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COVID-19 Strategic Preparedness and Response (SPRP)

Monitoring and Evaluation Framework

World Health Organization

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COVID-19 SPRP MONITORING AND EVALUATION FRAMEWORK

Rationale

Collecting and analysing global and country response indicators against planned actions or processes is essential to ensure accountability and transparency in monitoring progress and identifying gaps. The COVID-19 Strategic Preparedness and Response Plan (SPRP) Monitoring and Evaluation Framework (COVID-19 M&E Framework) lists key public health and essential health services and systems indicators to monitor preparedness, response, and situations during the COVID-19 pandemic.

Objectives

The COVID-19 M&E Framework aims to assess performance and to provide recorded information to support analysis of progress against the SPRP[1] and the related SPRP Strategy Update.[2]

The main objective is to establish and maintain a set of global and country indicators to support: strategic thinking, operational tracking, real-time evidence-based decision-making, and to ensure advocacy and transparency between donors, UN agencies, and partners involved in the response. This will allow WHO, other UN agencies, and partners to track progress against goals and to correct approaches and actions should this be necessary.

The specific objectives are to:

- Monitor COVID-19 response activities by measuring key input, output, and outcome indicators at both global and country levels;
- Produce systematic assessments and analyses of response activities;
- Compare activity results against the epidemiological progression of the pandemic;
- Help the prioritization of response activities and inform decision-making amongst all partners;
- Support and accelerate transparency and information sharing;
- Support preparedness and response planning;
- Produce evidence for operational reviews and lessons learned.

Scope

The COVID-19 M&E Framework encompasses the major areas of public health preparedness and response as outlined in the COVID-19 SPRP: Operational Planning Guidelines to Support Country Preparedness and Response.[3]

The COVID-19 M&E Framework, as outlined in the Structure section of this document, encompasses three categories of planning and monitoring needs: preparedness, response, and situation. The COVID-19 M&E Framework includes input, output, and outcome indicators to achieve the objectives. Indicators on Risk Communication and Community Engagement have been jointly defined between the UN Children's Fund (UNICEF), WHO, and the International Federation of Red Cross and Red Crescent Societies (IFRC) reflecting the joint leadership in pillar 2; and indicators on Points of Entry, International Travel, and Transport activities have been defined between the International Organization for Migration (IOM) and WHO. A set of indicators relevant for vulnerable groups, refugees, and displaced populations is included and aligned with the UN Office for the Coordination of Humanitarian Affairs (OCHA) Monitoring Framework of the COVID-19 Global Humanitarian Response Plan (GHRP) to ensure reporting consistency.

Structure

The COVID-19 M&E Framework is organized around three dimensions:

1 **Geographical scope.** The pandemic impacts all countries[4] worldwide, bringing together countries with diverse epidemiological profiles, resource availability, and data systems. These countries also have diversity in political and social contexts, including low capacity and conflict and humanitarian settings. Indicators are, therefore, regrouped as follows:

   - Global level: Set of key indicators to monitor global and cross-cutting issues for all countries;
   - Countries: All countries affected by the COVID-19 pandemic;
   - Priority countries: Countries affected by the COVID-19 pandemic as defined in the GHRP.[5]

1 To access the SPRP (3 February 2020) see: https://www.who.int/publications-detail/strategic-preparedness-and-response-plan-for-the-new-coronavirus

2 To access the SPRP Strategy Update (14 April 2020) see: https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_19

3 To access the Operational Planning Guidelines to Support Country Preparedness and Response (12 February 2020) see: https://www.who.int/docs/default-source/coronaviruse/COVID-19-sprp-unct-guidelines.pdf?sfvrsn=81ff43d8_4

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

5 To access the GHRP (April-December 2020) see: https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf

2 **Planning and monitoring needs.** Indicators aim to inform decision-making for both planning and monitoring purposes and can be regrouped as follows:

- **Preparedness:** Preconditions to respond;
- **Response:** Short-term emergency phase, primarily focusing on activities;
- **Situation:** Less reactive indicators that provide a situational snapshot at a certain point in time, including country requirements that are assessed on an annual or biannual basis, as well as indicators with delayed reporting (e.g., data from national health systems). The focus is on situation analysis and impact of the COVID-19 pandemic on routine public health initiatives, processes, and activities.

3 **Pillars/areas.** Indicators have been regrouped around nine pillars and one thematic area:

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

This is summarized in table 1.

Table 1 Structure of the COVID-19 M&E Framework

	Geographical scope		
	Global	**Countries**	**Priority countries**
Pillar			
1 Country-level coordination, planning, and monitoring	Preparedness Situation Response	Preparedness Situation Response	Preparedness Situation Response
2 Risk communication and community engagement	Preparedness Response	Preparedness Response	Preparedness Response
3 Surveillance, rapid response teams, and case investigation		Response	Response
4 Points of entry, international travel, and transport		Preparedness Situation	Preparedness Situation Response
5 National laboratories	Preparedness	Preparedness Situation Response	Preparedness Situation Response
6 Infection prevention and control	Situation	Situation	Situation Response
7 Case management	Response	Response	Response
8 Operational support and logistics			Response
9 Maintaining essential health services and systems		Situation	Situation Response
Cross-cutting issues			
	Preparedness		Response

Methodology

The COVID-19 M&E Framework is a collaborative initiative among multiple stakeholders. It is based on a logical framework aimed to identify inputs, outputs, outcomes, and impacts of the response.

The indicators proposed (see COVID-19 M&E Framework indicators section and Annex 1) were chosen from a consultative selection with COVID-19 response pillar leads, incident managers, and M&E focal points across the six WHO regions and with OCHA, IFRC, IOM, and UNICEF. Some indicators are derived from previously validated registries for outbreak response, as well as from previous strategic preparedness and response plans and other sector, cluster, or agency outcome indicator repositories and adapted to this context.

Frequency and analysis cycle

Indicators will be collected with differing frequency, though reporting will primarily follow the epidemiological week. Monthly indicators will be collected the second week of each month with reference to the previous month.

Indicators have different collection frequencies (e.g., weekly, quarterly, annually). Those referring to the existence of a certain capacity or plan need to be asked once (at baseline). Updates are necessary only for countries that have not reported a capacity or plan. Indicators with annual frequency should be reported once, unless unforeseen updates will be available that could impact the indicator. Table 2 summarizes the distribution of indicators by source and frequency.

The analysis plan will be collectively defined to respond to countries' needs for decision making. Final aggregation, analysis, and visualization will be provided at the beginning of each subsequent epidemiologic week, or monthly, according to previously established and agreed frequency of each indicator.

Table 2 Number of indicators by source and frequency

Frequency of reporting	Sources		
	Global	Regional	Total
Weekly	10	3	13
Monthly	8	11	19
Annual	5	1	6
Total	23	15	38

COVID-19 M&E Framework Indicators

Pillar 1 Country-level coordination, planning, and monitoring

- Percentage of countries with COVID-19 national plan;
- Percentage of countries with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response;
- Percentage of countries that recommended or required at least 4 out of 6 personal measures in the context of COVID-19;
- Percentage of countries that report having at least one mass gathering event affected by COVID-19 (cancelled, postponed, suspended, or re-opened in a post-crisis scenario) as a result of a Risk Assessment exercise.

Pillar 2 Risk communication and community engagement (RCCE)

- Percentage of countries which have a national COVID-19 risk communication and community engagement plan;[6]
- Percentage of countries where a RCCE coordination mechanism is active and formally implemented (e.g., multi-sectoral RCCE team, working group, task force);
- Percentage of countries that have mechanisms in place to capture community feedback (e.g., community meetings, hotlines, health volunteer network, social listening, surveys, etc.).

Pillar 3 Surveillance, rapid response teams, and case investigation

- Weekly number of new confirmed cases nationwide, disaggregated by age group and sex;
- Weekly number of new confirmed case deaths from COVID-19 disaggregated by age group and sex;
- Weekly number of new confirmed cases hospitalized due to COVID-19 disease, disaggregated by age group and sex; [7]
- Case fatality amongst confirmed COVID-19 cases, disaggregated by age group and sex;[7]
- Weekly number of new confirmed cases in health care workers,[8] disaggregated by sex;[7]
- Percentage of countries testing for COVID-19 and reporting routinely through established sentinel or non-sentinel Influenza-like Illness (ILI), severe acute respiratory infections (SARI), acute respiratory infections (ARI) surveillance systems such as the Global Influenza Surveillance and Response System (GISRS) or other WHO platforms;
- Percentage of countries with a focal point for contact tracing implementation and training;
- Percentage of countries implementing seroepidemiological investigations or studies.

