International Health Regulations (2005)

States Parties Self-assessment annual reporting tool

Second Edition

World Health Organization

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CONTENTS

ACRONYMS iv

INTRODUCTION 1
- The SPAR tool 2
- Processing of data 2
- e-SPAR electronic platform for online reporting 2

RESPONDING THE SELF-ASSESSMENT AND REPORTING QUESTIONNAIRE 3
- Respondent identification 3
- Completion of annual report 3
- Reporting level of capacities using indicators and its attributes 4
- List of capacities and indicators 5
- Questionnaire for reporting the level of capacities 6
- C1. Policy, legal and normative Instruments to implement IHR 6
- C2. IHR Coordination, National IHR Focal Point functions and advocacy 8
- C3. Financing 11
- C4. Laboratory 13
- C5. Surveillance 18
- C6. Human resources 20
- C7. Health emergency management 22
- C8. Health services provision 25
- C9. Infection prevention and control (IPC) 28
- C10. Risk communication and community engagement (RCCE) 32
- C11. Points of entry (PoEs) and border health 36
  - Section 1. Information by type of PoE 36
  - Section 2. Core capacities at PoEs and international travel-related measures 36
- C12. Zoonotic diseases 40
- C13. Food safety 42
- C14. Chemical events 44
- C15. Radiation emergencies 46

ANNEX 1. IMPROVEMENTS TO THE SPAR SECOND EDITION (2021) 48

ANNEX 2. EXAMPLES OF SELECTING LEVELS FOR CAPACITIES AND ITS INDICATORS 52

ANNEX 3. EXAMPLES OF THE USE OF COMMENT BOXES FOR INDICATORS AND CAPACITIES 53

ANNEX 4. GLOSSARY: WORKING DEFINITIONS 54

ACRONYMS

AAR	After Action Review
AMR	Antimicrobial resistance
EHS	Essential health services
EOC	Emergency operation centre
HCAI	Health care acquired infections
IAEA	International Atomic Energy Agency
IAR	Intra-action review
IATA	International Air Transport Association
ICAO	International Civil Aviation Organization
IHR	International Health Regulations (2005)
INFOSAN	International Food Safety Authorities Network
IPC	Infection prevention and control
NFP	National IHR Focal Point
PHEIC	Public health emergency of international concern
PoE	Point of entry
RCCE	Risk communication and community engagement
SimEx	Simulation exercise
SOP	Standard operating procedure
SPAR	States Parties self-assessment annual reporting
SSC	tool Ship Sanitation Certi icates
SSCC	Ship Sanitation Control Certificate
SSCEC	Ship Sanitation Control Exemption Certificate
WASH	Water, sanitation and hygiene
WHO	World Health Organization

INTRODUCTION

Under the International Health Regulations (2005) – known as the IHR[a] – States Parties are obliged to develop and maintain minimum core capacities for surveillance and response, including at points of entry into their territory, in order to detect, assess, notify and respond to any potential public health events of international concern.

Article 54 of the IHR requests States Parties and the Director-General of WHO to report to the World Health Assembly on the implementation of the Regulations. In 2008, the Health Assembly, through the adoption of Resolution WHA61(2) – and in 2018 through Resolution WHA71(15) – confirmed that "States Parties and the Director-General shall continue to report annually to the WHA on the implementation of the International Health Regulations (2005), using the self-assessment annual reporting tool".

This IHR States Parties self-assessment annual reporting tool (SPAR) is intended to support States Parties to fulfil these obligations. The submission of IHR annual reports using the SPAR tool allows WHO's Secretariat to compile a consistent report for the World Health Assembly.

a Available at: https://www.who.int/publications/i/item/9789241580496.

THE SPAR TOOL:

The annual report questionnaire used by States Parties from 2010 to 2017 was revised in 2018, with changes to the format, capacities and indicators. This version – renamed the States Parties self-assessment annual reporting tool (SPAR) – was used for reporting from 2018 to 2020.

Beginning in 2021 the SPAR was reviewed and further improved, taking account of the initial experience of countries to the COVID-19 pandemic. Although they improve the tool, these changes may limit comparison with scores from previous years. However, they will contribute to a better understanding of the strengths and gaps in preparedness on the basis of global experience of the COVID-19 pandemic. The second edition of SPAR (2021) contains 15 capacities and 35 indicators compared to 13 capacities and 24 indicators in the first edition. Details of the changes are contained in Annex 1.

The SPAR IHR annual report database is generated from information received from States Parties based on their national self-assessment and self-reporting. For that purpose WHO has made available an electronic platform for online reporting, known as e-SPAR.[b]

Exceptionally, standardized interactive PDF and Excel forms (an Excel file is used to share specific detailed data on identified/designated ports, airports and ground crossings) may be used when it is difficult to access the Internet. Submission of States Parties' annual reports in other formats will be considered as a submission of an annual report to the Health Assembly but cannot be considered for statistics of capacities since it will not allow the WHO Secretariat to analyse the data in a standardized manner.

PROCESSING OF DATA

WHO receives the data sent from each State Party by the designated National IHR Focal Point (NFP) or designated officers who have access to the e-SPAR page for online reporting. After submission of data by States Parties, WHO acknowledges receipt and reviews all data received, in coordination with WHO Regional and Country Offices, and produces a global report to be submitted for adoption by the World Health Assembly. All data are recorded safely in the e-SPAR platform and are available through the e-SPAR webpage.

Production of statistics by WHO is described below.

Indicator level:
The e-SPAR tool is based on the assessment of a level of performance for each of the indicators on a scale of 1–5. When processed, the score of each indicator level is classified as a percentage of performance along the 1–5 scale. For example, for a country selecting level 3 for indicator 2.1, the level of performance is expressed as: 3/5 x 100 = 60%).

Capacity level:
Performance at the capacity level is expressed as the average of the indicators related to this capacity. For example, for a country selecting level 3 for indicator 2.1 and level 4 for indicator 2.2, the level of performance of capacity 2 is expressed as: [(3/5 x 100) + (4/5 x 100)]/ 2 = 70%).

E-SPAR ELECTRONIC PLATFORM FOR ONLINE REPORTING

The e-SPAR electronic platform is available in all six United Nations official languages (Arabic, Chinese, English, French, Russian and Spanish), with statistical reports, data analysis (with maps, graphs, tables, PDF and Excel files), important links, references, manuals, videos and interactive tutorials.

To ensure that each State Party has IHR-NFP access to the restricted part of e-SPAR, inclusive of online reporting and access to detailed information from all annual reports since 2010, the designated national authorities responsible for IHR annual reporting are requested to update their contact details in the WHO contact list for NFPs, as appropriate, by contacting the WHO Secretariat (ihradmin@who.int). Once contact details have been verified and added to the WHO IHRADMIN database, the designated officer is granted access to e-SPAR and is able to consult all existing data of the State Party and to initiate and submit new reports.

For online reporting, the e-SPAR contains automatic checks and pop-up alerts to help avoid potential errors in data entry before submission on the e-SPAR public page at: https://extranet.who.int/e-spar/.

For any further information about the SPAR tool, users can send an email to ihrmonitoring@who.int.

b Available at: https://extranet.who.int/e-spar/.

RESPONDING THE SELF-ASSESSMENT AND REPORTING QUESTIONNAIRE

This section describes the different steps for use of the online version of the SPAR

RESPONDENT IDENTIFICATION

Respondents must identify themselves according to the information fields below

Date of report	
State Party	Choose a country
Name of the contact officer completing this report	
Title of the contact officer completing this report	
E-mail address of the contact officer completing this report	
Telephone number of the contact officer completing this report	

COMPLETION OF THE ANNUAL REPORT

Respondent is requested to identify who contributed to the compilation of this report, the sectors involved and the consultative process followed to collect and gather the information.

1. Compiled by:

- ❑ An individual Government official
- ❑ Officials representing several sectors

2. Sectors involved in compiling report:

- ❑ human health
- ❑ animal health
- ❑ agriculture
- ❑ disaster management
- ❑ food safety
- ❑ livestock
- ❑ fisheries
- ❑ trade
- ❑ International transport /point of entry
- ❑ tourism/travel
- ❑ emergency services
- ❑ environment
- ❑ finance
- ❑ chemical safety
- ❑ radiation safety
- ❑ labour
- ❑ education
- ❑ foreign affairs
- ❑ Civil Society
- ❑ Other sectors

3. Consultative process in compiling report:

- ❑ Via e-mail
- ❑ Face-to-face meeting
- ❑ Virtual meeting
- ❑ Other

Please provide information on any SimEx, IAR and/or AAR conducted during the reporting period.

4. Simulation exercises (SimEx), Intra-action reviews (IAR) and After-action reviews (AAR):

Has your country conducted a SimEx, an IAR or an AAR this year? If so, kindly check the relevant box(es) below:

- ❑ SimEx
- ❑ AAR
- ❑ IAR

If you are willing to share the findings from the above activities with WHO (for internal use only), please send them to: cer@who.int

REPORTING LEVEL OF CAPACITIES USING INDICATORS AND THEIR ATTRIBUTES

The SPAR tool covers 15 capacities, each of which consists of 1–5 indicators, with a total of 35 indicators. Each indicator is graded into five levels, corresponding to a continuum from limited to consolidated performance in the area indicated. Actions associated with each level and named attributes are described. Explanatory notes are provided as footnotes, as necessary. Further information is also available in Annex 1 – "Improvements to the SPAR Second edition (2021)".

Only one level of performance can be selected for each indicator, and that level should be the one that best describes the State Party's implementation status. All attributes associated with a level must be in place in order to consider the next level. For example, it is a prerequisite to comply with all attributes of Level 1 in order to examine the attributes in Level 2. If Level 2 is selected, this indicates that all attributes of Level 1 and Level 2 are fulfilled. See Annex 2 for examples of how to select levels for capacities.

It is recommended to respond to all indicators, even if the final report will provide data at the capacity level. If no level is selected, this is regarded as the absence of performance. In this case, a score of zero will be associated with the statistics of this indicator, which will have an impact on the result for capacity.

If capacity is not applicable within a country context, all the checkboxes for that indicator should be left blank. The comment box should indicate "not applicable" and any clarifications needed should be added in the comment box provided below each indicator. Other additional comments or contributions, including actions planned or ongoing to improve performance or help plan and monitor progress of the implementation, can also be added. See Annex 3 for examples of the use of comment boxes.

.

LIST OF CAPACITIES AND INDICATORS

C1. Policy, legal and normative instruments to implement IHR
- C1.1. Policy, legal and normative instruments
- C1.2. Gender equality in health emergencies

C2. IHR coordination and National IHR Focal Point
- C2.1. National IHR Focal Point functions
- C2.2. Multisectoral coordination mechanisms
- C2.3. Advocacy for IHR implementation

C.3. Financing
- C3.1. Financing for IHR implementation
- C3.2. Financing for public health emergency response

C4. Laboratory
- C4.1. Specimen referral and transport system
- C4.2. Implementation of a laboratory biosafety and biosecurity regime
- C4.3. Laboratory quality system
- C4.4. Laboratory testing capacity modalities
- C4.5. Effective national diagnostic network

C5. Surveillance
- C5.1. Early warning surveillance function
- C5.2. Event management

C6. Human resources
- C6.1. Human resources for implementation of IHR
- C6.2. Workforce surge during a public health event

C7. Health emergency management
- C7.1. Planning for health emergencies
- C7.2. Management of health emergency response
- C7.3. Emergency logistic and supply chain management

C8. Health services provision
- C8.1 Case management
- C8.2 Utilization of health services
- C8.3 Continuity of essential health services (EHS)

C9. Infection prevention and control (IPC)
- C9.1. Infection prevention and control programmes
- C9.2 Health care-associated infections (HCAI) surveillance
- C9.3 Safe environment in health facilities

C10. Risk communication and community engagement (RCCE)
- C10.1. RCCE system for emergencies
- C10.2. Risk communication
- C10.3. Community engagement

C11. Points of entry (PoEs) and border health
Section 1. Information by type of PoE
Section 2. Core capacities at PoEs and international travel-related measures
- C11.1. Core capacity requirements at all times for PoEs (airports, ports and ground crossings)
- C11.2. Public health response at PoEs
- C11.3. Risk-based approach to international travel-related measures

C12. Zoonotic diseases
- C12.1. One Health collaborative efforts across sectors on activities to address zoonoses

C13. Food safety
- C13.1. Multisectoral collaboration mechanism for food safety events

C14. Chemical events
- C14.1. Resources for detection and alert

C15. Radiation emergencies
- C15.1 Capacity and resources

QUESTIONNAIRE FOR REPORTING THE LEVEL OF CAPACITIES

C1. POLICY, LEGAL AND NORMATIVE INSTRUMENTS TO IMPLEMENT IHR[1]

States Parties should have a legal framework in all relevant sectors[2] that is adequate to support and facilitate the effective and efficient implementation of all their obligations and rights under the IHR. In some States Parties, IHR implementation may require new or modified legal instruments. Even where new or revised legal instruments may not be specifically required under a State Party's legal system, States Parties may still choose to revise some legislation, regulations or other instruments to facilitate their implementation and maintenance of the IHR in a more efficient, effective or beneficial manner. Through legal frameworks, the IHR should serve to institutionalize and strengthen essential public health functions in order to sustain improvements in overall health system capacities. Policies for adopting health measures and IHR implementation should follow IHR principles (IHR Article 3). The policies should be applied in a transparent and non-discriminatory manner and should reflect the principle of gender equality.[3]

	Indicators	
Level	**C1.1. Policy, legal and normative instruments[4]**	
Level 1	The country has not conducted a mapping[5] of relevant legal and normative instruments and policies for IHR implementation	❑
Level 2	The country has conducted a legal analysis (e.g., a legal mapping and assessment) of relevant legal and normative instruments and policies for IHR implementation at the national and subnational levels and documented, where applicable	❑
Level 3	The country has identified and reviewed gaps in the health sector and developed and/or revised the necessary legal and normative instruments and policies for IHR implementation at the national and subnational levels, where applicable	❑
Level 4	The country has identified and reviewed gaps in all sectors and across government levels[6] and developed and/or revised the necessary legal and normative instruments and policies for IHR implementation at the national and subnational levels, where applicable	❑
Level 5	The country has identified and reviewed gaps in all sectors and across government levels and developed and/or revised the necessary legal and normative instruments and policies for IHR implementation in all sectors and across government levels, which are regularly evaluated and improved based on lessons learned from real-world events and exercises (as applicable)	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

1 Questions on these should be answered by legal or legislative advisers, policy experts at the Ministry of Health or other relevant ministries with supporting evidence and documents. These include strategies and national plans to support the implementation of IHR capacities.

