This indicator will be measured globally within all countries, territories and areas.
Target	N/A
Data collection and reporting	
Data source	WHO HQ SPRP M&E Team will source reporting information through the WHO Coronavirus (COVID-19) Dashboard[39] in collaboration with the HQ Pillar 10 M&E focal point.
Reporting start date	Time since first dose was administered (December 2020)
Reporting frequency	Weekly

39 To access the WHO Coronavirus (COVID-19) dashboard see here: https://covid19.who.int/

Humanitarian and Fragile and Vulnerable Country Context Indicators[40]

Pillar 3 Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures	
Indicator: Proportion of countries with fragile, conflict-affected and vulnerable (FCV) settings reporting unusual all-cause mortality trends	
Rationale for use	In order to understand the impact of COVID-19 within communities, it is important to monitor for changing mortality trends. As a health system becomes overwhelmed, and routine and/or emergent services unrelated to COVID-19 are unavailable, or people may stop seeking care and mortality may exceed expected levels, especially in fragile and vulnerable settings. To monitor unusual all-cause mortality trends in fragile and vulnerable settings, countries may rely upon existing surveillance systems, health facility reporting (i.e. DHIS2 or existing mechanisms), or community-based monitoring systems. In addition, reporting on mortality trends may also rely upon key informant observation and/ or reporting, inclusive of community resources such as religious leaders, health worker associations, graveyard workers, and partners operating in the field. This qualitative approach can be applied in complement to existing surveillance data or in absence of reliable mortality data as appropriate to the country context. Any observed/ reported unusual all-cause mortality trends in FCV settings, especially those at higher than usual levels, will trigger an alert, which will require a follow-up assessment and action by health authorities. This indicator does not seek to quantify mortality rates necessarily but rather signal unusual trends in all-cause mortality that should trigger follow-up actions. Countries may also have varying thresholds for what is considered a usual and unusual mortality trend. Such a threshold for 'unusual' all-cause mortality trends can be ascertained through in-country agreement based on the best available information.
Definition of key terms	Unusual Trends in all-cause mortality • **Increasing all-cause mortality trend:** The trend of deaths observed is higher than 'normal' (same month in 2019 for example, if using DHIS/equivalent data, or using expert judgment and locally-defined threshold point agreement as defined above for action purposes). • **Decreasing all-cause mortality trend:** The trends of deaths observed are lower than a 'normal year' (same month in 2019 for example, if using DHIS/equivalent data, or using expert judgment and locally-defined threshold point agreement as defined above for action purposes). **Stable all-cause mortality trend:** Trends of all-cause mortality are seemingly stable/normal levels as compared to a 'normal' year/years. **Don't Know/No available information:** There is no available information (quantitative or qualitative) to monitor any unusual all-cause mortality trends.

40 These indicators focus on countries, territories and areas on the Global Humanitarian Overview and the full list can be found in Annex 5.

Measurement	
Numerator	The number of countries signaling unusual all-cause mortality trends of the humanitarian countries prioritized in the Global Humanitarian Overview (GHO) 2021
Denominator	Number of humanitarian countries prioritized in Global Humanitarian Overview 2021
Disaggregation	This indicator will be disaggregated by: • Unusual trends in all-cause mortality • Stable all-cause mortality • Don't know/No available information
Target	There is no associated target for this indicator as it is a signal for quick action and follow-up.
Data collection and reporting	
Data source	The Regional M&E focal point will consolidate this indicator reporting on a monthly basis by liaising with the WHO Country Office Incident Manager or designated focal person. The Regional M&E Focal Point will then share reporting with the HQ SPRP M&E Team. Indicator reporting on all-cause mortality trends may rely upon (but is not limited to) the following data sources: country surveillance data (i.e. DHIS2 or equivalent), health facility reporting, official data registries, community monitoring systems, or observations from key informants and stakeholders.
Reporting start date	Since April 2021
Reporting frequency	Monthly