Pillar 4 Points of entry (PoE), international travel, and transport

- Percentage of countries in which designated PoE have public health emergency contingency plans;
- Percentage of designated PoE which have notified at least one COVID-19-related alert in the previous week.

Pillar 5 National laboratories

- Percentage of countries with COVID-19 laboratory test capacity;
- Percentage of countries scoring 100% on External Quality Assessment Project (EQAP);
- Weekly number of persons tested for COVID-19, disaggregated by age group and sex.[7]

Pillar 6 Infection prevention and control (IPC)

- Percentage of countries that have a national IPC programme and water, sanitation and hygiene (WASH) standards within all health care facilities;
- Percentage of acute health care facilities with triage capacity;
- Percentage of acute health care facilities with isolation capacity;
- Percentage of countries with long-term care facilities (LTCF) that have a national policy and guidelines on IPC for LTCF;
- Percentage of countries with a focal point for IPC training;
- Number of health workers trained in IPC in the previous week.

Pillar 7 Case management

- Percentage of countries that have a clinical referral system in place to care for COVID-19 cases;
- Percentage of hospitalized COVID-19 cases that are discharged;
- Number of Intensive Care Units (ICU) beds provided to priority countries through Emergency Medical Teams (EMT) or similar surge mechanisms;
- Number of health workers trained in case management of COVID-19 patients in the previous week.

Pillar 8 Operational support and logistics

- Number and percentage of medical masks (3 plies) provided against country request;
- Number and percentage of laboratory tests provided against country request.

Pillar 9 Maintaining essential health services and systems

- DTP3 vaccination coverage amongst children under 12 months of age;
- Institutional delivery/Number of health facility-based deliveries;
- Essential health services during COVID-19 pandemic;
- Percentage of countries where at least one VPD immunization campaign was affected (postponed, suspended, fully or partially) by the COVID-19 pandemic.

Cross-cutting issues

- Percentage of countries with multi-sectoral mental health and psychosocial support technical working group;
- Percentage of countries that have national occupational safety and health plans or programmes for health workers.

6 Risk communication and community engagement are two different but interlinked subjects that are managed differently across countries. Some countries have one joint plan, others have two separate plans. Countries with disjoint RCCE plans are requested to respond to this indicator as one. In some countries, plans only relate to community engagement in the title, but also include risk communication elements. In this case, it can be reported as 'yes.'

7 Disaggregation by age group and sex is currently only available for confirmed cases and confirmed case deaths. It is under consideration for other indicators and may be added in the future as it becomes available.

8 This includes community health workers.

Dissemination plan, audience, and products

Products will reflect the needs of UN Country Teams (UNCTs) and partners in the regions. They will primarily consist of an activity report and a weekly updated dashboard that will be established to facilitate data visualization. The dashboard will provide global, regional, and functional data views tailored towards different audiences, including national government decision makers, donors, and partners. The dashboard will be available online and a link will be shared with key stakeholders on a weekly basis following updates.

Evaluation

A mid-term evaluation of the COVID-19 M&E Framework will be held three months after the launch of the COVID-19 M&E Framework.

Business Owner

The WHO Health Information Management and Strategic Planning Departments, in collaboration with Country Support Teams, will coordinate the collation, analysis, visualization, and dissemination of measured indicators.

Overview of the COVID-19 M&E Framework indicators

Indicator	Planning and monitoring needs	Type	Target	Geographical scope			Sources		Frequency		
				Global	All countries	Priority countries	Global	Regional	Weekly	Monthly	Annual
Pillar 1 Country-level coordination, planning, and monitoring											
Percentage of countries with COVID-19 national plan	Preparedness & Response	Process	100%	x				WHO		x	
Percentage of countries with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	Preparedness & Response	Process	100%	x				WH0		x	
Percentage of countries that recommended or required at least 4 out of 6 personal measures in the context of COVID-19	Response	Output	100%		x		WHO			x	
Percentage of countries that report having at least one mass gathering event affected by COVID-19 (cancelled, postponed, suspended or re-opened in a post-crisis scenario), as a result of a risk assessment exercise	Response	Output	100%		x		WHO			x	

Indicator	Planning and monitoring needs	Type	Target	Geographical scope			Sources		Frequency		
				Global	All countries	Priority countries	Global	Regional	Weekly	Monthly	Annual
Pillar 2 Risk communication and community engagement											
Percentage of countries which have a national COVID-19 risk communication and community engagement plan[9]	Response	Process	100%	x				UNICEF & WHO		x	
Percentage of countries where a RCCE coordination mechanism is active and formally implemented (e.g., multi-sectoral RCCE team, working group, task force)	Response	Process	100%			x		WHO		x	
Percentage of countries that have mechanisms in place to capture community feedback (e.g., community meetings, hotlines, health volunteer networks, social listening, surveys, etc.)	Response	Output	100%			x		WHO*		x	
Pillar 3 Surveillance, rapid response teams, and case investigation											
Weekly number of new confirmed cases nationwide, disaggregated by age and sex	Response	Outcome	N/A		x		WHO		x		
Weekly number of new confirmed case deaths from COVID-19, nationwide, disaggregated by age and sex	Response	Outcome	N/A		x		WHO		x		
Weekly number of new confirmed cases hospitalized due to COVID-19 disease, disaggregated by age and sex	Response	Outcome	N/A		x		WHO		x		

* with support from IFRC

9 Risk communication and community engagement are two different but interlinked subjects that are managed differently across countries. Some countries have one joint plan, others have two separate plans. Countries with disjoint RCCE plans are requested to respond to this indicator as one. In some countries, plans only relate to community engagement in the title, but also include risk communication elements. In this case, it can be reported as 'yes.'

Indicator	Planning and monitoring needs	Type	Target	Geographical scope			Sources		Frequency		
				Global	All countries	Priority countries	Global	Regional	Weekly	Monthly	Annual
Pillar 3 Surveillance, rapid response teams, and case investigation (continued)											
Case fatality amongst confirmed COVID-19 cases, disaggregated by age and sex	Response	Outcome	N/A		x		WHO		x		
Weekly number of new confirmed cases in health care workers by sex	Response	Outcome	0		x			WHO	x		
Percentage of countries testing for COVID-19 and reporting routinely through established sentinel or non-sentinel ILI, SARI, ARI surveillance systems such as GISRS or other WHO platforms.	Response	Outcome	50%		x		WHO		x		
Percentage of countries with a focal point for contact tracing implementation and training	Response	Output	100%			x		WHO		x	
Percentage of countries implementing seroepidemiological investigations or studies	Response	Outcome	20%	x			WHO			x	
Pillar 4 Points of entry, international travel, and transport											
Percentage of countries in which all designated PoE have public health emergency contingency plans	Situation	Process	100%		x		WHO				x
Percentage of designated PoE that have notified at least one COVID-19-related alert in the previous week	Response	Outcome	100%			x	IOM*			x	
Pillar 5 National laboratories											
Percentage of countries with COVID-19 laboratory test capacity	Preparedness	Outcome	100%	x				WHO		x	
Percentage of countries scoring 100% on EQAP	Situation	Outcome	75%		x		WHO				x
Weekly number of persons tested for COVID-19, disaggregated by age and sex	Response	Output	N/A		x		WHO				

* in collaboration with WHO

Pillar 6 Infection prevention and control											
Percentage of countries that have a national IPC programme and WASH standards within all health care facilities	Situation	Process	100%	x			WHO				x
Percentage of acute health care facilities with triage capacity	Response	Outcome	80%			x		WHO		x	
Percentage of acute health care facilities with isolation capacity	Response	Outcome	80%			x		WHO		x	
Percentage of countries with Long-Term Care Facilities (LTCF) that have a national policy and/ or guideline on IPC for COVID-19 in LTCF	Situation	Process	100%		x			WHO			x
Percentage of countries with a focal point for IPC training	Response	Output	100%			x		WHO		x	
Number of health workers trained in IPC in the previous week	Response	Output	N/A			x		UNICEF & WHO			
Pillar 7 Case management											
Percentage of countries that have a clinical referral system in place to care for COVID-19 cases	Response	Outcome	100%	x				WHO		x	
Percentage of confirmed hospitalized COVID-19 cases who are discharged	Response	Outcome	N/A		x		WHO			x	
Number of ICU beds provided to priority countries through EMT or similar surge mechanism	Response	Input	N/A			x	EMT			x	
Number of health workers trained in case management of COVID-19 cases in the previous week	Response	Output	N/A			x		WHO & UNICEF			