2 All sectors including human health, animal health, agriculture, disaster management, food safety, livestock, fisheries, trade, international transport/points of entry, emergency services, environment, finance, chemical safety, radiation safety, labour, education, foreign affairs, civil society and other sectors.

3 For the purposes of this report, "gender equality" is defined as follows: "Refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity – or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities." See the Glossary in Annex 4.

4 Legal instruments (e.g. constitutions, legislation, arrêté, decrees, regulations, administrative requirements and applicable international agreements).

5 Legal mapping helps in understanding what a legal instrument says. Mapping provides a look at legal instruments across jurisdictions and/or a review of legal instruments within a jurisdiction to understand how public health risks are addressed. Legal mapping involves the review and documentation of what legal authorities exist, what those authorities do or provide, and what they do not provide. Legal mapping is an objective activity. The process does not intend to evaluate the effectiveness of a legal instrument, nor analyse its gaps. In the context of this indicator, legal mapping supports and facilitates the development, implementation and strengthening of preparedness for and response to public health risks – in accordance with Article 1 of IHR (2005) – a likelihood of an event that may adversely affect the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger. This process is complemented by a legal assessment, as a functional review to evaluate the effectiveness of legal instruments, analysing gaps with the country's legal system and context in mind.

6 This should be at national, intermediate and local levels, as appropriate to the structure of the country.

	Indicators	
Level	**C1.2. Gender Equality in health emergencies**	
Level 1	No systematic assessment of gender gaps[7] in any of the IHR capacities has been conducted	❑
Level 2	Systematic assessment[8] of gender gaps has been conducted in at least one IHR capacity	❑
Level 3	An action plan[9] to address identified high priority[10] gender gaps in at least one IHR capacity is developed and incorporated in annual workplans	❑
Level 4	The developed action plan(s) to address at least one IHR capacity is funded and being implemented, with mechanisms in place for monitoring, evaluation and reporting	❑
Level 5	Systematic gender analysis of IHR capacities is conducted, and action plans to address gender gaps and inequalities are developed, funded and operationalized in at least three IHR capacities, with mechanisms in place for monitoring, evaluation and reporting	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

7 "Gender gaps": For the purpose of this document refers to sex-based and gender-based differentials or gender inequalities. Thus gender gaps here refer to differences between men and women that can arise because of biological, socioeconomic or sociocultural reasons.

8 In this report, "gender systematic assessment" refers to "evidence-based identification of a gender gap in order to understand the causes of that gender gap (sometimes referred to as gender analysis). Without knowing the causes of gender inequality it is not possible to develop an action plan to address it. Assessments can be done using secondary analysis of available data and research where possible, as well as with novel research. For further guidance see the following document: Gender mainstreaming for health managers: a practical approach. Participant's notes. Geneva: World Health Organization; 2011 (https://www.who.int/publications/i/item/9789241501057).

9 "Gender action plan" Refers to a planning document that includes: activity(ies) that will be undertaken to address identified and assessed gender gap(s); indicators to assess progress in closing each gender gap; data and measures required to track shifts in each indicator; training and (human and institutional) capacity requirements and how these will be met; an estimated line-item budget; and a timeline.

10 "Gender high priority gaps" refers to sex and gender gaps that are assessed in order to: 1. inhibit implementation effectiveness;, 2. potentially affect a large proportion of the population of the disadvantaged sex (women and girls, or men and boys); and 3. act as a constraint onto effective and full preparedness and response that the whole population can access. On the basis of the gender analysis conducted, each country will determine which elements of gender inequalities are high priority, with due consideration given to the differences in sociocultural contexts and gender norms across countries.

C2. IHR COORDINATION, NATIONAL IHR FOCAL POINT FUNCTIONS[11] AND ADVOCACY

To establish and maintain IHR capacities requires collaboration between all relevant sectors, ministries, agencies or other government bodies responsible for aspects of the implementation of IHR capacities at the national, intermediate and local levels. Depending on the country and its capacity, all relevant sectors may include: human health, animal health, agriculture, environment, food safety, livestock, fisheries, finance, transport, trade, points of entry, transport, travel, chemical safety, radiation safety, disaster management, emergency services, regulatory bodies, labour, education, foreign affairs, international treaties and conventions, and the media. Collaboration may also include sectors and agencies responsible for non-key aspects of various capacities, such as private stakeholders (industry, medical associations, farmers' associations) and academia. It is recommended that key members of the multisectoral, multidisciplinary coordination mechanism are gender-diverse. Advocacy and coordination are fundamental to this multisectoral approach in order to bring together all the relevant sectors and to ensure that they recognize that risks to human health can emerge from various sources – such as other humans, domestic animals/livestock, wildlife, food, chemicals and/or radiation. Therefore, all relevant sectors should have capacity to prevent, detect, report and respond to events or public health risks.

The NFP designated by each State Party is the national centre for IHR communications, including notification of events[12], with WHO regional IHR contact points and all relevant sectors and bodies in the country. States Parties should provide their NFP with the necessary authority, capacity, training and resources (e.g. competent staff, adequate finances) to carry out the functions required of them by the IHR. States Parties should provide WHO with contact details of the NFP and should continuously update and annually confirm these contact details.

The updated contact details will allow designated national officers to sign into the e-SPAR platform, proceed with the online reporting and access all national information about IHR annual reporting.

	Indicators	
Level	**C2.1. National IHR Focal Point functions**	
Level 1	The terms of reference describing the roles and responsibilities[13] of the established IHR National Focal Point are not in place or under development and represented by one individual who is entirely familiar with the mandatory National Focal Point functions under the IHR but lacks the authority, capacity and resources to effectively carry out these functions, including the around-the-clock accessibility	❑
Level 2	National IHR Focal Point is a designated centre and has a duty officer system to ensure accessibility at all times for urgent communications with WHO but legal, normative and institutional instruments and arrangements, including terms of reference describing the roles and responsibilities, are insufficient to communicate effectively with all levels and relevant sectors of the State Party's administration	❑
Level 3	National IHR Focal Point is a designated centre and has a clear legal and governmental mandate, with terms of reference describing the roles and responsibilities, is sufficiently organized, resourced and accessible at all times to communicate with WHO, but intersectoral collaboration and communication are inadequate to consolidate surveillance information or to obtain clearance from decision-makers in other domestic sectors	❑
Level 4	National IHR Focal Point is a centre sufficiently organized, resourced and positioned within the government with levels of authority and institutional arrangements and instruments to access the relevant information sources and decision-making level within the national surveillance and response system	❑
Level 5	National IHR Focal Point is a centre appropriately organized, positioned, trained and equipped with adequate levels of authority, efficient communication channels as well as administrative, human, technological, and financial resources to meaningfully engage with all relevant sectors and carry out the function as by IHR provisions and its functioning is exercised, reviewed, evaluated and updated on a regular basis and actions have been taken to strengthen and maintain its capacities	❑

11 The functions of National IHR Focal Points shall include: (a) sending to WHO IHR Contact Points, on behalf of the State Party concerned, urgent communications concerning the implementation of these Regulations, in particular under Articles 6 to 12; and (b) disseminating information to, and consolidating input from, relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments. See more in the appendix of IHR National Focal Point guide. Designation/establishment of National IHR Focal Points. Geneva, World Health Organization (https://www.who.int/publications/m/item/designation-establishment-of-national-ihr-focal-points).

12 See: IHR Article 6. Each State Party shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern (PHEIC) within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events. If the notification received by WHO involves the competency of the International Atomic Energy Agency (IAEA), WHO shall immediately notify the IAEA.

13 A National IHR Focal Point (NFP) is a national center, designated by each State Party, which is accessible at all times (7/24/365) for communications with WHO IHR Contact Points. Terms of reference for National IHR Focal Points can be considered mandatory components: 1) Remaining accessible at all times for communications with WHO IHR Contact Points. 2) On behalf of the State Party concerned, sending to WHO IHR Contact Points urgent communications arising from IHR implementation, in particular under Articles 6-12 of IHR(2005). 3) Disseminating information to relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments. 4) Consolidating input from relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments. See National IHR Focal Point guide. Designation/establishment of National IHR Focal Points. Geneva, World Health Organization (https://www.who.int/publications/m/item/designation-establishment-of-national-ihr-focal-points).

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

	Indicators	
Level	**C2.2. Multisectoral coordination mechanisms**	
Level 1	Multisectoral coordination mechanisms for IHR implementation are not in place or under development. Multisectoral coordination activities occur in ad hoc basis	❑
Level 2	Multisectoral coordination mechanisms for IHR implementation are developed but not disseminated. Multisectoral coordination activities occur in ad hoc basis	❑
Level 3	Multisectoral coordination mechanisms for IHR implementation are in place, disseminated and are being implemented at national level	❑
Level 4	Multisectoral coordination mechanisms for IHR implementation are in place, disseminated and are being implemented at national and intermediate levels	❑
Level 5	Multisectoral coordination mechanisms for IHR implementation are being implemented at all levels, and are exercised, reviewed, evaluated and updated on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

	Indicators	
Level	**C2.3. Advocacy[14] for IHR implementation**	
Level 1	Advocacy mechanisms[15] for IHR implementation are not in place or under development. Advocacy activities are conducted on ad hoc basis	❑
Level 2	The advocacy mechanisms are developed but not disseminated. Advocacy activities are conducted on ad hoc basis	❑
Level 3	The advocacy mechanisms are in place, disseminated and being implemented at the national level	❑
Level 4	The advocacy mechanisms are in place, disseminated and being implemented at the national and intermediate levels	❑
Level 5	The advocacy mechanisms are implemented at all levels in a multisectoral and whole of society approach. Mechanisms are exercised, reviewed, evaluated and updated on a regular basis at national, intermediate and local levels based on best practices and lessons learned	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice

❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication

❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation

❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice

❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication

❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation

❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

14 Advocacy for IHR implementation may involve different sectors and government agencies and other partners that provide key information for national self-assessment, planning, development, strengthening and maintenance of IHR capacities. National IHR Focal Points play an important role in dissemination of information to, and consolidating inputs from, relevant sectors of the administration of the State Party, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospital and other government departments (IHR Article 4).

15 Advocacy mechanisms include strategic frameworks, guidelines, procedures and Standard operating procedures (SOPs) and plans.

C3. FINANCING

States Parties should ensure they have adequate funding for implementing IHR capacities through the national budgetary process.

Budget is an itemized summary of a country's expected income and expenditure over a specified period – usually a financial year. Financing and funding refer to money which a government or organization provides for a particular purpose.

	Indicators	
Level	**C3.1. Financing for IHR implementation**	
Level 1	There is no financial planning, budget line or budgetary allocation available to finance IHR implementation, and is handled through extrabudgetary[16] means	❑
Level 2	Financial planning is limited with a budgetary allocation or substantial external financing[17] made for some of the relevant sectors[18] and their respective ministries to support the IHR implementation at the national level	❑
Level 3	Financial planning based on identified gaps and estimated resource needs with a budgetary allocation and/or substantial external financing made for relevant sectors is available to support IHR implementation at national level and some monitoring and accountability mechanisms are in place	❑
Level 4	Financial planning based on identified gaps and estimated resource needs with sufficient budgetary allocation for IHR implementation, that may include external financing. The budget is predictable, flexible, and distributed in a timely manner at the national and intermediate levels in all relevant ministries or sectors, with monitoring and accountability mechanisms in place to measure implementation and effectiveness	❑
Level 5	Financial planning with sufficient budgetary allocation for IHR implementation, that may include external financing is available at national, intermediate and local levels and all sectors; with predictable and flexible budget, distributed in a timely manner. The country is able to collaborate and provide financial support to other countries considering regional priorities, needs and global threats The budget is monitored against objectives, and accountability mechanisms are in place at each level for transparent and effective use of funds	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ achieved
- ❑ strength/best practice
- ❑ ongoing
- ❑ challenges/gaps
- ❑ other

Area Involved:

- ❑ financing
- ❑ policy
- ❑ leadership & governance
- ❑ risk communication
- ❑ guidelines & SOPs
- ❑ infrastructure & logistics
- ❑ assessments
- ❑ legislation
- ❑ coordination & collaboration mechanisms
- ❑ workforce
- ❑ health information systems
- ❑ others

16 "Extrabudgetary" refers to accounts held by government bodies, but not included in the government budget.
17 "External financing" refers to financing from non-domestic sources towards the implementation of IHR capacities (that use the JEE); whose amounts make up a (SPAR)) majority of national financing for emergency preparedness, detection and response.
18 Relevant sectors include human health, animal health, agriculture, disaster management, food safety, livestock, fisheries, trade, international transport/PoEs, emergency services, environment, finance, chemical safety, radiation safety, labour, education, foreign affairs, civil society and other sectors.