Pillar 7 Case management, clinical operations and therapeutics	
Indicator: Proportion of countries within fragile, conflict-affected and vulnerable settings reporting unusual pressure on hospital services	
Rationale for use	This indicator aims to monitor the impact of the COVID-19 pandemic on hospital services in humanitarian, fragile, conflict-affected and vulnerable contexts. High rates of hospital services utilization or bed occupancy may indicate increased COVID-19 transmission, including from undiagnosed cases, or other disease events. Unusually low hospitalization levels or bed occupancy rates may indicate barriers to health seeking behaviors and access to care, or stockouts of key medicines and products. To monitor this level of pressure on hospital services, reporting may rely on available health information system data, such as the number of hospital consultations reported per month as per the DHIS2 in certain countries, or hospital occupancy rates for which the information is available in other countries, compared to normal level (for example the same month in 2019 or another period as chosen by the country). The information may also come from observations of key informants (local health authorities, partner organizations, community feedback). To avoid additional data collection within countries, countries will rely upon existing proxy indicators from standard health information system data or information from key informant observation to describe the pressure on hospital services: • reporting unusual all-cause hospital services utilization; and/or • reporting unusual all-cause hospital occupancy rates; and/or • information from key informant observation on overall pressure on hospital services. The information above will then be used as reference to make an expert assessment on whether there are unusual levels of pressure on hospital services, categorized into four groups. Any selection of either overwhelmingly high or low pressure on hospital services will trigger an alert, which will require a follow-up assessment and action by health authorities. In the absence of reliable and relatively complete health information data, this qualitative expert assessment and reliance upon local context knowledge could be used on its own to assess the level of pressure on hospitals for action purposes.
Definition of key terms	**Pressure on hospital services is alarmingly high** • **All-cause hospital services utilization is alarmingly high during this past month** • **All-cause hospital bed occupancy rate is alarmingly high during this past month:** hospitals are facing significant challenges in meeting demands for hospital services, including from potentially undiagnosed COVID-19 cases – there are too many patients to treat and too few services available; the threshold for defining alarmingly high hospital utilization or bed occupancy can be established through in-country collective agreement based on best available information and does not need to have precise figures as the purpose is to raise alert to trigger actions. **Pressure on hospital services is alarmingly low** • **All-cause bed occupancy/hospitalizations are alarmingly low during this past month:** there is significantly less demand for hospitalizations compared to normal time (same month in 2019 for example), which may indicate barriers to access hospital services; stockouts of key medical products and supplies; absence of personnel, etc.; the threshold for defining alarmingly low hospital utilization or bed occupancy can be established through in-country collective agreement based on best available information and does not need to have precise figures as the purpose is to raise alert to trigger actions. **Pressure on hospital capacities is manageable:** indication of manageable pressure from COVID-19 cases (diagnosed and undiagnosed) and other causes of hospitalization on the hospital system. **District Health Information Software 2 (DHIS2):** an open source, web-based platform used as a health management information system (HMIS). DHIS2 is used by 73 low and middle-income countries and contains routine health facilities data.