Indicator	Planning and monitoring needs	Type	Target	Geographical scope			Sources		Frequency		
				Global	All countries	Priority countries	Global	Regional	Weekly	Monthly	Annual
Pillar 8 Operational support and logistics											
Number and percentage of medical masks (3 plies) shipped against country request	Response	Input	N/A			x	WHO				
Number and percentage of laboratory tests shipped against country request	Response	Input	N/A			x	WHO				
Pillar 9 Maintaining essential health services and systems											
DPT3 Vaccination coverage in children under 12 months of age	Situation	Outcome	N/A		x		WHO			x	
Institutional delivery	Situation	Outcome	N/A			x	WHO			x	
Essential health services during COVID-19 pandemic	Situation	Outcome	100%		x		WHO				x
Percentage of countries where at least one VPD immunization campaign was affected (suspended or postponed, fully or partially) by COVID-19	Response	Outcome	0%			x	WHO			x	
Cross-cutting issues											
Percentage of countries with multi-sectoral mental health and psychosocial support technical working group	Response	Output	100%			x	WHO			x	
Percentage of countries that have national occupational safety and health plans or programmes for health workers	Situation	Process	100%		x		WHO				x

ANNEX 1: INDICATOR COMPENDIUM

This section provides additional details per each indicator. This includes rationale, measurement details (including data disaggregation), and methods for data collection and reporting.

Pillar 1 Country-level coordination, planning, and monitoring

Percentage of countries with COVID-19 national plan	
Rationale for use	Planning is critical to help mitigate the impact of a public health event. A country with a plan will have better knowledge and capacities for timely response.
Definition of key terms	Plan: Document explaining the strategy to prepare and respond. Evidence of a plan can include a framework of response for national-level authorities and circulars to sub-national authorities on actions required. WHO provides Operational Planning Guidelines to Support Country Preparedness and Response.[10] For Member States that work closely on planning/response actions at sub-regional level (e.g., Pacific Island Countries), the existence of a sub-regional plan is sufficient in the absence of a national plan. The plan should not be limited to the Ministry of Health, but extended to all sectors and can include multi-agency collaboration plans.
Type	Process
Measurement	
Numerator	Number of Member States which have a COVID-19 national plan
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of January 2020
Reporting frequency	Updated once monthly in case additional countries have developed the capacity (i.e., to update any countries that had 'no' or 'no information/unknown'). To be reported the second week of each month with reference to the previous month.

10 To access the COVID-19 SPRP Operational Planning Guidelines to Support Country Preparedness and Response (12 February 2020) see: https://www.who.int/docs/default-source/coronaviruse/COVID-19-sprp-unct-guidelines.pdf?sfvrsn=81ff43d8_4

Pillar 1 Country-level coordination, planning, and monitoring

Percentage of countries with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	
Rationale for use	Coordination is critical for effective response to public health emergencies. The activation of a Health Emergency Operations Centre (EOC) or other coordination system (relevant to national context for emergency multi-sectoral and multi-partner coordination) is evidence of the presence of a mechanism.
Definition of key terms	Functional: The mechanism has the key components as outlined in the Framework for a Public Health Emergency Operations Centre including plans/procedures, physical infrastructure, information and communication technology infrastructure, information systems and standards, and human resources. Functional, therefore, means active and equipped with the key components; it does not imply performance. Multi-sectoral coordination goes beyond the Ministry of Health to include other national ministries, institutions, and bodies operating in the country (i.e., UN agencies, NGOs, clusters, etc.). Ideally, it would include also the utilization of an Emergency Operation Centre.
Type	Process
Measurement	
Numerator	Number of Member States which have multi-sectoral coordination mechanism for the COVID-19 preparedness and response
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of January 2020
Reporting frequency	Updated once monthly in case additional countries have developed the capacity (i.e., to update any countries that had 'no' or 'no information/unknown'). To be reported the second week of each month with reference to the previous month.

Pillar 1 Country-level coordination, planning, and monitoring

Percentage of countries that recommended or required at least 4 out of 6 personal measures in the context of COVID-19	
Rationale for use	Personal and individual behaviour is central in the containment and prevention of the spread of infections. To reduce the risk of COVID-19 transmission, many countries have, therefore, issued guidance on personal measures.
Definition of key terms	Personal or individual measures are actions or measures taken by individuals to reduce personal risk of infection or prevent spread of COVID-19. Personal or individual measures are defined as in the "Taxonomy and Glossary of Public Health and Social Measures that may be Implemented to Limit the Spread of COVID-19, 28 April 2020" which can be found on WHO's Tracking Public Health and Social Measure website. These include performing hand hygiene, limiting face touching, performing respiratory etiquette, using other personal protective equipment, wearing a mask, and physical distancing.
Type	Output
Measurement	
Numerator	Number of countries that recommended or required 4 out of 6 personal measures in the context of COVID 19
Denominator	WHO Member States
Scope	All countries
Target	100%
Data collection & reporting	
Data source	WHO – global WHO Public Health and Social Measures Database[11]
Period covered	As of April 2020
Reporting frequency	Monthly

11 To access the WHO Tracking Public Health and Social Measures Database see: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/phsm

Pillar 1 Country-level coordination, planning, and monitoring

Percentage of countries that reported having at least one mass gathering event affected by COVID-19 (cancelled, postponed, suspended or re-opened in post crisis scenario) as a result of a risk assessment exercise	
Rationale for use	WHO recommends that any decision related to holding a mass gathering should be based on a rigorous assessment of the associated risks and of the organizers' capacity to mitigate them though the implementation of a defined set of mitigation measures.
Definition of key terms	A COVID-19 Mass Gathering Risk Assessment exercise relies on the use of at least one of the tools developed by WHO for this purpose, or of any of the derivative adaptations. The decision-making process leading to holding mass gatherings should be driven by a thorough risk assessment[12] that takes into consideration the characteristics of the event and the mitigation measures applied to decrease the risk associated with the event. Event planners should undertake such an assessment in partnership with relevant health authorities and international bodies. The risk assessment must be regularly reviewed to ensure appropriate and adequate responses.
Type	Output
Measurement	
Numerator	WHO Member States that reported having at least one mass gathering event affected by COVID-19 (cancelled, postponed, suspended or reopened in a post-crisis scenario), as a result of a Risk Assessment exercise.
Denominator	WHO Member States that reported having at least one mass gathering event affected by COVID-19 (cancelled, postponed, suspended or reopened in a post-crisis scenario).
Scope	All countries
Target	100%
Data collection & reporting	
Data source	WHO – global Event database managed by the WHO Collaborating Centre for Global Health Security; Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA; and WHO global/regional with international bodies (IOC, FIFA, UEFA, eligious).
Period covered	As of April 2020
Reporting frequency	Quarterly

12 To access information on mass gatherings and the COVID-19 risk assessment see: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/points-of-entry-and-mass-gatherings