	Indicators	
Level	**C3.2. Financing for public health emergency response**	
Level 1	Public financing for responding to public health emergencies is not identified and funds are allocated and distributed in an ad hoc manner	❑
Level 2	Public financing exists that allows for structured reception, rapid distribution and use of funds for responding to public health emergencies	❑
Level 3	Public financing for responding to public health emergencies is identified for immediate mobilization when needed, at the national level for all the relevant sectors in advance of a public health emergency	❑
Level 4	Public financing for responding to public health emergencies is in place at national and intermediate levels and allows for the timely execution of funds by all relevant sectors during a public health emergency	❑
Level 5	Public financing for responding to public health emergencies in place, with an appropriate emergency contingency, at national intermediate and local levels, that allows for the timely execution of funds by all relevant sectors during a public health emergency. The country is able to collaborate and provide financial support to other countries during a public health emergency	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

C4. LABORATORY

Laboratory is a critical part of surveillance, preparedness and response. It includes detection, investigation and response, with the analysis of samples carried out either within the country or through international referral to collaborating centres or reference laboratories.

States Parties need to maintain mechanisms to ensure that: specimens are shipped to appropriate reference laboratories[19] as necessary; laboratory testing is both reliable and timely; there is characterization of infectious agents and other hazards likely to cause public health emergencies of national and international concern; and results are shared in a timely manner.

	Indicators	
Level	**C4.1. Specimen referral and transport system**	
Level 1	No system in place for transporting specimens from intermediate levels/districts to national laboratories; only ad hoc transportation[20] is available	❑
Level 2	Referral and transport of specimens is organized[21] for some priority diseases[22] but may be restricted within districts or at the intermediate and national level	❑
Level 3	Referral and transport of specimens is organized for diagnostics and/or confirmation of most priority diseases from subnational to national level	❑
Level 4	Referral and transport of specimens is organized systematically for diagnostics and/or confirmation of all priority diseases at all levels	❑
Level 5	Sustainable referral and transport systems, that are exercised (as appropriate) reviewed, evaluated and updated on a regular basis, are in place for all specimen types[23] and requests for the diagnosis, confirmation, characterization of all specimens with complete coverage at all levels	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

19 Reference laboratories could be national laboratories and/or international reference laboratory where the country has a formal memorandum of understanding for testing.
20 Ad hoc transportation: i.e. there are no standard operating procedures (SOPs) on how to transport samples.
21 This is an organized or established procedure within the country or outside it. Some island countries may not require a system to be in place at the country level and can have access to regional or international laboratories.
22 Priority diseases are based on the local epidemiology and as defined in the national surveillance guidelines for priority diseases and/or notifiable diseases.
23 Specimen types should be defined and a list of common specimen types included.

	Indicators	
Level	**C4.2. Implementation of a laboratory biosafety[24] and biosecurity[25] regime**	
Level 1	National laboratory biosafety and biosecurity guidelines and/or regulations are under development	❑
Level 2	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by some laboratories at the national level	❑
Level 3	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by all laboratories at the national level	❑
Level 4	National laboratory biosafety and biosecurity guidelines and/or regulations are implemented by all laboratories at national, intermediate and local levels	❑
Level 5	National laboratory biosafety and biosecurity guidelines and/or regulations are exercised, reviewed, evaluated and updated on a regular basis, as applicable and a system for oversight of the regulation is in place	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

24 Laboratory biosafety refers to containment principles, technologies and practices that are implemented to prevent unintentional exposure to pathogens and toxins, or their accidental release.
25 Laboratory biosecurity refers to institutional and personal security measures designed to prevent the loss, theft, misuse, diversion or intentional release of pathogens and toxins. Refer to WHO laboratory biosafety manual. Fourth edition. Geneva: World Health Organization; https://www.who.int/publications/i/item/9789240011311.

	Indicators	
Level	**C4.3. Laboratory quality system[26]**	
Level 1	National laboratory quality standards are not available or under development	❑
Level 2	National quality standards have been developed but not implemented	❑
Level 3	National quality standards have been developed and implemented at national level. Activities include licensing of laboratories in conformity with national quality standards	❑
Level 4	National quality standards have been developed and are being implemented at national and subnational levels, Activities include mandatory licensing of laboratories in line with basic quality requirements or national laboratory standards	❑
Level 5	National quality standards are implemented at all levels including mandatory licensing of all laboratories in conformity with international quality standards and exercised, reviewed, evaluated and updated on a regular basis, as applicable	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

26 In conformity with the national quality standard, based on the quality assurance system of the country. See: WHO manual for organizing a national external quality assessment programme for health laboratories and other testing sites. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/250117/1/9789241549677-eng.pdf?ua=1).

	Indicators	
Level	**C4.4. Laboratory testing capacity[27] modalities**	
Level 1	Laboratory system can support one or two testing modalities such as rapid diagnostic testing (antigen and antibody) and microscopy services for pathogen detection	❑
Level 2	Laboratory system can support testing modalities including serological tests (i.e., antigen and antibody enzyme immunoassays) and quality assurance process is in place	❑
Level 3	Laboratory system can perform nucleic acid amplification testing, bacterial culture with antimicrobial sensitivity testing with quality assurance process in place and have access to (or has) sequencing capacity	❑
Level 4	Laboratory system can perform nucleic acid amplification testing, bacterial culture with antimicrobial sensitivity testing with quality assurance process in place and has some basic sequencing capacity and country has ability to test for all its endemic diseases and its priority diseases[28]	❑
Level 5	Laboratory system can perform in all capacities including access to whole genome sequencing;[29] identification of unknown and high consequence pathogens and has access to viral culture. Laboratory networks configured to support all diagnostic services[30] that are integrated,[31] sustainable, with maximum population coverage, and exercised, reviewed, evaluated and updated on a regular basis as applicable	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

27 Refers to laboratory test capacities that are available within the country (including research laboratories and private laboratories) to support surveillance and response; or that are available through referral mechanisms to designated central or international reference laboratories (e.g. WHO collaborating centres).
28 Priority diseases include epidemic prone diseases, diseases earmarked for eradication/elimination and diseases of public health importance.
29 Access to whole genome sequencing may be through international collaboration including WHO collaborating centres.
30 This may include whole genomic sequencing, and access to whole genome sequencing may be through international collaboration including WHO collaborating centres.
31 Between the human, animal and environmental health sectors.

	Indicators	
Level	**C4.5. Effective national diagnostic network**	
Level 1	Tier-specific diagnostic testing strategies[32] are not available or under development	❑
Level 2	Tier-specific diagnostic testing strategies are developed	❑
Level 3	Tier-specific diagnostic testing strategies exist, but not fully implemented	❑
Level 4	Tier-specific diagnostic testing strategies are being implemented at national level	❑
Level 5	Tier-specific diagnostic testing strategies are being implemented at national, intermediate and local levels, and exercised, reviewed, evaluated, and updated on a regular basis, as applicable	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

32 Tier specific refers to the different administrative levels such as reference laboratories at national level, intermediate and local levels facility laboratories.

C5. SURVEILLANCE

The IHR require the rapid detection of public health risks associated with biological, chemical and radiation events, as well as risk assessment, notification and response. A sensitive surveillance[33] system, including at points of entry, is needed to ensure that countries have an early warning function and to inform decision-making during public health events and emergencies. This involves a multisectoral and integrated health-system approach and may include sentinel surveillance and contact-tracing during health emergencies.

	Indicators	
Level	**C5.1. Early warning surveillance function**	
Level 1	National guidelines and/or SOPs for surveillance are not available or under development	❑
Level 2	National guidelines and/or SOPs for surveillance have been developed but not implemented. The surveillance system is functioning but lacks systematic immediate reporting or weekly reporting of events and/or data	❑
Level 3	National guidelines and/or SOPs for surveillance have been developed and are being implemented at the national level and provide immediate and weekly reporting of events and/or data	❑
Level 4	National guidelines and/or SOPs for surveillance have been developed and are being implemented at the national and intermediate levels and provide immediate and weekly reporting of events and/or data	❑
Level 5	National guidelines and/or SOPs for surveillance have been developed and implemented at national, intermediate and local[34] levels; and the system is exercised (as applicable), reviewed, evaluated and updated on a regular basis, with improvement at all levels in the country	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

33 Surveillance refers to the systematic ongoing collection, collation and analysis of data for public health purposes and the timely dissemination of public health information for assessment and public health response, as necessary. Key components of surveillance include indicator-based surveillance and event-based surveillance.

34 At local level, community participation can be achieved through community-based surveillance. Event-based surveillance is a key part of syndromic surveillance and community-based surveillance.

	Indicators	
Level	**C5.2. Event management (i.e., verification, investigation,[35] analysis,[36] and dissemination of information)**	
Level 1	Process or mechanism for managing detected events is not available or under development	❑
Level 2	Process or mechanism for managing detected events has been developed but not implemented	❑
Level 3	Process or mechanism for managing detected events has been developed and is being implemented at the national level	❑
Level 4	Process or mechanism for managing detected events has been developed and is being implemented at the national and intermediate levels	❑
Level 5	Process or mechanism for managing detected events is being implemented at national, intermediate and local levels, and exercised (as applicable), reviewed, evaluated and updated on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice
❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication
❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation
❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice
❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication
❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation
❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

35 Investigation includes contact-tracing to identify all potential contacts and affected individuals.
36 All surveillance data are systematically analysed for informed decision-making and dissemination.

C6. HUMAN RESOURCES

As required by the IHR, strategies should be in place to ensure that a multisectoral workforce is available and is trained to detect, prevent, prepare for and response to potential events of international concern at all levels of health systems.

The availability and accessibility of a quality health workforce[37] with surge capacity in emergencies – including a workforce for surveillance (e.g. field investigation and contact-tracing teams) – is critical for building the resilience of communities and for the continuity of health services.

	Indicators	
Level	**C6.1. Human resources for implementation of IHR**	
Level 1	Country does not have appropriate human resources[38] capacity in relevant sectors[39] required, to detect, assess, notify, report and respond to events according to IHR provisions	❑
Level 2	Appropriate human resources are available in relevant sectors at national level, to detect, assess, notify, report and respond to events according to IHR provisions	❑
Level 3	Appropriate human resources are available in all relevant sectors at national and intermediate levels, to detect, assess, notify, report and respond to events according to IHR provisions	❑
Level 4	Human resources are available as required in all relevant sectors at the national, intermediate and local levels, to detect, assess, notify, report and respond to events according to IHR provisions	❑
Level 5	Country has documented policies or procedures for sustainable appropriate human resources in all relevant sectors to detect, assess, notify, report and respond to events according to IHR provisions, that are exercised (as applicable), reviewed, evaluated and updated on a regular basis and country may assist other countries in planning and developing human resources for IHR implementation, to the extent possible	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

37 Attention to gender differentials in proportion of males to females holding decision-making roles.

38 Appropriate human resources may include doctors, nurses, midwives, community-based health workers, clinicians, toxicologists, veterinarians, food safety experts, radiation medicine, field epidemiologists, risk communication specialists, laboratory experts, public health experts, legal/policy experts, officials at human resources unit or department responsible for planning, mapping, development and distribution of public health and emergencies workforce at national and intermediate level etc., as defined by function, country standards and needs.

39 Relevant sectors include human health, animal health, agriculture, disaster management, food safety, livestock, fisheries, trade, international transport/PoEs, emergency services, environment, finance, chemical safety, radiation safety, labour, education, foreign affairs, civil society and other sectors.

	Indicators	
Level	**C6.2. Workforce surge during a public health event**	
Level 1	A national multisectoral workforce surge strategic plan in emergencies[40] is not available or is under development	❑
Level 2	A national multisectoral workforce surge strategic plan in emergencies is developed to carry out the functions attributed at the national level, including the government and nongovernmental partners workforce as applicable	❑
Level 3	A national multisectoral workforce surge strategic plan in emergencies is implemented to carry out the functions attributed at the national level, with procedures and limited capacity to send and receive multidisciplinary personnel within the country (shifting resources), including the government and nongovernmental partners workforce as applicable	❑
Level 4	A national multisectoral workforce surge strategic plan in emergencies is implemented to carry out the functions at national and intermediate levels, with procedures and adequate capacity to send and receive multidisciplinary personnel within the country (shifting resources), including the government and nongovernmental partners workforce as applicable	❑
Level 5	A national multisectoral workforce surge strategic plan in emergencies is implemented to carry out the functions attributed at national, intermediate and local levels, with procedures and adequate capacity to send and receive multidisciplinary personnel within the country (shifting resources), including the government and nongovernmental partners workforce, as applicable, and exercised, reviewed, evaluated and updated annually, and may well provide international collaboration for assisting emergency response	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

40 A national multisectoral workforce surge strategic plan in emergencies includes a gap analysis for the surge workforce required in all sectors for emergencies (e.g. security, human health, animal health, environment) and has a surge workforce plan, with systems in place for identification and recruitment of the required surge workforce personnel and with programmes for competency development, including procedures or policies for pre-deployment, deployment and post-deployment.