Measurement	
Numerator	The number of humanitarian countries prioritized in the Global Humanitarian Overview (GHO) 2021 reporting unusual pressure on hospital services
Denominator	Number of humanitarian countries prioritized in GHO 2021
Disaggregation	Unusual hospitalization levels will be disaggregated into four categories: Pressure on hospital services is unusually high this past month Pressure on hospital services is unusually low this past month Pressure on hospital services is at usual/expected levels this past month Don't know/unclear
Scope	This indicator is focused on countries included in the Global Humanitarian Overview, which includes Humanitarian Response Plans (HRP), Regional Refugee Response Plans (RRPs), Migrant Response Plan (MRP), Joint Response Plans (JRP), Regional Refugee and Migrant Response Plan (RMRP). This list can be found in Annex 5.
Target	This indicator is a monitoring indicator for action and does not have a set target. Instead, actions to support countries signaling unusual pressure on hospital services will be tracked.
Data collection and reporting	
Data source	The Regional M&E Focal Point will liaise with the WHO country office designated focal point to monitor unusual patterns and trends of pressure on hospital services. When reporting for this indicator, regional M&E focal points may also add further contextualization as desired. This may include but is not limited to: plans to progressively expand health services, internal reorganization to increase bed capacities, early discharge and referrals to lower levels of care or outpatient medicine, home health care engagements and other adjustments. The Regional M&E Focal Point will consolidate inputs from all WCOs with FCV settings and then share data with the HQ SPRP M&E Team on a monthly basis. Reporting against this indicator may resource, although not limited to, the following data sources: available surveillance data (DHIS2 or equivalent), hospital reporting and/or observation and reporting from key informants and stakeholder feedback to monitor for hospital service utilization or bed occupancy trends.
Reporting start date	April 2021
Reporting frequency	Monthly

Pillar 9 Maintaining essential health services and systems	
Indicator: Proportion of countries with a functioning multi-sectoral mental health and psychosocial support (MHPSS) coordination group	
Rationale for use	This indicator aims to monitor the progress of the International Health Regulations (IHR, 2005) Emergency Committee's (29 October 2020) advice to WHO to "work with partners to support countries in strengthening their essential health services, with a particular focus on mental health" and to "strengthen health systems to cope with mental health impacts of the pandemic." Mental health and psychosocial support (MHPSS) is recognized as a cross-cutting issue relevant to a number of public health emergency pillars and range of sectors engaged in the humanitarian as well as public health responses. In any emergency there are actors providing MHPSS services in education, protection, nutrition, health and other sectors, and coordination of MHPSS requires multisectoral country level technical platforms.
Definition of key terms	**Functional MHPSS multi-sectoral coordination group** will be defined as meeting at least three of the following criteria: • Coordination group has more than 4 Member Agencies of Governmental departments from at least two different sectors; • Coordination group has met at least once during the last two months; • Coordination group has TORs and workplan or mapped deliverables; • Coordination has dedicated funding to support its activities through at least one of the member agencies; • Group has a monitoring and evaluation system in place.
Measurement	
Numerator	Number of countries with functional MHPSS multisector coordination group from the humanitarian countries prioritized in Global Humanitarian Overview 2021
Denominator	Number of humanitarian countries prioritized in Global Humanitarian Overview 2021
Disaggregation	N/A
Scope	This indicator is focused on countries included in the 2021 Global Humanitarian Overview, which includes Humanitarian Response Plans (HRP), Regional Refugee Response Plans (RRPs), Migrant Response Plan (MRP), Joint Response Plans (JRP), Regional Refugee and Migrant Response Plan (RMRP). This list can be found in Annex 5.
Target	100%
Data collection and reporting	
Data source	WHO HQ MHPSS focal point will liaise with Inter-Agency Standing Committee, partners, and WHO Regional Office MHPSS focal points to consolidate inputs for the reporting of this indicator to the WHO HQ SPRP M&E Team.
Reporting start date	January 2021
Reporting frequency	Monthly

Annex 3: Epidemiological intelligence data collected by WHO

Pillar 3 (Surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures) routinely collects data to provide epidemiological intelligence and monitor the COVID-19 situation. This epidemiological intelligence, in conjunction with operational intelligence, allows for dynamic translation of knowledge into coordinated action according to the SPRP 2021. This annex lists the data routinely collected, analysed, and reported including through Weekly Epidemiological Updates.