Pillar 2 Risk communication and community engagement

Percentage of countries which have a national COVID-19 risk communication and community engagement plan[13]	
Rationale for use	Communication and community engagement are essential elements in every aspect of the response to COVID-19. In the absence of effective treatment or vaccine, coordinated, clear communication with and engagement of citizens about risks and behavioural modification is the main intervention available. People must trust response authorities, and this begins with proactively communicating what is known, what is unknown, and what is being done to get more information, with the objectives of saving lives and minimizing adverse consequences. Providing clear and actionable information, based on community concerns and perceptions, helps transform and deliver complex scientific knowledge so that it is understood by, accessible to and trusted by populations and communities. Preparedness and response activities should be designed and conducted in a participatory community-based way, as well as informed and continually optimized according to community feedback to detect and respond to concerns, rumours, and misinformation. These differ and change according to the transmission scenario which characterizes each country at a given time.
Definition of key terms	A RCCE plan establishes the rationale and strategy to ensure that communities are at the centre of the response, identifies key audiences, addresses audience perceptions of health (and humanitarian) response strategies, and provides accurate and actionable information. It is recommended that the plan defines the coordination mechanism for implementing the RCCE plan, establishes roles and responsibilities for partners, identifies accountabilities between governments, partners, and communities, and sets milestones for coordination and improvement over time. A RCCE plan includes risk assessment, risk perception and risk communication strategy. More specifically, it defines information provision (on prevention, preparedness, and response at individual, community, and system levels), audiences and influencers, coordination mechanism and partners, and defines activities to be implemented. Information, mechanisms, and actors involved should be adapted to the context (social and geographic) according to the dynamic evolution of the event. WHO guidance is available.[14] Furthermore, it should include at least 4 out of the 6 recommended actions from the global guidance related to community engagement:[17] establish methods for understanding the concerns, attitudes, and beliefs of key audiences; identify target audiences and gather information about their knowledge and behaviours (e.g., who they trust, how they are likely to receive information, their daily habits, their concerns); engage through social media by proactively informing audiences and collecting and answering all questions; engage through radio programmes so that people can call in and ask questions; identify community influencers (e.g., community leaders, religious leaders, health workers, traditional healers, alternative medicine providers) and networks (e.g., women's groups, community health volunteers, youth associations, religious groups, unions, and social mobilizers for polio, malaria, HIV) that can help with community engagement, and anticipate special information and engagement needs for people who are disabled or illiterate.
Type	Process

13 Risk communication and community engagement are two different but interlinked subjects that are managed differently across countries. Some countries have one joint plan, others have two separate plans. Countries with disjoint RCCE plans are requested to respond to this indicator as one. In some countries, plans only relate to community engagement in the title, but also include risk communication elements. In this case, it can be reported as 'yes.'

14 To access Risk Communication and Community Engagement Readiness and Response to Coronavirus Disease (COVID-19) (19 March 2020) see: https://www.who.int/publications-detail/risk-communication-and-community-engagement-readiness-and-initial-response-for-novel-coronaviruses-(-ncov)

To access IFRC, UNICEF, WHO Risk Communication and Community Engagement Action Plan Guidance: COVID-19 Preparedness and Response see: https://www.who.int/publications-detail/risk-communication-and-community-engagement-(rcce)-action-plan-guidance

Pillar 2 Risk communication and community engagement

Percentage of countries which have a national COVID-19 risk communication and community engagement plan[13] (continued)	
Measurement	
Numerator	Number of Member States with a national COVID-19 RCCE plan (Note: Some Member States have a National COVID-19 Response Plan and RCCE is incorporated as a pillar; Some Member States have comprehensive RCCE plans endorsed by lead government partner for RCCE.)
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	UNICEF, WHO with support of IFRC – regional
Period covered	As of January 2020
Reporting frequency	Monthly. To be reported, and/or monitored if already reported, the second week of each month with reference to the previous month.

13 Risk communication and community engagement are two different but interlinked subjects that are managed differently across countries. Some countries have one joint plan, others have two separate plans. Countries with disjoint RCCE plans are requested to respond to this indicator as one. In some countries, plans only relate to community engagement in the title, but also include risk communication elements. In this case, it can be reported as 'yes.'

Pillar 2 Risk communication and community engagement

Percentage of countries where a RCCE coordination mechanism is active and formally implemented (e.g., multi-sectoral RCCE team, working group, task force)	
Rationale for use	Coordination is a key part of RCCE response. It better ensures that response organizations, governments, and partners synchronize strategy and plans to ensure that target audiences/communities are communicated with and engaged through trusted organizations, networks, or individuals. Coordination also better ensures that health recommendations and guidance are consistent and timely and can be adapted per realities and transmission scenario and needs of different populations.
Definition of key terms	A COVID-19 RCCE coordination mechanism is a national working group or task force with sub-national coordination. The RCCE coordination mechanism is led or co-led by governmental response entities, and includes representatives from government, multi-sectoral entities and civil society, and/or NGO and local associations with direct responsibility and accountability for risk communications and community engagement functions. "Active" means that the coordination mechanism is recognized by lead/co-lead partners as well as implementing partners engaged in the COVID-19 response. The coordination mechanism has agreed upon roles and responsibilities, regular communication, as well as meeting frequency, and standing objectives for coordination, strategy, and activity alignment. It will map partners and organizations to identify who is working with which target audiences/communities and where and has mechanisms to identify opportunities for coordination activities and policies to be adjusted at different phases of the response.
Type	Process
Measurement	
Numerator	Number of countries that have a formal RCCE coordination mechanism for COVID-19 (e.g., multi-sectoral RCCE team, working group, task force)
Denominator	All priority countries
Scope	Priority countries
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of May 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Pillar 2 Risk communication and community engagement

Percentage of countries that have mechanisms in place to capture community feedback (e.g., community meetings, hotlines, health volunteer networks, social listening, surveys, etc.)	
Rationale for use	Mechanisms or platforms for community feedback ensure that communities and individuals can access needed information, obtain answers to questions, and raise concerns or complaints as needed.
Definition of key terms	RCCE for COVID-19 depends on government and partner ability to use existing feedback mechanisms towards COVID-19 RCCE objectives. These should be identified in the RCCE Plan (see 2.1). Established two-way community feedback mechanisms or platforms can include one or more of the following channels: hotlines, information centres, WhatsApp chats, social media channels, radio shows, face-to-face interactions when the context permits, participation in qualitative assessments, interactive messaging platforms, Q&A forums, digital engagement platforms, social network platforms, etc.
Type	Output
Measurement	
Numerator	Number of countries that have at least one active mechanism/platform in place to capture community feedback (e.g., community meetings, hotlines, health volunteer networks, etc.)
Denominator	All priority countries
Scope	Priority countries
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of May 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Pillar 3 Surveillance, rapid response teams, and case investigation

Weekly number of new confirmed cases nationwide, disaggregated by age group and sex	
Rationale for use	To assess epidemiology, identify trends and intensity of epidemic, and direct operational decision and resources accordingly.
Definition of key terms	All Pillar 3 indicators use definitions provided by WHO surveillance and case definition guidance.[15] Age groups are as follows: 0<5, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above, age missing.
Type	Outcome
Measurement	
Numerator	Weekly number of new confirmed cases nationwide, disaggregated by age group and sex
Denominator	N/A
Scope	All countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Weekly

15 To access Global Surveillance for COVID-19 Caused by Human Infection with COVID-19 Virus (20 March 2020) see: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions

Pillar 3 Surveillance, rapid response teams, and case investigation

Weekly number of new confirmed case deaths from COVID-19, nationwide, disaggregated by age group and sex	
Rationale for use	To assess epidemiology, identify trends and intensity of epidemic, and direct operational decision and resources accordingly.
Definition of key terms	All Pillar 3 indicators use definitions provided by WHO Surveillance and case definition guidance.[16] Age groups are as follows: 0<5, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above, age missing.
Type	Outcome
Measurement	
Numerator	Weekly number of new confirmed case deaths from COVID-19, disaggregated by age group and by sex
Denominator	N/A
Scope	All countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Weekly

16 To access Global Surveillance for COVID-19 Caused by Human Infection with COVID-19 Virus (20 March 2020) see: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions

Pillar 3 Surveillance, rapid response teams, and case investigation

Weekly number of new confirmed cases hospitalized due to COVID-19 disease, nationwide, disaggregated by age group and sex[17]	
Rationale for use	To assess epidemiology, identify trends and intensity of epidemic, and direct operational decision and resources accordingly.
Definition of key terms	All Pillar 3 indicators use definitions provided by WHO surveillance and case definition guidance.[18]
Type	Outcome
Measurement	
Numerator	Total number of new confirmed cases hospitalized due to COVID-19 disease
Denominator	N/A
Scope	All countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Weekly

17 Disaggregation by age group and sex is currently only available for confirmed cases and confirmed case deaths. It is under consideration for other indicators and may be added in the future as it becomes available.