C7. HEALTH EMERGENCY MANAGEMENT

This capacity focuses on national planning for health emergency management and for systems that enable countries to be prepared for – and operationally ready to respond to – any public health events, including emergencies, in accordance with the requirements of the IHR.

In order to ensure a timely response to public health emergencies, it is critical to have risk-based plans for emergency preparedness and response, robust emergency management structures and the mobilization of resources during an emergency.

	Indicators	
Level	**C7.1. Planning for health emergencies**	
Level 1	All-hazard risk informed[41] health emergency plan[42] is not available or under development	❑
Level 2	All-hazard risk informed health emergency plan is developed but not being implemented	❑
Level 3	All-hazard risk informed health emergency plan is developed and being implemented at the national level	❑
Level 4	All-hazard risk informed health emergency plan is developed and being implemented at the national and intermediate levels	❑
Level 5	All-hazard risk informed health emergency plan is developed and being implemented at national, intermediate and local levels and exercised, reviewed, evaluated and updated, with improvements based on SimEx[43] and lessons learned from real-world events, e.g., IARs[44] or AARs[45]	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

41 Health emergency risk profiles should be based on a strategic multisectoral and multihazard health emergency risk assessment and should be updated on a regular basis.

42 There are different types of plans: such as a plan for coordinating emergency preparedness measures, which includes multisectoral, multihazard emergency response plans, contingency plans and business continuity plan for specific hazards or risk scenarios. Plans should be multisectoral, multidisciplinary and interoperable. These plans should be linked to a hazard-specific plan such as for chemical events or radiation emergencies. There should be a chemical/radiation event response plan describing procedures, roles, responsibilities and requirements to ensure an adequate response to a chemical release with the aim of minimizing the impact of the release on human health and the environment.

43 A SimEx can help to develop, assess and test functional capabilities of emergency systems, procedures and mechanisms to be able to respond to outbreaks or public health emergencies. See the definition of "SimEx" in the Glossary (Annex 4). For further information, see: WHO simulation exercise manual. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/254741/WHO-WHE-CPI-2017.10-eng.pdf).

44 An intra-action review (IAR) is a country-led facilitated discussion that allows national and subnational stakeholders of the COVID-19 response to reflect on actions being undertaken to prepare for and respond to the COVID-19 outbreak at the country level in order to identify current best practices, gaps and lessons learned, and propose corrective actions to improve and strengthen the continued response to COVID-19. Additionally, IAR findings and recommendations may contribute to improving the management of concurrent emergencies and to long-term health security. See: Guidance for conducting a country COVID-19 intra-action review (IAR). Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Country_IAR-2020.1). See also IAR in the Glossary (Annex 4). For further information, see: Country COVID-19 intra-action review (IAR): facilitator's manual. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/341029).

45 An after-action review (AAR) is a qualitative review of actions taken to respond to an emergency as a means of identifying best practices, gaps and lessons learned by bringing together relevant stakeholders involved in the preparedness for and the response to the public health event under review. An after-action review (AAR) provides an opportunity to review the functional capacity of public health and emergency response systems and to identify practical areas for continued improvement. See the definition of "AAR" in the Glossary (Annex 4). For further information, see: Guidance for after action review (AAR). Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/WHO-WHE-CPI-2019.4).

	Indicators	
Level	**C7.2. Management of health emergency response[46]**	
Level 1	An incident management system[47] integrated with a national public health emergency operations centre[48] or equivalent structure is not available or under development	❑
Level 2	An incident management system integrated with a national public health emergency operations centre, or equivalent structure is developed but not operational	❑
Level 3	An incident management system integrated with a national public health emergency operations centre, or equivalent structure is in place and operational at the national level	❑
Level 4	An incident management system integrated with a national public health emergency operations centre, or equivalent structure is in place and operational at the national level and able to support intermediate levels	❑
Level 5	An incident management system integrated with a national levels public health emergency operations centre, or equivalent structure is in place and operational at national level and is able to support national, intermediate and local levels, and is exercised, reviewed, evaluated and updated, with improvements based on SimEx and lessons learned from real-world events, e.g. IARs or AARs	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

46 These include entities, such as points of contact, emergency operation centres (EOCs), or response committees, to coordinate health-sector actors and resources in response to emergencies, and to coordinate the health-sector response with other sectors. Coordination mechanisms may apply incident management systems to fulfil the coordination function.

47 Incident management system refers to the emergency management structure and set of protocols that provide an approach to guiding government agencies, the private sector, nongovernmental organizations and other actors to work in a coordinated manner primarily to respond to and mitigate the effects of all types of emergencies. The incident management system may also be utilized to support other aspects of emergency management, including preparedness and recovery (also called incident command system).

48 National public health emergency operations centres (EOCs) are networked with health EOCs at subnational and local levels, and are interoperable with EOCs in other sectors, including with the National disaster management office. EOC plans and SOPs describe key structural and operational elements; forms and templates for EOC data management, reporting and briefing; role descriptions and job aids for EOC functional positions (including incident management or command, operations, planning, logistics and finance) including information systems to connect public health decision-makers to appropriate data sources; communications equipment; and staff that are trained and capable of coordinating an emergency response. National health EOC plans are in place for functions including public health science (epidemiology, medical and other subject matter expertise), public communications and partner liaison. There are additional trained staff who can support and replace regular EOC staff on a rotational basis.

	Indicators	
Level	**C7.3. Emergency logistic and supply chain management[49]**	
Level 1	Emergency logistics and supply chain management system/mechanism[50] is under development and/or not able to provide adequate support for health emergencies	❑
Level 2	Emergency logistics and supply chain management system/mechanism is developed but not able to provide adequate support for health emergencies[51]	❑
Level 3	Emergency logistics and supply chain management system/mechanism is developed and is able to provide adequate support for health emergencies at national level	❑
Level 4	Emergency logistics and supply chain management system/mechanism is developed and is able to provide adequate support for health emergencies at national and intermediate levels	❑
Level 5	Emergency logistics and supply chain management system/mechanism is implemented at national, intermediate and local levels, and is exercised (as appropriate), reviewed, evaluated and updated on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice

❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication

❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation

❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice

❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication

❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation

❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

49 To maintain an updated emergency logistic and supply chain management system/mechanism may include having a robust regulatory system in place that allows for the emergency use and distribution of newly developed or newly available drugs, diagnostics and other materials.

50 "Mechanism" can include human resources (experts), financial, logistics (medical countermeasures, stockpiles), and health facilities (beds, equipment etc.).

51 "Emergency logistics and supply chain system and mechanism" includes the capacity to purchase, store and deliver essential products and materials necessary for the response (emergency kits, protective equipment, diagnostics, medical consumables, therapeutics, drugs and biomedical equipment) wherever they may be required in adequate quantity and in a timely manner. It also gathers and organizes the material, the capacities and processes allowing the deployment and the implementation of the response, including emergency medical infrastructures, teams' means of transportation, emergency offices and telecommunications.

C8. HEALTH SERVICES PROVISION

Resilient national health systems are essential for countries to prevent, detect, respond to and recover from public health events while ensuring the continuity of health services at all levels.

Particularly in emergencies, health services provision for event-related case management (C8.1) and routine essential health services (C8.3) are equally important.

	Indicators	
Level	**C8.1. Case management**	
Level 1	National clinical case management guidelines for priority health events[52] are not available or under development	❑
Level 2	National clinical case management guidelines for priority health events are developed but not being implemented[53]	❑
Level 3	National clinical case management guidelines for priority health events are developed and being implemented at national level	❑
Level 4	National clinical case management guidelines for priority health events are developed and being implemented at national and subnational levels	❑
Level 5	National clinical case management guidelines for priority health events are implemented at all levels and are exercised (as applicable), reviewed, evaluated and updated on regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

In order to be able to fulfill their event-related case-management role, health care facilities need to be trusted and used prior to and during the emergency. Indicator C8.2, Outpatient health services utilization, proxy-measures access and quality of services and trust in the health system.

In most countries, health services are provided by public and private providers. This evaluation should cover both sectors. Intermediate and local levels include both urban and rural areas. Therefore, quantitative indicators require geographically disaggregated data.

52 These should include SOPs with a list of designated referral health-care facilities, referral procedures, field t riage, safe transportation a nd c ase m anagement g uidelines t o treat pathologies resulting from events included in the national list of priority health events (e.g., epidemic-prone diseases, trauma, chemical events, radiation emergencies etc.).

53 Implementation of guidelines includes dissemination, orientation and training of health workers on guidelines and compliance/use with the guidelines in practice.

	Indicators	
Level	C8.2. Trusted and utilized health services[54]	
Level 1	Very low levels of outpatient service utilization* (number of outpatient contacts per person per year < 1.00 visit/ person/ year; in both urban and rural areas)	❑
Level 2	Low levels of outpatient service utilization (number of outpatient department visits per person per year 1.0 ≤ X < 2.0 visit/person/year; in both urban and rural areas)	❑
Level 3	Satisfactory levels of outpatient service utilization (number of outpatient contacts per person per year ≥ 2.0 visit/person/year, in both urban and rural areas)	❑
Level 4	Strong levels of outpatient service utilization (number of outpatient contacts per person per year ≥ 3.0 visit/ person/ year, in both urban and rural areas)	❑
Level 5	Strong levels of outpatient service utilization (number of outpatient contacts per person per year ≥ 3.0 visit/ person/ year, in both urban and rural areas) AND Information on service utilization and from patient experience (or satisfaction) surveys is reviewed on an annual basis and used to improve access and quality of services.	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice

❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication

❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation

❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

Definition of Outpatient Utilization Rate:
The number of outpatient visits to health facilities (or providers) relative to the total population of the same geographical area

- Numerator: the number of visits to health facilities for ambulant care, not including immunization.
- Denominator: the total population for the same geographical area.

54 Utilization of health services is measured by the number of outpatient department visits per person per year. Up to a certain point, the utilization rate goes up when, for instance, barriers to service provision are removed or minimized. This indicator can be used as a measure to ascertain the level of disruptions to health services during emergencies by noting changes in utilization rates for the same service during the same time/season. See: Global reference list of 100 core health indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/259951).

	Indicators	
Level	**C8.3. Continuity of essential health services (EHS)**	
Level 1	A package of EHS[55] is not defined and there are no plans or guidelines for continuity EHS during emergency	❑
Level 2	A package of EHS is defined but plans/guidelines on continuity of EHS in emergencies is not developed	❑
Level 3	A package of EHS and plans/guidelines on continuity of EHS in emergencies are developed and mechanism for monitoring service continuity during emergency is in place at national level	❑
Level 4	A package of EHS and plans/guidelines on continuity of EHS in emergencies are developed and mechanism for monitoring service continuity during emergency is in place at national and intermediate levels	❑
Level 5	A package of EHS, plans/guidelines on continuity of EHS in emergencies, and mechanisms for monitoring service continuity based on existing guidelines are defined and functional at national, intermediate and local[56] levels and exercised, reviewed, evaluated and updated, with improvements based on SimEx and lessons learned from real- world events, e.g. IARs or AARs	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

55 Essential health services (EHS): maternal and child health services, health promotion, reproductive health services, prevention and control of communicable and prevention and treatment of noncommunicable diseases, emergency health services, mental health services.

56 All levels include national, intermediate and local levels.

C9. INFECTION PREVENTION AND CONTROL (IPC)

Preventing harm to patients, health workers and visitors due to HCAIs contributes to quality care, patient safety, health security and reduced antimicrobial resistance (AMR). Strong and effective IPC programmes increase the safety of health care. They help deliver essential services by preventing and controlling outbreaks throughout the health system. It is essential initially that at least the minimum requirements for IPC are in place at both national and facility levels, and then to progress gradually to achieving all requirements of WHO's core components for IPC programmes.

The minimum requirements of IPC – based on WHO's recommended core components – are defined as standards that should be in place at both national and health-facility levels to provide minimum protection and safety to patients, health-care workers and visitors.

These requirements are the basis for building additional critical components of IPC programmes through a stepwise approach based on assessments of the local situation.

	Indicators	
Level	**C9.1. IPC programmes**	
Level 1	An active[57] national IPC programme[58] or operational plan according to the WHO minimum requirements[59] is not available or is under development	❑
Level 2	An active national IPC programme or operational plan according to WHO minimum requirements exists but is not fully implemented. National IPC guidelines/ standards exist but are not fully implemented	❑
Level 3	An active national IPC programme exists, and a national IPC operational plan according to the WHO minimum requirements is available. National guidelines/standards for IPC in health care are available and disseminated. Selected health facilities are implementing guidelines using multimodal strategies,[60] including health workers' training and monitoring and feedback	❑
Level 4	An active national IPC programme is available according to WHO IPC core components guidelines[61] and is leading implementation of the national IPC operational plan and guidelines nationwide using multimodal strategies, including health workers' training and monitoring and feedback in place. More than 75% of health care facilities meet WHO minimum requirements for IPC programmes, guidelines, training, and monitoring/feedback	❑
Level 5	IPC programmes are in place and functioning at national and health facility levels according to the WHO IPC core components and their compliance and effectiveness are exercised (as applicable), reviewed, evaluated and published. Plans and guidance are regularly updated in response to monitoring and feedback	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

57 "Active" is defined as a functioning programme with annual workplans and budget.