Intelligence:
- Cases
- Deaths
- Notable COVID-related events

Case-based reporting:
- Detailed case information, including (variably completed): by age, sex, healthcare worker status, outcomes, comorbidities

Weekly aggregate reporting:
- Cases, probable and confirmed
- Deaths, probable and confirmed
- Cases, by age and sex
- Deaths, by age and sex
- Hospitalizations
- Hospital discharges
- Healthcare worker cases and deaths
- Number of laboratory tests
- Transmission classification

Vaccination data:
- Doses administered
- Doses per population
- Number of people with at least one dose
- Number of people fully vaccinated
- Number of vaccines in use
- Which vaccines, when did they start

Calculated indicators based on above data:
- Case fatality ratio (CFR)
- Effective reproduction number (Rt)
- Doubling/halving time

Other
- Death-certificate-based cause of death and demographic data

Annex 4: Gavi COVAX AMC-eligible participating economies

According to information available on the Gavi website,[41] the list of 92 Gavi COVAX AMC-eligible economies (based on 2018 and 2019 World Bank GNI data) is as follows:

Low income: Afghanistan, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Congo, Dem. Rep., Eritrea, Ethiopia, Gambia, The Guinea, Guinea-Bissau, Haiti, Korea, Dem. People's Rep., Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Rwanda, Sierra Leone, Somalia, South Sudan, Syrian Arab Republic, Tajikistan, Tanzania, Togo, Uganda, Yemen, Rep.

Lower-middle income: Angola, Algeria, Bangladesh, Bhutan, Bolivia, Cabo Verde, Cambodia, Cameroon, Comoros, Congo, Rep. Côte d'Ivoire, Djibouti, Egypt, Arab Rep., El Salvador, Eswatini, Ghana, Honduras, India, Indonesia, Kenya, Kiribati, Kyrgyz Republic Lao PDR, Lesotho, Mauritania, Micronesia, Fed. Sts., Moldova, Mongolia, Morocco, Myanmar, Nicaragua, Nigeria, Pakistan, Papua New Guinea, Philippines, São Tomé and Principe, Senegal, Solomon Islands, Sri Lanka, Sudan, Timor-Leste, Tunisia, Ukraine, Uzbekistan, Vanuatu, Vietnam, West Bank and Gaza, Zambia, Zimbabwe

Additional IDA eligible: Dominica, Fiji, Grenada, Guyana, Kosovo, Maldives, Marshall Islands, Samoa, St. Lucia, St. Vincent and the Grenadines, Tonga, Tuvalu

41 To access the list of Gavi COVAX AMC-Eligible economies (12 May 2021) see here: https://www.gavi.org/sites/default/files/covid/pr/COVAX_CA_COIP_List_COVAX_PR_12-05-21.pdf

Annex 5: Global humanitarian overview (GHO) countries, territories and areas

Countries, territories and areas for 2021 as indicated on the GHO 2021 for Humanitarian Response Plans (HRP), Regional Response Plans (RRP), a Joint Response Plan (JRP), a Migrant Response Plan (MRP), and a Refugee and Migrant Response Plan (RMRP).[42]

- Afghanistan
- Angola
- Argentina
- Aruba
- Bangladesh (for the Rohingya Refugee Response)
- Bolivia (Plurinational State of)
- Brazil
- Burkina Faso
- Burundi
- Cameroon
- Central African Republic
- Chad
- Chile
- Colombia
- Costa Rica
- Curaçao
- Democratic Republic of the Congo
- Djibouti
- Dominican Republic
- Ecuador
- Egypt
- Ethiopia
- Guyana
- Haiti
- Honduras
- Iraq
- Jordan
- Kenya
- Lebanon
- Libya
- Madagascar
- Mali
- Mexico
- Mozambique
- Myanmar
- Niger
- Nigeria
- occupied Palestinian territory, including eastern Jerusalem
- Pakistan
- Panama
- Peru
- Republic of the Congo
- Rwanda
- Somalia
- South Sudan
- Sudan
- Syrian Arab Republic
- Trinidad and Tobago
- Turkey
- Uganda
- Ukraine
- United Republic of Tanzania
- Venezuela (Bolivarian Republic of)
- Yemen
- Zambia
- Zimbabwe

42 To access the full list, see here: https://gho.unocha.org/

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Switzerland
WHO in Emergencies:
www.who.int/emergencies/en