18 To access Global Surveillance for COVID-19 Caused by Human Infection with COVID-19 Virus (20 March 2020) see: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions

Pillar 3 Surveillance, rapid response teams, and case investigation

Case fatality amongst confirmed COVID-19 cases,[19] disaggregated by age group and sex[20]	
Rationale for use	Case fatality is a measure of the disease severity.
Definition of key terms	Case fatality is calculated as the number of deaths reported to date, divided by the number of cases reported to date. This figure may not reflect the true risk of dying from COVID-19 infection, as it does not account for individual case progression; country variations in case and death reporting, including differences in testing strategies; differences in country population age and risk factor profiles; and time lags between being reported as a case and having a fatal outcome; amongst other factors.
Type	Outcome
Measurement	
Numerator	Cumulative number of deaths amongst confirmed COVID-19 cases
Denominator	Cumulative number of confirmed COVID-19 cases
Scope	All countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Weekly

19 Disclaimer to be added when reporting or visualizing this indicator: Case fatality ratio is calculated as the number of deaths reported to date, divided by the number of cases reported to date. This figure may not reflect the true risk of dying from COVID-19 infection, as it does not account for individual case progression; country variations in case and death reporting, including differences in testing strategies; differences in country population age and risk factor profiles; and time lags between being reported as a case and having a fatal outcome; amongst other factors

20 Disaggregation by age group and sex is currently only available for confirmed cases and confirmed case deaths. It is under consideration for other indicators and may be added in the future as it becomes available.

Pillar 3 Surveillance, rapid response teams, and case investigation

Weekly number of new confirmed cases in health workers disaggregated by sex[21]	
Rationale for use	The assessment and control of occupational risks to health workers and responders for protecting their health, safety, and well-being is central for safe and effective emergency response.
Definition of key terms	Weekly number of confirmed cases amongst health workers (medical doctors, nurses, community health workers, other support staff in clinical facilities). This does not include people working in the health response outside clinical facilities (e.g., field surveillance workers).
Type	Outcome
Measurement	
Numerator	Weekly number of confirmed cases who are health workers by sex
Denominator	Weekly total number of confirmed cases
Scope	All countries
Target	0
Data collection & reporting	
Data source	WHO – regional
Period covered	As of January 2020
Reporting frequency	Weekly

21 Disaggregation by age group and sex is currently only available for confirmed cases and confirmed case deaths. It is under consideration for other indicators and may be added in the future as it becomes available.

Pillar 3 Surveillance, rapid response teams, and case investigation

Percentage of countries testing for COVID-19 and reporting routinely through established sentinel or non-sentinel ILI, SARI, ARI surveillance systems such as GISRS or other WHO platforms	
Rationale for use	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	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.[22] These systems can include: hospital-based SARIs, primary care ILIs, GISRS, or other syndromic respiratory disease systems
Type	Outcome
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 (N=125)
Scope	All countries
Target	50%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Weekly

22 To access Operational Considerations for COVID-19 Surveillance Using GISRS (26 March 2020) see: https://apps.who.int/iris/bitstream/handle/10665/331589/WHO-2019-nCoV-Leveraging_GISRS-2020.1-eng.pdf

Pillar 3 Surveillance, rapid response teams, and case investigation

Percentage of countries with a focal point for contact tracing implementation and training	
Rationale for use	In countries with a limited number of cases or attempting to control the epidemic while easing social distancing restrictions, contact tracing represents a key component of the containment strategy.
Definition of key terms	A national (e.g., Ministry of Health, Academy, etc.) or international (e.g., WHO, GOARN, etc.) focal point is a person in charge of the organization and implementation of training on contact tracing including the deployment of contact tracing app to improve standardization of contact tracing. It does not need to be a full-time position. This position can be based in the national authorities or on one of the partners' teams.
Type	Output
Measurement	
Numerator	Number of countries with a focal point for contact tracing implementation and training
Denominator	Number of countries
Scope	Priority countries
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of May 2020
Reporting frequency	Monthly. To be updated in case additional countries have developed the capacity (i.e., to update any countries that had 'no' or 'no information/unknown'). To be reported the second week of each month with reference to the previous month.

Pillar 3 Surveillance, rapid response teams, and case investigation

Percentage of countries implementing seroepidemiological 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. 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	Seroepidemiological: Epidemiological investigations involving the identification of antibodies to specific antigens in populations of individuals.
Type	Outcome
Measurement	
Numerator	Number of Member States which have implemented at least one early sero-epidemiological investigation using WHO Unity Studies Master Protocols
Denominator	All Member States
Scope	Global
Target	20%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Pillar 4 Points of entry, international travel, and transport

Percentage of countries in which designated PoE have public health emergency contingency plans	
Rationale for use	Under the International Health Regulations (IHR), the public health authorities at PoEs – international ports, airports, and ground crossings – are required to establish effective contingency plans and arrangements for responding to a public health emergency of international concern and to communicate with the national IHR focal point on relevant public health measures.[23]
Definition of key terms	A PoE is a defined by IHR as a "passage for international entry or exit of travelers, baggage, cargo, containers, conveyances, goods and postal parcels, as well as agencies and areas providing services to them on entry or exit." These include international airports, ports, and ground crossings. Based on a public health assessment, IHR state parties designate ports and airports. All designated PoEs are required to have multi-sectoral public health emergency contingency plans for events caused by all hazards.
Type	Process
Measurement	
Numerator	Number of IHR state parties with designated PoEs having a multi-sectoral public health emergency contingency plan
Denominator	196 States Parties to IHR (2005)
Scope	All countries
Target	100% Cut off point for each country is 80%. If 80% of all designated ports have a contingency plan, the country is considered compliant (i.e., it is 'yes'). The aggregated level (i.e., the global figure) is calculated as the number of 'yes' countries/number of reporting countries. The global target is 100% (i.e., 100% of countries have at least 80% of all designated ports having contingency plans).
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Based on IHR State Party Self-Assessment Annual Reporting tool (SPAR) score for C 11/annually. Frequency could be increased as states might be required to monitor this aspect more frequently due to COVID-19.

23 To access PoEs: IHR, Annex 1B and Relevant Articles see: http://www.euro.who.int/en/health-topics/health-emergencies/international-health-regulations/points-of-entry/points-of-entry

Pillar 4 Points of entry, international travel, and transport

Percentage of designated PoE that have notified at least one COVID-19-related alert in the previous week	
Rationale for use	The current COVID-19 outbreak has spread across several borders, which has prompted the demand for the detection and management of suspected cases at PoEs.
Definition of key terms	A PoE is a defined by IHR as a "passage for international entry or exit of travelers, baggage, cargo, containers, conveyances, goods and postal parcels, as well as agencies and areas providing services to them on entry or exit." These include international airports, ports, and ground crossings. Based on a public health assessment, IHR state parties designate ports and airports. Following the detection of ill travelers through self-reporting, visual observation, or temperature measurement, PoE health authorities should report COVID-19-related alerts to the national health surveillance system. Mechanisms, procedures and means of communication should be established as per WHO guidance.[24]
Type	Outcome
Measurement	
Numerator	Number of designated PoEs that have notified at least one COVID-19-related alert (detected at PoE or on-board a conveyance) in the previous week
Denominator	Total PoEs
Scope	Priority countries
Target	100%
Data collection & reporting	
Data source	IOM in collaboration with WHO
Period covered	As of March 2020
Reporting frequency	Monthly

24 To access Management of Ill Travelers at Points of Entry in the Context of COVID-19 (19 March 2020) see: https://apps.who.int/iris/bitstream/handle/10665/331512/WHO-2019-nCoV-POEmgmt-2020.2-eng.pdf

Pillar 5 National laboratories

Percentage of countries with COVID-19 laboratory test capacity	
Rationale for use	Countries need access to laboratories to confirm the presence of the virus or to monitor virus spread and characteristics. Countries without the capacity to test should establish a system to access a reference laboratory for testing.
Definition of key terms	"Laboratory testing capacity" is defined as either in-country laboratory testing capacity, or access to international laboratories that can provide results within 72 hours.
Type	Outcome
Measurement	
Numerator	Number of Member States with COVID-19 laboratory test capacity
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of January 2020
Reporting frequency	To be updated once monthly in case additional countries have developed the capacity (i.e., to update any countries that had 'no' or 'no information/unknown'). To be reported the second week of each month with reference to the previous month.