58 IPC programmes should have clearly defined objectives based on local epidemiology and priorities according to risk assessment, as well as defined functions and activities that align with and contribute towards the prevention of health care-associated infections and AMR in health care. They should also include dedicated, trained IPC professionals. For more information, see: Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/9789241549929).

59 IPC minimum requirements are minimum standards identified by WHO, key IPC stakeholders and country representatives, that should be in place at both national and health-facility level to provide minimum protection and safety to patients, health-care workers and visitors, based on the WHO recommendations on the core components for IPC programmes. The existence of these requirements constitutes the initial starting point for building additional critical elements of the IPC core components according to a stepwise approach based on assessments of the local situation. For more information, see: Minimum requirements for infection prevention and control programmes. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/9789241516945).

60 A multimodal strategy comprises several components or elements (three or more, usually five) implemented in an integrated way with the aim of improving an outcome and changing behaviour. It includes tools, such as bundles and checklists, developed by multidisciplinary teams that consider local conditions. The five most common elements include: 1) system change (availability of the appropriate infrastructure and supplies to enable IPC good practices); 2) education and training of health-care workers and key players (e.g. managers); 3) monitoring infrastructures, practices, processes, outcomes and providing data feedback; 4) reminders in the workplace/communications; and 5) culture change within the establishment or the strengthening of a safety climate. For further information, see: WHO multimodal improvement strategy. Geneva: World Health Organization (https://www.who.int/publications/m/item/who-multimodal-improvement-strategy).

61 These guidelines are to provide evidence- and expert consensus-based recommendations on the core components of IPC programmes that are required to be in place at the national and facility level to prevent HCAI and to combat AMR through IPC good practices. They are intended to provide a feasible, effective and acceptable framework for the development or strengthening of IPC programmes.

	Indicators	
Level	**C9.2. Health care-associated infections (HCAI) surveillance**	
Level 1	No national HCAI surveillance programme or national strategic plan for HCAI surveillance, including pathogens that are antimicrobial resistant and/or prone to outbreaks is available or under development	❑
Level 2	A national strategic plan for HCAI surveillance (including antimicrobial resistant pathogens that are antimicrobial resistant and/or prone to outbreaks) is available but not implemented	❑
Level 3	A national strategic plan for HCAI surveillance (including antimicrobial resistant pathogens that are antimicrobial resistant and/or prone to outbreaks) is available and implemented through a national system. Selected secondary and tertiary health care facilities are conducting HCAI surveillance (as specified above) and provide timely and regular feedback to senior management and health workers	❑
Level 4	A national strategic plan for HCAI surveillance (including antimicrobial resistant pathogens that are antimicrobial resistant and/or prone to outbreaks) is available and implemented nationwide in all health care facilities through a national system according to the WHO recommendations on IPC core components. Regular reports are available for providing feedback	❑
Level 5	A national strategic plan for HCAI surveillance (including antimicrobial resistant pathogens that are antimicrobial resistant and/or prone to outbreaks) is available and implemented nationwide in health care facilities through a national system according to the WHO recommendations on IPC core components. Data are shared and being used continuously and in a timely manner to inform prevention efforts. The quality and impact of the system are regularly evaluated, and improvement actions are taken accordingly	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ achieved
- ❑ strength/best practice
- ❑ ongoing
- ❑ challenges/gaps
- ❑ other

Area Involved:

- ❑ financing
- ❑ policy
- ❑ leadership & governance
- ❑ risk communication
- ❑ guidelines & SOPs
- ❑ infrastructure & logistics
- ❑ assessments
- ❑ legislation
- ❑ coordination & collaboration mechanisms
- ❑ workforce
- ❑ health information systems
- ❑ others

	Indicators	
Level	**C9.3. Safe environment in health facilities**	
Level 1	National standards and resources for safe built environment,[62] e.g., water, sanitation and hygiene (WASH) in health care facilities,[63] including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and for optimization of staffing levels in health care facilities are not available or under development	❑
Level 2	National standards and resources for safe built environment e.g., WASH in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and optimization of staffing levels in health care facilities, according to WHO minimum requirements, exist but they are not fully implemented through a national plan	❑
Level 3	National standards and resources for safe built environment, e.g., WASH in health care facilities, including appropriate infrastructure, materials and equipment fort IPC; as well as standards for reduction of overcrowding and optimization of staffing levels in health care facilities, according to WHO minimum requirements, exist and are implemented in health care facilities at national level through a national plan	❑
Level 4	National standards and resources for safe built environment, e.g., WASH in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and optimization of staffing levels in health care facilities, according to WHO minimum requirements, are implemented at national and intermediate levels according to a national plan	❑
Level 5	National standards and resources for safe built environment, e.g., WASH in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and for optimization of staffing levels in health care facilities, according to WHO minimum requirements, are implemented at national and subnational levels according to a national plan, and are regularly exercised (as applicable) and monitored and improvement actions are taken accordingly	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ achieved
- ❑ strength/best practice
- ❑ ongoing
- ❑ challenges/gaps
- ❑ other

Area Involved:

- ❑ financing
- ❑ policy
- ❑ leadership & governance
- ❑ risk communication
- ❑ guidelines & SOPs
- ❑ infrastructure & logistics
- ❑ assessments
- ❑ legislation
- ❑ coordination & collaboration mechanisms
- ❑ workforce
- ❑ health information systems
- ❑ others

62 A safe environment, also called a "built environment", is a core component for IPC programmes which enables delivery of patient care activities in a clean and/or hygienic environment that facilitates practices related to the prevention and control of HCAI, as well as AMR, including all elements around WASH infrastructure and services and the availability of appropriate IPC materials and equipment (i.e. personal protective equipment, hand hygiene-related products etc.).

63 For global standards on WASH in health-care facilities refer to: Adams J, Bartram J, Chartier Y. Essential environmental health standards in health care. Geneva: World Health Organization; 2008 (https://apps.who.int/iris/bitstream/handle/10665/43767/9789241547239_eng.pdf). WASH in health-care facilities should include national WASH policy and standards, operational strategy, and facility guidelines, education and training programmes, and surveillance, monitoring and audit, and maintenance of essential WASH services (see the WHO website at: https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health).

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

C10. RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

RCCE have proved to be vital in all public health emergencies. Risk communication refers to real-time exchange of information, advice and opinion between experts or officials and people who face a threat. Its purpose is for everyone at risk to be able to take informed decisions to mitigate the effects of the threat and take protective and preventive action. Community engagement is a more focused set of activities that is intended to put communities at the centre of preparedness, readiness and response. It provides voices and choices for communities in the decision-making process of community-level public health measures.

	Indicators	
Level	**C10.1. RCCE system for emergencies**	
Level 1	Mechanisms[64] for coordination of RCCE functions[65] and resources[66] are under development, or coordination of RCCE functions and resources is conducted on an ad hoc basis	❑
Level 2	Mechanisms for coordination of RCCE functions and resources, including plans, SOPs and formal government arrangements are developed	❑
Level 3	Mechanisms for coordination of RCCE functions and resources, including plans, SOPs and formal government arrangements are developed and being implemented at the national level[67]	❑
Level 4	Mechanisms for coordination of RCCE functions and resources, including plans, SOPs and formal government arrangements are developed and being implemented at the national and intermediate levels[68]	❑
Level 5	Mechanisms for coordination of RCCE functions and resources are implemented at the national, intermediate and local levels; are fully integrated into emergency response systems; and are exercised, reviewed, evaluated and updated on a regular basis[69]	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

64 Mechanisms include plans, SOPs, guidelines, policies and procedures such as, multi-hazard and multi-sectoral plans for coordination of RCCE functions; formal government arrangements, including policies and procedures, for coordination of RCCE functions as well as arrangement for scale-up in emergencies; quality assurance processes for communication products; and integration of RCCE within the emergency operations centre or incident management system.

65 Functions include training of RCCE personnel, communication with other sectors, transparent and early/regular communication with target audiences through conventional media (print and broadcast), online and offline media monitoring to shape messages and strategies; analyses of target audiences based on online and offline community listening to inform the design of communications, interventions and programmatic improvements; and infodemic monitoring.

66 Resources include finance; skilled staff (e.g. at least a risk communication specialist in the emergency response team, an adequate number of qualified staff, a trained spokesperson) and arrangements for workforce surge; equipment and materials (e.g. Information, education and communication (IEC) materials); and communication platforms for coordination of RCCE functions.

67 Formal government arrangements and systems are in place at national level, including national multi-hazard, multisectoral RCCE capability, policies and procedures. However, human and financial resources are limited, and there is sporadic coordination with other technical areas.

68 Formal government arrangements and systems are in place at national and intermediate levels, including multi-hazard, multisectoral RCCE capability, policies, procedures. Human and financial resources are available and coordination with other sectors is structured.

69 The national multi-hazard, multisectoral RCCE plan is reviewed at least every 24 months. Evidence and data gathered are systematically used for measurement, evaluation, learning and continuous improvement of RCCE interventions.

	Indicators	
Level	**C10.2. Risk communication**	
Level 1	Mechanisms for public communication and/or media relations, including infodemics, are under development or implemented on an ad hoc basis[70]	❑
Level 2	Mechanisms for public communication and/or media relations, including infodemics, are developed but not fully implemented with significant gaps[71]	❑
Level 3	Mechanisms for public communication and/or media relations, including infodemics, are developed and activities are being implemented at the national level	❑
Level 4	Mechanisms for public communication and/or media relations, including infodemics, are developed and activities are being implemented and coordinated across all sectors at national and intermediate levels	❑
Level 5	Mechanisms for public communication and/or media relations, including infodemics, are developed and activities are being implemented and coordinated across sectors[72] at national, intermediate and local levels, and information is shared in a timely manner.[73] The mechanisms and related activities are exercised (as applicable), reviewed, evaluated and updated on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

70 The work is limited to conventional media. There are no risk communication specialists in the national incident management system team or emergency operations centre. Infodemic monitoring is not conducted. 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. See: (https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation).

71 Gaps may include limited implementation of best practices and community listening activities to inform the design of a communication strategy. Trained risk communicators serve as surge staff in an emergency and are resourced to conduct media relations and maintain a basic online presence.

72 Coordination of RCCE involves the whole of government and sectors, and international and national partners. Coordination is facilitated through online and offline channels of communication in an accurate, timely and understandable way. Risk communication includes a culture of learning and collaboration with social science researchers. An interdisciplinary team routinely uses online and offline community listening activities to conduct integrated analyses to tailor the design of communications, interventions and programmatic improvements.

73 Information provided regarding the emergency situation should be up to date and timely and should include the government response and health recommendations. The messages address people's concerns and rumours, as well as misinformation, and provide actionable advice.

	Indicators	
Level	**C10.3. Community engagement[74]**	
Level 1	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, are under development or community engagement activites[75] are implemented on an ad hoc basis[76]	❑
Level 2	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed but not implemented	❑
Level 3	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed, disseminated and community engagement activities are being implemented and supported at the national level	❑
Level 4	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed, disseminated and community engagement activities are being implemented and supported at national and intermediate levels	❑
Level 5	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed, disseminated, and community engagement activities are being implemented and supported at the national, intermediate and local levels. Qualitative and quantitative socio-behavioural research is conducted;[77] and mechanisms and activities for community engagement are exercised (as applicable), reviewed, evaluated and updated on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ achieved
- ❑ strength/best practice
- ❑ ongoing
- ❑ challenges/gaps
- ❑ other

Area Involved:

- ❑ financing
- ❑ policy
- ❑ leadership & governance
- ❑ risk communication
- ❑ guidelines & SOPs
- ❑ infrastructure & logistics
- ❑ assessments
- ❑ legislation
- ❑ coordination & collaboration mechanisms
- ❑ workforce
- ❑ health information systems
- ❑ others

74 Communities are equal partners in the risk communication and emergency response process and co-design interventions.

75 Community activities include establishment of intermittent two-way community feedback communication channels (e.g. hotline, complaint systems, social listening); collection of data from qualitative and quantitative sources including socio-behavioural research of affected and at-risk populations; analysis and integration of social- behavioural and epidemiological data to inform decision-making (e.g. vaccine confidence, vaccine distribution); regular training of social mobilization and community engagement teams, including volunteers; scale-up and operationalization of surge capacities; mapping of stakeholders, engagement and activation of stakeholders at national and subnational levels including community influencers such as opinion and religious leaders, civil society and community-based organizations as part of the emergency response system; development of IEC materials; and briefings and training of social mobilization and community engagement teams, including volunteers.

76 Community engagement may be conducted by nongovernmental entities on specific health topics but are not systematically linked to the governmental health system. Some key stakeholders are identified locally. Civil society organizations are not connected to government-level emergency response mechanisms.

77 Response decisions are informed by qualitative and quantitative socio-behavioural research. Social-behavioural data and epidemiological data are used in an integrated and equal way to inform decision-making.

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

C11. POINT OF ENTRY (PoE) AND BORDER HEALTH

A point of entry (PoE) is defined in the IHR as a passage for international entry or exit of travellers, baggage, cargo, containers, conveyances, goods and postal parcels, as well as the agencies and areas providing services to the PoE on entry or exit. PoEs are integral to surveillance and response systems and help to support a country's public health functions.

Factors to consider when designating a PoE for the development of IHR capacities are found in the introductory chapter of WHO's Assessment tool for core capacity requirements at designated airports, ports and ground crossings.[78] Section 1 below requests specific information on the State Party's designated PoE (Note that users should create an additional row in the table for each PoE). The scoring table for this core capacity in Section 2 below should be based on the results of an in-depth assessment of each designated PoE – as well as some non-designated PoEs of public health significance. The assessment should be based on the detailed Assessment tool as well as the document on Coordinated public health surveillance between points of entry and national health surveillance systems.[79]

SECTION 1. INFORMATION BY TYPE OF POINTS OF ENTRY

1. Please indicate the number of designated PoE that shall develop the capacities provided in Annex 1 of the IHR (n/a if not applicable)	
Number of designated ports	Choose a number
Number of designated airports	Choose a number
Number of designated ground crossings[80]	Choose a number

2. Please list the names of designated PoEs (ports, airports and ground crossings as applicable) and indicate the information required in relation to the designated PoE. To complete this table, fill in information for each designated PoE. Please add lines as needed if there are more than five designated airports, ports or ground crossings.

SECTION 2. CORE CAPACITIES AT PoEs AND INTERNATIONAL TRAVEL-RELATED MEASURES

Download		IATA airport location code or other code for ports and ground crossings[81]	ICAO airport or other code for ports and ground crossings[82]	United Nations Code for Trade and Transport Locations (UNLOCODE)[83]	Competent authorities identified at designated PoE level (Y/N)	Level[84] of core capacity requirements at all times for designated PoE (routine core capacities, Annex 1B)	Programme for vector surveillance and control at PoE (Y/N)	Level[85] of effective public health response at each designated PoE (capacities to respond to emergencies, Annex 1B)	PoE public health emergency contingency plan[86] (Y/N)
Type	Name of designated PoE								
Airports									
Ports									
Ground crossings									

3. Has your country authorized ports to issue ship sanitation certificates?[87]

Yes ❑ No ❑ Not applicable ❑

78 See: International Health Regulations (2005). Assessment tool for core capacity requirements at designated airports, ports and ground crossings. Lyon: World Health Organization; 2009 (https://www.who.int/publications/i/item/WHO-HSE-IHR-LYO-2009-9). See the Introduction to the assessment tool and also the definition of "designated point of entry" in the Glossary (Annex 4).

79 See: Coordinated public health surveillance between points of entry and national health surveillance systems: advising principles. Lyon: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144805/WHO_HSE_GCR_LYO_2014.12_eng.pdf).

80 Designation of ground crossings is not required by the IHR unless deemed necessary by the State Party.

81 IATA airport codes can be found at the IATA/International Air Transport Association website (https://www.iata.org/en/publications/directories/code-search/). For port facilities and ground crossings countries may use their national location codes for geo-reference.

82 The International Civil Aviation Organization (ICAO) airport code is a four-letter code designating aerodromes globally, as defined by the ICAO and published in ICAO document DOC7910 Location Indicators (https://www.icao.int). For port facilities and ground crossings countries may use their national location codes for geo-reference.

83 UN/LOCODE is the United Nations Code for Trade and Transport Location which is published by the United Nations Economic Commission for Europe (https://unece.org/trade/cefact/unlocode-code-list-country-and-territory).

84 Refer to: International Health Regulations (2005). Assessment tool for core capacity requirements at designated airports, ports and ground crossings. Lyon: World Health Organization; 2009 (https://apps.who.int/iris/handle/10665/70839) to determine the level of implementing the IHR routine capacities at each specific point of entry, utilizing the criteria in Section 2, e.g. Level 1: Strategic risk assessment for individual PoE as an integral part of a national risk assessment has not been completed; Level 2: Some designated PoE are implementing routine core capacities based on a completed associated strategic risk assessment; Level 3: Some designated PoE are implementing routine core capacities AND These are integrated into the national surveillance system for biological hazards/all hazards (e.g. event-based and early warning surveillance); Level 4: All designated PoE are implementing routine core capacities with an all-hazard and multisectoral approach integrated into the national surveillance system; Level 5, Routine core capacities implemented at all designated PoE are exercised (as appropriate), reviewed, evaluated, updated and actions are taken to improve capacity on a regular basis.

85 Refer to: International Health Regulations (2005). Assessment tool for core capacity requirements at designated airports, ports and ground crossings. Lyon: World Health Organization; 2009 (https://apps.who.int/iris/handle/10665/70839) to determine the level of implementing the IHR effective public health response capacities at each specific point of entry, utilizing the criteria in Section 2, e.g. Level 1: PoE designated based on a strategic risk assessment are in the process of developing a PoE public health emergency contingency plan; Level 2: Some designated PoE have developed a PoE public health emergency contingency plan for events caused by biological hazards; Level 3: All designated PoE have developed PoE public health emergency contingency plans for events caused by biological hazards and integrated into national emergency response plans; Level 4: All designated PoE have developed PoE public health emergency contingency plans for events caused by all hazards and integrated into national emergency response plans; Level 5, All PoE public health emergency contingency plans for events caused by all hazards all designated PoE are exercised (as appropriate), reviewed, evaluated and updated on a regular basis.

86 A public health emergency contingency plan is one of the required capabilities for designated ports, airports and ground crossings under the IHR framework. For a detailed recommended approach, structure and logical set of considerations to guide the development of a "public health emergency contingency plan" at PoE, see: International health regulations (2005). A guide for public health emergency contingency planning at designated points of entry. Manila: World Health Organization Regional Office for the Western Pacific; 2012 (https://www.who.int/publications/i/item/international-health-regulations-(-2005)-a-guide-for-public-health-emergency-contingency-planning-at-designated-points-of-entry).

87 If you respond yes, please ensure that the ports are duly updated in https://extranet.who.int/ihr/poedata/public/en. States Parties shall keep the information about their authorized ports regularly updated in the list in accordance with IHR Art. 20.3a, either by communicating such information to WHO, or updating it at https://extranet.who.int/ihr/poedata/data_entry/en.

	Indicators	
Level	**C11.1 Core capacity requirements at all times for PoEs (airports, ports and ground crossings)**	
Level 1	Strategic risk assessment for individual PoE as an integral part of a national risk assessment has not been completed	❑
Level 2	Some designated PoE are implementing routine core capacities based on a completed associated strategic risk assessment	❑
Level 3	Some designated PoE are implementing routine core capacities AND These are integrated into the national surveillance system for biological hazards/all hazards (e.g., event-based and early warning surveillance)	❑
Level 4	All designated PoE are implementing routine core capacities with an all-hazard and multisectoral approach integrated into the national surveillance system	❑
Level 5	Routine core capacities implemented at all designated PoE are exercised (as appropriate), reviewed, evaluated, updated and actions are taken to improve capacity on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

	Indicators	
Level	**C11.2. Public health response at points of entry**	
Level 1	PoE designated based on a strategic risk assessment are in the process of developing a PoE public health emergency contingency plan	❑
Level 2	Some designated PoE have developed a PoE public health emergency contingency plan for events caused by biological hazards	❑
Level 3	All designated PoE have developed PoE public health emergency contingency plans for events caused by biological hazards and integrated into national emergency response plans[88]	❑
Level 4	All designated PoE have developed PoE public health emergency contingency plans for events caused by all hazards[89] and integrated into national emergency response plans	❑
Level 5	All PoE public health emergency contingency plans for events caused by all hazards all designated PoE are exercised (as appropriate), reviewed, evaluated and updated on a regular basis	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice

❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication

❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation

❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

88 See: Coordinated public health surveillance between points of entry and national health surveillance systems: advising principles. Lyon: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144805/WHO_HSE_GCR_LYO_2014.12_eng.pdf).

89 Consistent with any applicable international agreements.

	Indicators	
Level	**C11.3. Risk-based approach to international travel-related measures**	
Level 1	National multisectoral process with mechanisms to determine the adoption of international travel-related measures,[90] on a risk-based manner, is not available or under development	❑
Level 2	National multisectoral process with mechanisms to determine the adoption of international travel-related measures, on a risk-based manner, is developed including guidelines and SOPs for their implementation	❑
Level 3	National multisectoral process with mechanisms to determine the adoption of international travel-related measures, on a risk-based manner, is developed and being implemented at national level	❑
Level 4	National multisectoral process with mechanisms to determine the adoption of international travel-related measures; on a risk-based manner, is developed and being implemented at national and intermediate levels	❑
Level 5	National multisectoral process and mechanisms to determine the adoption of international travel-related measures are being implemented at national, intermediate and local levels and exercised (as appropriate), reviewed, evaluated and updated on a regular basis, in response to an event or emergency	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice
❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication
❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation
❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

❑ planned ❑ achieved ❑ strength/best practice
❑ ongoing ❑ challenges/gaps ❑ other

Area Involved:

❑ financing ❑ policy ❑ leadership & governance ❑ risk communication
❑ guidelines & SOPs ❑ infrastructure & logistics ❑ assessments ❑ legislation
❑ coordination & collaboration mechanisms ❑ workforce ❑ health information systems ❑ others

90 Multisectoral process and mechanism to determine the adoption of travel-related measures on a risk-based manner, includes measures at PoE for prevention, detection/investigation, response and recovery. These also include national plans, guidelines and SOPs.

C12. ZOONOTIC DISEASES

It is essential to have operational coordination in preparedness, planning, surveillance and response to zoonotic diseases and other health events that exist or emerge at the human–animal–environment interface. The IHR require there to be mechanisms and documented procedures in place in all relevant sectors[91] – particularly those responsible for human, animal (livestock, pets, wild animals)[92] and environmental health.

This capacity includes a country's ability to prepare for, prevent, identify, conduct risk assessment for and report health concerns at the human–animal–environment interface that may not currently be considered as zoonoses but that have characteristics that strongly suggest some potential future zoonotic threat. Similarly, investigation of the epidemiology of a new disease in humans should include consideration of a possible source in livestock or wildlife.

	Indicators	
Level	**C12.1. One Health[93] collaborative efforts across sectors on activities to address zoonoses**	
Level 1	The animal, human, and environment health sectors work together on zoonoses on an ad hoc basis	❑
Level 2	The animal, human and environment health sectors have jointly mapped existing and areas of collaboration and agreed on prioritized zoonoses for coordinated prevention and control activities	❑
Level 3	The animal, human and environment health sectors collaborate regularly and coordinate their activities[94] at national level to prevent, detect assess/investigate and respond to one or more prioritized zoonoses(s). Their ability to detect new or emerging zoonotic diseases has been demonstrated in some occasions	❑
Level 4	The animal, human and environment health sectors collaborate regularly and coordinate their activities at national and intermediate level to prevent, detect assess/investigate and to respond to prioritized zoonoses, and have appropriate procedures to jointly react in case of emergency, including in case of new or emerging zoonotic diseases	❑
Level 5	One Health multisectoral capacities to prevent, detect, assess/investigate and respond to zoonotic events (endemic and emerging) are exercised (as applicable, reviewed, evaluated, updated on a regular basis and improvements are implemented accordingly)	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

91 See: C2. IHR coordination and National IHR Focal Point functions.
92 Technical note on definition of "animal" includes wildlife, domestic and livestock.
93 "One Health" is an approach for designing and implementing programmes, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes. The areas of work in which the One Health approach is particularly relevant include food safety, the control of zoonosis and combating antimicrobialresistance (What is "One Health"? News Release, 21 September 2017. Geneva: World Health Organization (https://www.who.int/news-room/questions-and-answers/item/one-health).
94 Specific activities could include surveillance (epidemiology and laboratory), data-sharing (including cross-sectoral and internationally), situation or risk assessments, planning, risk reduction and risk communication.

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

C13. FOOD SAFETY

States Parties should have adequate capacity for timely detection, investigation and response to food safety events. These may involve foodborne diseases and/or food contamination that could constitute a public health emergency of national or international concern. There should be collaboration between the relevant authorities at national level as well as through active membership in the International Food Safety Authorities Network (INFOSAN). Food safety is a multisectoral issue and the agencies/sectors responsible for detecting, investigating and responding to a food safety emergency should adopt a One Health approach.

	Indicators	
Level	**C13.1 Multisectoral collaboration mechanism[95] for food safety[96] events**	
Level 1	A multisectoral collaboration mechanism that includes an INFOSAN[97] Emergency Contact Point[98] is under development, activated on an ad hoc basis.	❑
Level 2	A multisectoral collaboration mechanism that includes the INFOSAN Emergency Contact Point is in place at the national level AND Communication channels[99] between the INFOSAN Emergency Contact Point, the National IHR Focal Point and all relevant sectors for food safety events, including for emergencies, have been established at the national level.	❑
Level 3	A multisectoral collaboration mechanism and communication channels that includes the INFOSAN Emergency Contact Point is in place at the national, intermediate and local levels, if appropriate, to the structure and governance of the country.	❑
Level 4	A multisectoral collaboration mechanism and communication channels between the INFOSAN Emergency Contact Point, the National IHR Focal Point and all relevant sectors for food safety events including emergencies, at the international level have been established.	❑
Level 5	The multisectoral collaboration mechanism related to food safety events and Communication channels between the INFOSAN emergency contact, the National IHR Focal Point, and other relevant sectors for food safety events including emergencies at national and international level have been exercised (as applicable), reviewed, evaluated and updated as appropriate.	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ achieved
- ❑ strength/best practice
- ❑ ongoing
- ❑ challenges/gaps
- ❑ other

Area Involved:

- ❑ financing
- ❑ policy
- ❑ leadership & governance
- ❑ risk communication
- ❑ guidelines & SOPs
- ❑ infrastructure & logistics
- ❑ assessments
- ❑ legislation
- ❑ coordination & collaboration mechanisms
- ❑ workforce
- ❑ health information systems
- ❑ others

95 A multisectoral collaboration mechanism for food safety should include all sectors relevant to food safety across national, regional and local government as applicable, and industry, with clearly defined roles and responsibilities, hierarchies and channels of communication between the stakeholders documented. Documented procedures for the detection of and response to food safety emergencies should also be specified.