Pillar 5 National laboratories

Percentage of countries scoring 100% on EQAP	
Rationale for use	Assess diagnostic capacity of countries
Definition of key terms	WHO's EQAP was established to improve the global laboratory capacity for the detection of both seasonal and avian influenza viruses by monitoring the quality and standards of performance of the National Influenza Centres. To ensure quality and reliability of results and to improve global laboratory diagnostic capacity, national public health laboratories testing for COVID-19 and reporting data to WHO through GISRS Flu Net and FluID are requested to participate in a WHO COVID-19 EQAP.[25] The score given to countries is based on the proportion of samples correctly identified (i.e., number of samples correctly identified over the total number of samples).
Type	Outcome
Measurement	
Numerator	Number of countries scoring 100% on EQAP
Denominator	All countries participating to EQAP for COVID-19
Scope	All countries (with PCR capacity)
Target	75%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Annual and after each EQAP

25 To access Operational Considerations for COVID-19 Surveillance Using GISRS (26 March 2020) see: https://apps.who.int/iris/bitstream/handle/10665/331589/WHO-2019-nCoV-Leveraging_GISRS-2020.1-eng.pdf

Pillar 5 National laboratories

Weekly number of persons tested for COVID-19, disaggregated by age group and sex[26]	
Rationale for use	Testing is a key component in the response effort as it allows prompt identification of cases, quick treatment, and immediate isolation to prevent spread.
Definition of key terms	A person tested for COVID-19 is a person who has been screened for the virus with nucleic acid amplification tests (NAAT), such as RT-PCR.
Type	Output
Measurement	
Numerator	Number of persons tested for COVID-19
Denominator	N/A
Scope	All countries with lab test capacity
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of April 2020
Reporting frequency	Weekly

26 Disaggregation by age group and sex is currently only available for confirmed cases and confirmed case deaths. It is under consideration for other indicators and may be added in the future as it becomes available.

Pillar 6 Infection prevention and control

Percentage of countries that have a national IPC programme and WASH standards within all health care facilities	
Rationale for use	IPC measures in health care facilities are central to ensure safety of health workers and patients. Early recognition of suspected patients allows for timely initiation of IPC, and early identification of those with severe manifestations allows for immediate optimized supportive care treatments and safe, rapid admission (or referral) to intensive care units, according to institutional or national protocols. To minimize the risk of onward transmission, clinical care should at all times adhere to optimum IPC practices.
Definition of key terms	An IPC programme should align with WHO Guidelines on Core Components of Infection Prevention and Control Programmes at the National and Acute Health Facility Level.[27]
Type	Process
Measurement	
Numerator	Number of countries which have an IPC programme and WASH standards within health care facilities
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Based on IHR State Party Self-Assessment Annual Reporting tool (SPAR) score for C 11/annually. Frequency could be increased as states might be required to monitor this aspect more frequently due to COVID-19.

27 Access Infection Prevention and Control during Health Care when COVID-19 is Suspected (19 March 2020) see: https://apps.who.int/iris/handle/10665/331495

Pillar 6 Infection prevention and control

Percentage of acute health care facilities with triage capacity	
Rationale for use	During infectious disease outbreaks, identifying and separating patients likely to be infected is particularly important to prevent and minimize infections of health care workers and of other patients. Health care facilities, therefore, need the required set up, infrastructure, and equipment to ensure IPC measures are implemented. Standard operating procedures to triage patients are available.[28]
Definition of key terms	Acute health care facilities are defined as settings used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention. The term acute care encompasses a range of clinical health care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care, and short-term inpatient stabilization.[29] According to the country national health system structure, acute health care facilities can include secondary, tertiary or field hospitals, public or private, with inpatient capacity that are expected to provide acute care in a given country. Triage is the sorting out and classification of patients to determine priority of need and proper place of treatment. Acuity-based triage is the standard method of sorting patients in the medical setting. A standard validated tool should be used to assess the severity of patients such as the Integrated Interagency Triage Tool.
Type	Outcome
Measurement	
Numerator	Number of acute health care facilities with triage capacity
Denominator	Number of health care facilities
Scope	Priority countries
Target	80%[30]
Data collection & reporting	
Data source	WHO – regional
Period covered	As of April 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

28 To access Operational Considerations for Case Management of COVID-19 in Health Facility and Community (18 March 2020) see: https://www.who.int/publications-detail/operational-considerations-for-case-management-of-COVID-19-in-health-facility-and-community

29 To access Guidelines on Core Components of Infection Prevention and Control Programmes at the National and Acute Health Care Facility Level (November 2010) see: https://www.who.int/gpsc/ipc-components-guidelines/en

30 Target may increase to 100% in the next three months.

Pillar 6 Infection prevention and control

Percentage of acute health care facilities[31] with isolation capacity	
Rationale for use	During infectious disease outbreaks, separating patients likely to be infected is particularly important to prevent and minimize infections of health care workers and of other patients. Health care facilities therefore need the required set up, infrastructure, and equipment to ensure IPC measures are implemented. Standard operating procedures to triage patients are available.[32]
Definition of key terms	Acute health care facilities are defined as settings used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention. The term acute care encompasses a range of clinical health care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care, and short-term inpatient stabilization.[33] According to the country national health system structure, acute health care facilities can include secondary, tertiary or field hospitals, public or private, with inpatient capacity that are expected to provide acute care in a given country. Isolation capacity is defined as the availability of single rooms and/or areas for cohorting appropriately equipped with personal protective equipment (PPE) for contact and droplet precautions.
Type	Outcome
Measurement	
Numerator	Number of acute health care facilities with isolation capacity
Denominator	Number of acute health care facilities
Scope	Priority countries
Target	80%[34]
Data collection & reporting	
Data source	WHO – regional
Period covered	As of April 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

31 In certain situations (e.g., due to high bed occupancy rate in acute healthcare facilities), physical space that complies with minimum requirements/standards of IPC and good practices for provision of care should be considered as a non-traditional setting or even part of the healthcare facility. In this sense, if a healthcare facility has a place to isolate a patient, even outside it's blueprint, it should be considered as part of the healthcare facility capacity.

32 To access Operational Considerations for Case Management of COVID-19 in Health Facility and Community (18 March 2020) see: https://www.who.int/publications-detail/operational-considerations-for-case-management-of-COVID-19-in-health-facility-and-community

33 To access Guidelines on Core Components of Infection Prevention and Control Programmes at the National and Acute Health Care Facility Level (November 2010) see: https://www.who.int/gpsc/ipc-components-guidelines/en/

34 Target may increase to 100% in the next three months.

Pillar 6 Infection prevention and control

Percentage of countries with Long-Term Care Facilities (LTCF) that have a national policy and/or guideline on IPC for COVID-19 in LTCF	
Rationale for use	LTCFs, such as nursing homes, are facilities that care for people who are care dependent due to physical or mental disability, some of whom are of advanced age. LTCFs are not present in all countries. Given the congregate nature and residents served (e.g., older adults with multiple medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. If infected, residents are at increased risk of serious illness and mortality. In countries where LTCFs exist, national policy and guidelines on IPC are essential to take special precautions to protect the older adults, employees, and visitors in the LTCF.[35]
Definition of key terms	An IPC national policy and guidelines should align with WHO Guidelines on Core Components of Infection Prevention and Control Programmes at the Long-Term Care Facility Level.
Type	Process
Measurement	
Numerator	Number of countries that have national policy and/or guidelines on IPC for the LTCF
Denominator	Total number of countries with LTCFs
Scope	All countries
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of January 2020
Reporting frequency	Annual

35 To access Infection Prevention and Control Guidance for Long-Term Care Facilities in the Context of COVID-19 (21 March 2020) see: https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf

Pillar 6 Infection prevention and control

Percentage of countries with a focal point for IPC training	
Rationale for use	IPC education and training should be a part of an overall health facility education strategy, including new employee orientation and the provision of continuous educational opportunities for existing staff, regardless of level and position (for example, senior administrative and housekeeping staff). A focal point for IPC training should promote the timely implementation of IPC training in the respective country.
Definition of key terms	A focal person for IPC training is in charge of the coordination and implementation of training on IPC in the country. Training includes sessions for Ministry of Health staff, health care workers at health facilities, training of trainers, etc. This position can be based in the national authorities or on one of the partners' teams.
Type	Output
Measurement	
Numerator	Number of countries with a focal point for IPC training
Denominator	Number of countries
Scope	Priority countries
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of April 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Pillar 6 Infection prevention and control