96 Reflecting the multidisciplinary nature and complexity of food safety, the detection and response to food safety emergencies is very rarely managed within one ministry and is a collaborative effort between several national authorities, such as food safety, agriculture, fisheries, veterinary services, trade, standards, health and various other authorities dependent on the structure of the respective Member State.

97 INFOSAN – the International Food Safety Authorities Network (https://www.who.int/groups/fao-who-international-food-safety-authorities-network-infosan/about).

98 The INFOSAN Emergency Contact Point is a member of the national authority responsible for the coordination of national food safety emergency response. (See Level 3 for the INFOSAN Emergency Contact Point.).

99 Communication channels refer to the way information flows within and between organizations and stakeholders. This can be informal (i.e. person-to-person, undocumented telephone calls and emails) or formal (i.e. following established documented procedures, such as the ones for risk management, documented meetings and teleconferences).

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

C14. CHEMICAL EVENTS

Chemical events – including emergencies resulting from technological incidents, natural disasters, deliberate actions or contaminated foods and products – are common and occur worldwide. This IHR capacity relates to the resources for detecting those events and alerting the population to the danger. Other capacities required for these kinds of events – i.e. legislation and policies, preparedness planning, response, strategic coordination – are incorporated into relevant capacities described earlier. It is important to be aware that some of the responsibilities for these capacities fall on sectors other than the health sector – such as the sectors for environment, labour, agriculture, civil protection, transport or customs. Coordination and collaboration between these sectors are therefore important to ensure the timely detection of potential chemical risks and/or events, and an effective response to them.[100]

	Indicators	
Level	**C14.1 Resources for detection and alert**	
Level 1	Surveillance mechanisms and resources[101] for chemical events or poisoning are under development	❑
Level 2	Surveillance capacity for chemical exposures is available on an ad hoc basis, e.g., a poison information service that operates only during office hours or that only serves part of the country AND access to laboratory capacity[102] for identifying and quantifying exposures to key chemicals of concern[103] is available on an ad hoc basis	❑
Level 3	A poisons information service[104] or equivalent national service that performs surveillance for chemical exposures, and for communication of alerts is in place on a 24/7 basis	❑
Level 4	Access to laboratory that conforms to national quality standard for identifying and quantifying chemical exposures to key chemicals of concern is in place	❑
Level 5	An integrated system of public health surveillance linked with environmental monitoring,[105] that captures and assesses data on chemical exposures from multiple sources, is under development or in place	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ achieved
- ❑ strength/best practice
- ❑ ongoing
- ❑ challenges/gaps
- ❑ other

Area Involved:

- ❑ financing
- ❑ policy
- ❑ leadership & governance
- ❑ risk communication
- ❑ guidelines & SOPs
- ❑ infrastructure & logistics
- ❑ assessments
- ❑ legislation
- ❑ coordination & collaboration mechanisms
- ❑ workforce
- ❑ health information systems
- ❑ others

100 See also: International Health Regulations (2005) and chemical events. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/249532/9789241509589-eng.pdf).

101 Mechanisms for surveillance include policies, guidelines and systems for reporting actual or potential chemical events to a central authority, and guidance for assessing and taking action on these events. The resources needed for this activity include one or more poisons information centres, and toxicological and environmental laboratories.

102 There should be access to at least one laboratory that is able to measure key chemicals of public health importance in the country, e.g. toxic metals and metalloids, pesticides and persistent organic pollutants.

103 List to be determined by the responding State Party.

104 The poisons information service (which may comprise one or more centres) should have dedicated staff and provide national coverage. Its contact (telephone) number should be widely known among its intended users (e.g. published in telephone directories, in hospital and primary care internal directories, on a website etc.) Refer to: Guidelines for poison control. Geneva: World Health Organization; 1997 (https://apps.who.int/iris/handle/10665/41966).

105 These include primary and secondary health facilities, poisons centres, toxicology laboratories and environmental monitoring.

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

C15. RADIATION EMERGENCIES

Radiological emergencies and nuclear accidents – referred to as radiation emergencies[106] – are rare. However, when they happen, they can range from minor to catastrophic. Management of large events can be exhausting in terms of both resources and human capacity. The consequences of a radiation emergency may last for decades. The response to such emergencies is multisectoral and requires specific infrastructure and expertise that are different from what is needed to respond to outbreaks. Specific legislation is required, along with cross-sectoral coordination. In most countries, the competence and responsibility for responding to radiation emergencies are outside the national health authorities. Consequently, coordination between national radiation authorities, health and non-health sectors (e.g. meteorological services, environmental protection, trade and travel, law enforcement etc.) is needed at all stages of preparedness, surveillance, response and long-term management of the consequences of radiation emergencies.[107] The relevant core capacities differ for countries with different risk profiles. Thus, the required core capacities for countries that make limited use of radioactive sources will differ from the capacities required by countries that possess nuclear technologies in industry, medicine and research. The international radiation safety standards published by the International Atomic Energy Agency (IAEA) and co-sponsored by WHO and other international organizations give guidance on generic requirements for preparedness and response to radiological emergencies and nuclear accidents.

	Indicators	
Level	**C15.1. Capacity and resources**	
Level 1	Surveillance mechanisms and resources[108] for radiation emergencies are under development.	❑
Level 2	Radiation sources have been inventoried and radiation risk mapping[109] has been conducted and documented.	❑
Level 3	Access to specialized health care for radiation injuries[110] is in place AND access to laboratory testing capacity for monitoring, identification and assessment of radiation exposure is in place.	❑
Level 4	Access to technical expertise for managing radiation emergencies,[111] including guidelines, protocols and regularly trained experts, is in place AND access to stockpile to support radiation emergency preparedness and response is in place.	❑
Level 5	Radiation emergency arrangements are formally exercised (as applicable), reviewed, evaluated on a regular basis, and improvements are made accordingly.	❑

Please add below comments describing the rationale for the checked level for this **indicator** and specify the activities that are related to capacity-building for this indicator. Choose all applicable checkboxes according to the status of implementation and the area related to your comments

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

106 For the purpose of this document the terms "radiological emergencies" and "nuclear accidents" are shortened to "radiation emergencies" that encompasses both types of emergencies.
107 Refer to: Preparedness and response for a nuclear or radiological emergency: general safety requirements. IAEA Safety Standards No. GSR Part 7. Vienna: International Atomic Energy Agency; 2015 (https://www.iaea.org/publications/10905/preparedness-and-response-for-a-nuclear-or-radiological-emergency).
108 Mechanisms for surveillance include policies, guidelines and systems for reporting actual or potential radiation emergencies to a central authority, and guidance for assessing and acting on these events. The resources needed include infrastructure for monitoring, identification and assessment of radiation exposure.
109 Radiation risk mapping implies that an inventory of all radiation sources and potential risks has been completed, so that national plans are focused on country-specific scenarios of a potential radiation emergency.
110 This refers to facilities and case management of individuals with radiation injuries.
111 This refers to the public health response to radiation emergencies, such as resource mobilization and risk communication.

Please add any additional comments for this **capacity** as applicable. Choose all applicable checkboxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- ❑ planned
- ❑ ongoing
- ❑ achieved
- ❑ challenges/gaps
- ❑ strength/best practice
- ❑ other

Area Involved:

- ❑ financing
- ❑ guidelines & SOPs
- ❑ coordination & collaboration mechanisms
- ❑ policy
- ❑ infrastructure & logistics
- ❑ workforce
- ❑ leadership & governance
- ❑ assessments
- ❑ health information systems
- ❑ risk communication
- ❑ legislation
- ❑ others

ANNEX 1

IMPROVEMENTS TO THE SPAR SECOND EDITION (2021)

The second edition of SPAR (2021) has 15 capacities and 35 indicators compared to 13 capacities and 24 indicators in the first edition.

The two new capacities are Financing and Health Services Provision. The eleven new indicators are mentioned in the table below. The sequence of the capacities has changed, as highlighted in the table below.

Summary of changes between version one and version two of the SPAR		
New capacities	**SPAR 1st ed. 2018–2020**	**SPAR 2nd ed. 2021**
Splitting of capacity, with name change and creation of new capacity (Financing)	C1. Legislation and financing	Two separate capacities renamed to: C1. - Policy, legislation and normative instruments to implement the IHR and new capacity as C3. (Financing)
Creation of new capacity from previous indicator (IPC)	C9. – Health service provision, indicator C9.2. – Capacity for IPC and chemical and radiation decontamination	Previous indicator C9.2. deleted from capacity C9. – Health service provision and became a new capacity: C9. – Infection prevention and control (IPC)
List of changes in capacities and indicators	**SPAR 1st ed. 2018–2020**	**SPAR 2nd ed. 2021**
Change of name of capacities and new indicator	**C1. – Legislation and financing**	**C1. – Policy, legislation and normative instruments to implement the IHR**
Change of name of indicator	C1.1. Legislation, laws, regulations, policy, administrative requirements or other government instruments to implement the IHR	C1.1. Policy, legislation and normative instruments
New indicator	C1.2. Financing for the implementation of IHR capacities (See new C3.)	C1.2. Gender equality in health emergencies New indicator
Old indicator had moved for new capacity	C1.3. Financing mechanism and funds for timely response to public health emergencies (See new C3.)	----------
No change	**C2. IHR coordination and National IHR Focal Point functions**	**C2. IHR coordination, National IHR Focal Point functions and advocacy**
No change	C2.1. National IHR Focal Point functions under IHR	C2.1. National IHR Focal Point functions under IHR
No change	C2.2. Multisectoral IHR coordination mechanisms	C2.2. Multisectoral coordination mechanisms
New indicator C2.3.	----------	C2.3. Advocacy for IHR implementation New indicator
Change of name of capacity, with new capacity in place	**C3. Zoonotic events and the human–animal interface** (See new C12.)	**C3. Financing**

Change of name of indicator, with new capacity in place	C3.1. One Health collaborative efforts across sectors on activities to address zoonoses	C3.1. Financing for IHR implementation
New indicator	----------	C3.2. Financing for public health emergency response
Change of place for Laboratory with new indicators	**C4. Food Safety** (See new C13)	**C4. Laboratory**
Change of place of indicator	C4.1. Multisectoral collaboration mechanism for food safety events	C4.1. Specimen referral and transport system
Change of place of indicator	----------	C4.2. Implementation of a laboratory biosafety and biosecurity regime
New indicator	----------	C4.3. Laboratory quality system New indicator
Change of name and place of indicator	----------	C4.4. Laboratory testing-capacity modalities
New indicator	----------	C4.5. Effective national diagnostic network New indicator
Change of place for Surveillance	**C5. Laboratory**	**C5. Surveillance**
Change of place of indicator	C5.1. Specimen referral and transport systems	C5.1. Early warning surveillance function
Change of place of indicator	C5.2. Implementation of a laboratory biosafety and biosecurity regime	C5.2. Event management
Change of place of indicator	C5.3 Access to laboratory testing capacity for priority diseases	----------
Change of place for Human Resources with new indicators	**C6. Surveillance**	**C6. Human resources**
Change of place for indicator	C6.1. Early warning Surveillance function	C6.1. Human resources for implementation of IHR
New indicator	C6.2. Event management	C6.2. Workforce surge during a public health event New indicator
Change of name and place for Health emergency management with new names for indicators	**C7. Human resources**	**C7. Health emergency management**
Change of place and name of indicator	C7.1 Human resources for the implementation of IHR capacities	C7.1. Planning for health emergencies
Change of place and name of indicator	----------	C7.2. Management of health emergency response
Change of place and name of indicator	----------	C7.3. Emergency logistics and supply chain management