Number of health workers who have been trained in IPC in the previous week	
Rationale for use	IPC education and training should be a part of an overall health facility education strategy, including new employee orientation and the provision of continuous educational opportunities for existing staff, regardless of level and position (for example, senior administrative and housekeeping staff). This indicator monitors the provision of capacity building activities by WHO.
Definition of key terms	Training can be either in person or online (given the increasing reliance on remote/home working). If online, it should be part of a training programme/strategy developed by relevant actors, such as national government, national and international partners, individually or in collaboration. A list of invited participants should be available for online trainings, and a mechanism to confirm their participation to the training should exist. Open and publicly available webinars are not included. Health workers include both facility-based staff and community health workers.
Type	Output
Measurement	
Numerator	Number of health workers trained in IPC the previous week
Denominator	N/A
Scope	Priority countries
Target	N/A
Data collection & reporting	
Data source	UNICEF, WHO – regional (Health cluster as a possible secondary source on a monthly basis.)
Period covered	As of January 2020
Reporting frequency	Weekly

Pillar 7 Case management

Percentage of countries that have a clinical referral system in place to care for COVID-19 cases	
Rationale for use	Health facilities should be identified, equipped, and prepared to triage and treat cases of COVID-19. Early recognition of suspected patients allows for timely initiation of IPC, and early identification of those with severe manifestations allows for immediate optimized supportive care treatments and safe, rapid admission (or referral) to intensive care units, according to institutional or national protocols. For those with mild illness, hospitalization may not be required unless there is a concern for rapid deterioration.
Definition of key terms	A clinical referral system should outline how patients need to be managed and streamlined by the health care system (e.g., first points of contact for individuals, fever clinics, designated referral facilities, hotlines, as relevant in the national context).
Type	Outcome
Measurement	
Numerator	Number of Member States that have a clinical referral system in place to care for COVID-19 cases
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	WHO – regional
Period covered	As of January 2020
Reporting frequency	To be updated once monthly in case additional countries have developed capacity (i.e., to update any countries that had 'no' or 'no information/unknown'). To be reported the second week of each month with reference to the previous month.

Pillar 7 Case management

Percentage of confirmed hospitalized COVID-19 cases that are discharged	
Rationale for use	It can be used as a proxy for quality of care in hospitals treating COVID-19 cases and to detect patient flows.
Definition of key terms	This is the percentage of confirmed hospitalized COVID-19 cases who are discharged from health facilities amongst those confirmed patients admitted to the health facilities.
Type	Definition of discharged as per surveillance guidance.
Measurement	**Outcome**
Numerator	Monthly number of discharged COVID-19 confirmed cases
Denominator	Monthly number of confirmed hospitalized COVID-19 cases
Scope	All countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Pillar 7 Case management

Number of intensive care unit (ICU) beds provided to priority countries through Emergency Medical Teams (EMTs) or similar surge mechanism	
Rationale for use	This indicator works as proxy to assess the performance of EMTs.
Definition of key terms	An "ICU bed" is a specially designed bed for the patients in the intensive care unit. ICU beds are generally made of anti-bacterial or anti-microbial properties. This indicator counts the ICU beds provided by WHO/EMTs to priority countries.
Type	Input
Measurement	
Numerator	Number of ICU beds designated for COVID-19 that have been provided to priority countries
Denominator	N/A
Scope	Priority countries
Target	N/A
Data collection & reporting	
Data source	EMT
Period covered	As of April 2020
Reporting frequency	Monthly

Pillar 7 Case management

Number of health workers trained in case management of COVID-19 cases in the previous week	
Rationale for use	Training on case management of COVID-19 patients is key to reduce mortality. This indicator monitors the provision of capacity building activities by WHO.
Definition of key terms	Training can be either in person or online (given the increasing reliance on remote/home working). If online, it should be part of a training programme/strategy developed by relevant actors such as national government, national and international partners, individually or in collaboration. A list of invited participants should be available for online trainings, and a mechanism to confirm their participation to the training should exist. Open and publicly available webinars are not included.
Type	Output
Measurement	
Numerator	Number of health workers trained in case management of COVID-19 cases in the previous week
Denominator	N/A
Scope	Priority countries
Target	N/A
Data collection & reporting	
Data source	WHO, UNICEF – regional
Period covered	As of January 2020
Reporting frequency	Weekly

Pillar 8 Operational support and logistics

Number and percentage of medical masks (3 plies) provided by WHO against country request	
Rationale for use	Focuses on capacity to deploy supplies to countries during the event.
Definition of key terms	Medical masks (3 plies) are one of the components of PPE and are used as a tracer indicator.
Type	Input
Measurement	
Numerator	Number of medical masks (3 plies) provided by WHO to a country
Denominator	Number of medical masks (3 plies) requested by the same country
Scope	Priority countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of April 2020
Reporting frequency	Weekly

Pillar 8 Operational support and logistics

Number and percentage of laboratory tests provided against country request	
Rationale for use	Focuses on capacity to deploy supplies to countries during the event.
Definition of key terms	Laboratory tests include both laboratory confirmatory and laboratory screening equipment.
Type	Input
Measurement	
Numerator	Number of laboratory tests provided to a country
Denominator	Number of laboratory tests requested by the same country
Scope	Priority countries
Target	N/A
Data collection & reporting	
Data source	WHO – global
Period covered	As of April 2020
Reporting frequency	Weekly

Pillar 9 Maintaining essential health services and systems

DTP3 vaccination coverage in children under 12 months of age	
Rationale for use	Monitoring the coverage of key childhood vaccination coverage can provide insights on the impact of COVID-19 on health system capacity to maintain routine health services. Diphtheria-Tetanus-Pertussis vaccine (DTP) coverage is a widely used measure of the performance of routine vaccine delivery systems. Dose-specific vaccination coverage can be used to monitor initial engagement with the vaccine delivery system (first dose), and completion of the vaccination series (third dose, DTP3).
Definition of key terms	DTP3 is the third dose of the DTP vaccine given to children under 12 months of age.
Type	Outcome
Measurement	
Numerator	Number of children under the age of 12 months who received the third dose of DTP vaccine during the month
Denominator	Estimated population under the age of 12 months in the areas from which numerator is provided (* the number of months in the numerator/12)
Scope	All countries
Target	Depending on data availability, the following analyses can be conducted: • Trend analysis of the monthly number of children vaccinated (i.e., evolution of the numerator only). Need to consider whether other factors, such as population displacement, could explain a change in the number of vaccinated children; • Comparison of the vaccination coverage with the coverage reported in the same areas in the same month in the previous year (when denominator is available); • Comparison of the vaccination coverage with the average coverage reported in the same areas in the same month in the past three years (when both denominator and historical data are available).
Data collection & reporting	
Data source	WHO – global and regional
Period covered	As of January 2020
Reporting frequency	Monthly/Quarterly

Pillar 9 Maintaining essential health services and systems

Institutional delivery	
Rationale for use	Deliverers in health facilities can ensure that women are attended by skilled personnel, which is an important factor in reducing maternal mortality in resource-poor settings. Monitoring the number of facility-based deliveries can provide insights into the impact of COVID-19 on health system capacity to provide routine services.
Definition of key terms	Deliveries in health facility are childbirths that occur in a health facility and exclude deliveries that occur at home.
Type	Outcome
Measurement	
Numerator	Number of deliveries that occur in a health facility in a country
Denominator	Expected number of deliveries in the same country (annual births * the number of months in the numerator/12)
Scope	Priority countries
Target	Depending on data availability, the following analyses can be conducted: • Trend analysis of the monthly number of facility-based deliveries (i.e., evolution of the numerator only). Need to consider whether other factors, such as population displacement, could explain a change in the number of deliveries; • Comparison of the institutional delivery coverage with the coverage reported in the same areas in the same month in the previous year (when denominator is available); • Comparison of the institutional delivery coverage with the average coverage reported in the same areas in the same month in the past three years (when both denominator and historical data are available).
Data collection & reporting	
Data source	WHO – global and regional
Period covered	As of January 2020
Reporting frequency	Monthly/Quarterly

Pillar 9 Maintaining essential health services and systems

Essential health services during COVID pandemic	
Rationale for use	To assess status of essential services.
Definition of key terms	For the definition, access guidance on COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak.[36]
Type	Outcome
Measurement	
Numerator	Number of Member States that have defined the set of core essential services to be maintained during the COVID-19 pandemic
Denominator	All Member States
Scope	Global
Target	100%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Annual/Quarterly, where applicable

36 To access COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak see: https://www.who.int/publications-detail/COVID-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak

Pillar 9 Maintaining essential health services and systems

Percentage of countries where at least one VPD-immunization campaign was affected (suspended or postponed partially or fully) by COVID-19	
Rationale for use	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).
Definition of key terms	Included VPD mass campaigns are those for measles and rubella, Td, bOPV, mOPV2, YF, TCV, OCV, and Men A.
Type	Outcome
Measurement	
Numerator	Number of countries where at least one planned VPD vaccination campaign was postponed or suspended, either fully or partially, because of COVID-19
Denominator	Number of priority countries
Scope	Priority countries
Target	0
Data collection & reporting	
Data source	Measles IMST at WHO/IVB repository
Period covered	As of January 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

Cross-cutting issues

Percentage of countries with multi-sectoral mental health and psychosocial support technical working group	
Rationale for use	The burden of the COVID-19 pandemic and related response measures on the mental and psychosocial status of affected communities is significant. Mental health and psychosocial support (MHPSS) should be a core component of any public health response and needs to be integrated across sectors to become an integral component of their services, approaches, and strategies.
Definition of key terms	MHPSS refers to any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions.[37] A multi-sectoral MHPSS technical working group refers to initiatives that aim to strengthen MHPSS coordination between MHPSS agencies, governments, and other partners and to ensure integration of MHPSS technical expertise into health services, as well as approaches and activities in other relevant sectors. MHPSS should be considered as a cross-cutting issue amongst all sectors/pillars involved in the response.
Type	Output
Measurement	
Numerator	Number of priority countries with a multi-sectoral MHPSS technical working group
Denominator	Priority countries
Scope	Priority countries
Target	100%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Monthly. To be reported the second week of each month with reference to the previous month.

37 To access the Inter-Agency Standing Committee Interim Briefing Note: Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak, Version 1.5 (February 2020) see: https://bit.ly/2S1Z7c0

Cross-cutting issues

Percentage of countries that have national occupational safety and health plans or programme for health workers	
Rationale for use	Occupational health is part of the WHO Emergency Response Framework, as the assessment and control of occupational risks to health workers and responders for protecting their health, safety, and well-being is central for safe and effective emergency response. Occupational health complements IPC measures with protection from other biological, physical, chemical, and psycho-social hazards and providing health surveillance, vaccinations, and psychosocial support to health workers and responders. WHO has also duty of care to countries to provide technical advice and assist them to build capacities to protect health, safety, and well-being of all health workers and responders (local and international).[38]
Definition of key terms	An occupational safety and health plan or policy is a document outlining the national policy or programme on occupational risks, prevention, and response strategies, and mechanisms to implement such strategies.
Type	Process
Measurement	
Numerator	Number of Member States that have national occupational safety and health plans or programmes for health workers
Denominator	All Member States
Scope	All countries
Target	100%
Data collection & reporting	
Data source	WHO – global
Period covered	As of January 2020
Reporting frequency	Annual

38 To access COVID-19 Occupational Health (8 March 2020) see: https://www.who.int/news-room/detail/09-03-2020-COVID-19-for-health-workers

To access Occupational Safety and Health in Public Health Emergencies: A Manual for Protecting Health Workers and Responders (1 January 2018) see: https://www.who.int/publications-detail/occupational-safety-and-health-in-public-health-emergencies-a-manual-for-protecting-health-workers-and-responders

ANNEX 2: LIST OF PRIORITY COUNTRIES

Priority countries are defined as countries affected by the COVID-19 pandemic currently with a Humanitarian Response Plan (HRP) as defined by the GHRP.

Countries prioritized in the first GHRP, March 2020

In its first iteration launched on 25 March 2020, the GHRP prioritised all countries with: ongoing HRPs, regional Refugee Response Plans (RRPs), the Regional Refugee and Resilience Plan (3RP) for the Syria crisis, the Regional Refugee and Migrant Response Plan (RMRP) for the Venezuela crisis, and the Joint Response Plan for the Rohingya Humanitarian Crisis (JRP). These countries were considered a priority due to prevailing humanitarian needs and pre-existing low national response capacity. The Islamic Republic of Iran was added in view of the scale and severity of the outbreak and government appeal for international assistance.

- **Countries with HRPs:** Afghanistan, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Colombia, Democratic Republic of the Congo, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, Occupied Palestinian Territory, Somalia, South Sudan, Sudan, Syrian Arab Republic, Ukraine, Venezuela, and Yemen.
- **Countries with RRPs:** Angola, Burundi, Cameroon, Chad, Democratic Republic of the Congo, Egypt, Iraq, Jordan, Kenya, Niger, Nigeria, Lebanon, Congo, Rwanda, South Sudan, Syrian Arab Republic, Uganda, United Republic of Tanzania, Turkey, and Zambia.
- **Venezuela RMRP:** Argentina, Aruba,[39] Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao,[39] Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay.
- **Others:** Bangladesh (JRP), Democratic People's Republic of Korea, and Iran.

Countries included in the updated GHRP, May 2020

The Inter-Agency Standing Committee expanded the definition of priority countries based on the impact of the outbreak on affected people's ability to meet their essential needs, considering other shocks and stresses (e.g., food insecurity), the capacity of the government to respond, and the possibility to benefit from other sources of assistance from development plans and funding. Criteria included were:

- COVID-19 risk analysis based on vulnerability (transmission and epidemic risk factors) and response capacity (institutional capacities; access to water, sanitation and hygiene services; and access to health care) to the pandemic;
- Low income country status;
- Existing humanitarian concerns,[40] despite the absence of an ongoing humanitarian plan;
- Countries part of the Regional Migrant Response Plan for the Horn of Africa;
- Existing shocks or stresses, such as food insecurity, displacement, high number of migrants in-country or in transit.

In addition to the 54 priority countries listed above, the following nine countries, plus one country part of the Regional Migrant Response Plan for the Horn of Africa, are considered as a priority in the GHRP: Benin, Djibouti (part of the RMRP[41]), Eritrea, Liberia, Mozambique, Pakistan, Philippines, Sierra Leone, Togo, and Zimbabwe.

In addition, the following nine countries or sub-groups are considered at risk and "to watch:" Côte d'Ivoire, Guinea, Kenya, Malawi, Northern Triangle of Central America (El Salvador, Guatemala, and Honduras), Papua New Guinea, TimW or-Leste, Small Island Developing States in the Caribbean and the Pacific, and Uganda.

39 Netherlands

40 Existing humanitarian concerns were proxied by the designation and presence of a Humanitarian Coordinator in-country.

41 Ethiopia, Somalia, and Yemen are also part of the RMRP for the Horn of Africa, but are already prioritised as they have ongoing HRPs.

Priority countries as of 30 April 30 2020

Country	HRP	RRP	Venezuela RMRP	Other plans	May GHRP update
Afghanistan	x				
Angola		x			
Argentina			x		
Aruba			x		
Bangladesh				x	
Benin					x
Bolivia (Plurinational State of)			x		
Brazil			x		
Burkina Faso	x				
Burundi	x	x			
Cameroon	x	x			
Central African Republic	x				
Chad	x	x			
Chile			x		
Colombia	x		x		
Congo		x			
Costa Rica			x		
Curaçao			x		
Democratic People's Republic of Korea				x	
Democratic Republic of the Congo	x	x			
Djibouti					x
Dominican Republic			x		
Ecuador			x		
Egypt		x			
Eritrea					x
Ethiopia	x				
Guyana			x		
Haiti	x				
Iran (Islamic Republic of)				x	
Iraq	x	x			
Jordan		x			
Kenya		x			

Priority countries as of 30 April 30 2020 (continued)

Country	HRP	RRP	Venezuela RMRP	Other plans	May GHRP update
Lebanon		x			x
Liberia					x
Libya	x				
Mali	x				
Mexico			x		
Mozambique					x
Myanmar	x				
Niger	x	x			
Nigeria	x	x			
Occupied Palestinian Territory	x				
Panama			x		
Pakistan					x
Paraguay			x		
Peru			x		
Philippines					x
Rwanda		x			
Sierra Leone					x
Somalia	x				
South Sudan	x	x			
Sudan	x				
Syrian Arab Republic	x	x			
United Republic of Tanzania		x			
Togo					x
Trinidad and Tobago			x		
Turkey		x			
Uganda		x			
Ukraine	x				
Uruguay			x		
Venezuela (Bolivarian Republic of)	x				
Yemen	x				
Zambia		x			
Zimbabwe					x

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