Change of place with new names for indicators	**C8. National Health Emergency Framework** (see new C7.)	**C8. Health services provision**
Change of place and name of indicator	C8.1. Planning for emergency preparedness and response mechanism	C8.1. Case management
Change of place and name of indicator	C8.2. Management of health emergency response operations	C8.2. Utilization of health services
Change of place and name of indicator	C8.3. Emergency resource mobilization	C8.3. Continuity of essential health services (EHS)
New capacity	**C9. Health service provision**	**C9. Infection prevention and control (IPC)**
New indicator	C9.1. Case management capacity for IHR relevant hazards	C9.1. IPC programmes New indicator
New indicator	C9.2. Capacity for IPC and chemical and radiation decontamination	C9.2. Health care-associated infections (HCAI) surveillance New indicator
New indicator	C9.3. Access to essential health services (EHS)	C9.3. Safe environment in health facilities New indicator
New name for capacity with new indicators	**C10. Risk communication**	**C10. Risk communication and community engagement (RCCE)**
Change of name of indicator	C10.1 Capacity for emergency risk communications	C10.1. RCCE system for emergencies
New indicator	----------	C10.2. Risk communication New indicator
New indicator	----------	C10.3. Community engagement New indicator
New name for capacity with new indicator	**C11. Points of entry (PoEs)**	**C11. Points of entry (PoEs) and border health**
Small change, adding field for ICAO, IATA and ports, and ground crossing codes for geo-information systems to use to produce maps	Section 1. Information by type of points of entry	Section 1. Information by type of points of entry
No change	Section 2. Overall national profile of the implementation of core capacities at points of entry	Section 2. Implementation of core capacities at points of entry and travel-related measures
No change	C11.1 Core capacity requirements at all times for designated airports, ports and ground crossings	C11.1. Core capacity requirements at all times for points of entry
No change	C11.2 Effective public health response at points of entry	C11.2. Public health response at points of entry
New indicator	----------	C11.3. Risk-based approach to international travel-related measures New indicator

Change of place	**C12. Chemical events**	**C12. Zoonotic diseases**
Change of place	C12.1 Resources for detection and alert	C12.1. One Health collaborative efforts across sectors on activities to address zoonoses
Change of place	**C13. Radiation emergencies**	**C13. Food safety**
Change of place	C13.1. Capacity and resources	C13.1 Multisectoral collaboration mechanism for food safety events
Change of place	----------	**C14. Chemical events**
Change of place	---------	C14.1. Resources for detection and alert
Change of place	---------	**C15. Radiation emergencies**
Change of place	---------	C15.1. Capacity and resources
Total capacities and indicators	**13 capacities 24 indicators**	**15 capacities 35 indicators**

ANNEX 2

EXAMPLES OF SELECTING LEVELS FOR CAPACITIES AND INDICATORS

The table below provides scenarios and recommendations on what level to choose. As noted at the beginning of the document, only one level of performance can be selected for each indicator, and that level should be the one that best describes the State Party's implementation status. All attributes associated with a level must be in place in order to consider the next level.

	Description	Level to be selected
Scenario 1	All attributes exist in Levels 2, 3, 4 and 5, but some attributes are missing in Level 1.	There should be no score as some attributes are missing to warrant a score of Level 1 for this indicator. This, despite the presence of some attributes that fulfil the score Levels 2, 3, 4 or 5. Please add rationale in the Comments box
Scenario 2	All attributes are available in Level 1. Some attributes are missing in Level 2 All attributes are available in Levels 3, 4, or 5 Level 1 –all attributes available **Level 2 –some attributesare available** Level 3 – all attributes available Level 4 – all attributes available Level 5 – all attributes available	The indicator should be scored at Level 1. Level 2 should not be selected because of missing attributes despite the presence of all attributes in Levels 3, 4 or 5.
Scenario 3	Under rare circumstance when no information on the attributes for Level 2 is available and when all attributes are available for Level 1. Attributes for Levels 3, 4 or 5 are also available. Level 1 – all attributes available **Level 2 – no information** Level 3 – all attributes available Level 4 – all attributes available Level 5 – all attributes available	The indicator should be scored Level 1. Level 2 should not be selected because of lack of information on existence of attributes. Level 1 should be chosen despite the presence of all attributes in Levels 3, 4 or 5.

ANNEX 3

EXAMPLE OF THE USE OF COMMENT BOXES FOR INDICATORS AND CAPACITIES

The purpose of the comment boxes under each indicator is to allow States Parties to provide additional information and the rationale for the indicator score. Under the comments section, there are two sets of queries, namely: «Status of implementation" and "Areas involved". These queries are aimed at detailing what has been written under the comments section, as in the example for the "Indicator" comment box provided below.

The "Status of implementation" field relates to the level of implementation of activities that your comments refer to while the "Areas involved" field identifies the areas being referred to. The items in both queries were extracted from the classification of the answers received in 2019 and 2020.

Comment boxes are also available for capacities. In the PDF version, they are located after the last indicator for that capacity. Comments to be written under the "Capacity" comment box are broader compared to indicator-specific comments.

Note: In the online version, "Capacity" comment boxes are under each "Indicator" comment box to allow for ease in documentation.

Example of country comments related to the indicator C10.1. RCCE systems for emergencies			
Indicator: Comment box			
The risk communication strategic plan and RCCE policy are developed; however, they are not yet endorsed and emergency risk communications are done on an ad hoc basis.			
Status of implementation:			
☐ planned	☑ achieved	☐ strength/best practice	
☑ ongoing	☑ challenges/gaps	☐ other	
Areas Involved:			
☐ financing	☑ policy	☐ leadership & governance	☑ risk communication
☐ guidelines & SOPs	☐ infrastructure & logistics	☐ assessments	☐ legislation
☐ coordination & collaboration mechanisms	☐ workforce	☐ health information systems	☐ others

Example of country comments related to the capacity C5. Surveillance			
Capacity: Comment box			
Currently there is a need to finalize SOPs for surveillance teams. Surveillance teams have been established to respond rapidly to public health events/risks. There are SOPs for certain diseases under surveillance but these need to be inclusive of multisectoral agencies (i.e. One Health approach).			
Status of implementation:			
☐ planned	☑ achieved	☐ strength/best practice	
☑ ongoing	☑ challenges/gaps	☐ other	
Area Involved:			
☐ financing	☐ policy	☐ leadership & governance	☐ risk communication
☑ guidelines & SOPs	☐ infrastructure & logistics	☐ assessments	☐ legislation
☐ coordination & collaboration mechanisms	☑ workforce	☐ health information systems	☐ others

ANNEX 4

GLOSSARY: WORKING DEFINITIONS

NB: The definitions provided below for words and phrases found in the text relate to their use in the context of this document only and may differ from definitions used in other documents.

Affected	Persons, baggage, cargo, containers, conveyances, goods, postal parcels or human remains that are infected or contaminated, or that carry sources of infection or contamination, so as to constitute a public health risk.
After-Action Review (AAR)	Qualitative review of actions taken to respond to an emergency as a means of identifying best practices, gaps and lessons learned by bringing together relevant stakeholders involved in the preparedness for and the response to the public health event under review. See: WHO's Guidance for after action review (AAR). Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/WHO-WHE-CPI-2019.4).
Attribute	One of a set of specific elements or characteristics that reflect the level of performance or achievement of a specific indicator.
Authorized Port to issue Ship Sanitation Certificates (SSCs)	According to the IHR, States Parties authorize certain ports to inspect ships and issue the certificates (or their extensions) and to provide related services and control measures, as referred to in Article 20.3 and Annex 1 of the IHR (2005). Any port authorized to issue the Ship Sanitation Control Certificate (SSCC) must have the capability to inspect ships, issue certificates and implement (or supervise the implementation of) necessary health control measures. States Parties may also authorize ports to issue the Ship Sanitation Control Exemption Certificate (SSCEC) or to grant extensions of up to one month to conveyance operators if they are unable to carry out the necessary measures at the port in question. The States Parties must also send to WHO the list of their ports authorized to: • issue SSCCs and provide the related services referred to in IHR Annex 3 (Requirements for the SSC) and Annex 1B (Core capacity requirements for designated ports); • issue SSCECs only and extend a valid SSCEC or SSCC for one month until the ship arrives in a port at which the certificate may be issued. Each State Party must inform WHO of any changes that occur in the status of the listed ports. WHO publishes and updates a list of these authorized ports, with related information. This list is available on WHO's website (https://extranet.who.int/ihr/poedata/public/en). For further information, see: WHO's Handbook for inspection of ships and issuance of ship sanitation certificates. Geneva; World Health Organization; 2011 (https://www.who.int/publications/i/item/9789241548199).
Biological hazards	Infectious disease events, including zoonotic and food safety events.
Biosafety	Maintenance of safe conditions in storing, handling and disposing of biological substances to prevent inadvertent exposure of personnel and accidental release to the community or environment.
Biosecurity	Institutional and personal security measures designed to prevent the loss, theft, misuse, diversion or intentional release of pathogens and toxins. See WHO's Laboratory biosafety manual. Fourth edition. Geneva: World Health Organization; 2004 (https://www.who.int/publications/i/item/9789240011311).

Budget	Itemized summary of expected income and expenditure of a country, company, etc., over a specified period, usually a financial year.
Case definition	Set of diagnostic criteria for use during surveillance and outbreak investigations that must be fulfilled for an individual to be regarded as a case of a particular disease for the purposes of surveillance and outbreak investigations. Case definitions can be based on clinical criteria, laboratory criteria or a combination of the two, along with the elements of time, place and person. The case definitions relating to the four diseases in connection with which all cases must be notified by States Parties to WHO, regardless of circumstances, are published on the WHO website under Annex 2 of the International Health Regulations (2005). (See: https://www.who.int/publications/m/item/annex-2-of-the-international-health-regulations-(2005)).
Communicable disease or infectious disease	Illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or the inanimate environment (Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001).
Competent authority	Authority responsible for the implementation and application of health measures under the IHR. See: International Health Regulations (2005), third edition. Geneva: World Health Organization; 2016 [See: Article 22 Role of competent authorities]. https://www.who.int/publications/i/item/9789241580496).
Contamination	Presence of an infectious or toxic agent or matter on a human or animal body surface, in or on a product prepared for consumption or on other inanimate objects, including conveyances, that may constitute a public health risk.
Decontamination	Procedure whereby health measures are taken to eliminate an infectious or toxic agent or matter present on a human or animal body surface, in or on a product prepared for consumption or on other inanimate objects, including conveyances, that may constitute a public health risk.
Designated point of entry	According to Articles 20 and 21 of the IHR, a designated point of entry is an airport, port or ground crossing designated by a State Party to develop the capacities in Annex 1 of IHR.
Disease	Illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans.
Documented procedures	Agreed and approved strategies for operation, standard operating procedures, roles and responsibilities, agreements, terms of reference, chains of command, reporting mechanisms, etc.
Early warning system	In disease surveillance this is a specific procedure to detect as early as possible any abnormal occurrence or any departure from usual or normally observed frequency of phenomena (e.g. one case of Ebola fever). An early warning system is useful only if it is linked to mechanisms for early response (adapted from Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001).

Emergency Operation Centre (EOC)	• The national health EOCs are networked with health EOCs at subnational and local levels, and are interoperable with EOCs in other sectors, including with the National disaster management office. – EOC plans and SOPs describe key structural and operational elements; forms and templates for EOC data management, reporting and briefing; role descriptions and job aids for EOC functional positions (including incident management or command, operations, planning, logistics and finance) including information systems to connect public health decision-makers to appropriate data sources; – communications equipment; and – staff that are trained and capable of coordinating an emergency response. • National health EOC plans are in place for functions including public health science (epidemiology, medical and other subject matter expertise), public communications and partner liaison. • There are additional trained staff who can support and replace regular EOC staff on a rotational basis.
Evaluation	Process that seeks to determine, as systematically and objectively as possible, the relevance, effectiveness, efficiency and sustainability of a programme or strategy keeping in mind its objectives and accomplishments. This could include evaluation of structures, processes and outcomes (adapted from Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001).
Event	Manifestation of disease or an occurrence that creates a potential for disease as a result of events including, but not limited to, those that are of infectious, zoonotic, food safety, chemical, radiological or nuclear in origin or source.
Event-based surveillance	Organized and rapid capture of information about events that are a potential risk to public health, including events related to the occurrence of disease in humans and events related to potential risk-exposures in humans. This information can be rumours or other ad hoc reports transmitted through formal channels (e.g. established routine reporting systems) or informal channels (e.g. reports by the media, health workers or nongovernmental organizations). It is a component of early warning surveillance.
External financing	Financing from non-domestic sources towards the implementation of IHR capacities, the amounts of which make up a majority of, or complement, national financing for emergency preparedness, detection and response.
Extrabudgetary	Accounts held by government bodies, but not included in the government budget.
Financing	Funds and resources identified, allocated, distributed and executed on activities and interventions. The term does not consider costing or identifying how many resources or funds are necessary for the implementation of activities or interventions.
Funding	Money which a government or organization provides for a particular purpose.
Gender equality	Refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity – or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary strategies that are needed to reduce gender- based health inequities. For more information refer to the following WHO website: https://www.who.int/health-topics/gender.

Gender gaps	For the purpose of this document refers to sex-based and gender-based differentials or gender inequalities. Thus gender gaps here refer to differences between men and women that can arise because of biological, socioeconomic or sociocultural reasons.
Gender systematic assessment	Refers to evidence-based identification of a gender gap in order to understand the causes of that gender gap (sometimes referred to as gender analysis). Without knowing the causes of gender inequality it is not possible to develop an action plan to address it. Assessments can be done using secondary analysis of available data and research where possible, as well as with novel research. For further guidance see the following document: Gender mainstreaming for health managers: a practical approach (participant's notes). Geneva: World Health Organization; 2011 (https://www.who.int/publications/i/item/9789241501057).
Gender action plan	Refers to a planning document that includes: • activity(ies) that will be undertaken to address identified and assessed gender gap(s) • indicators to assess progress in closing each gender gap • data and measures required to track shifts in each indicator • training and (human and institutional) capacity requirements and how these will be met • an estimated line-item budget • a timeline
Gender high priority gaps	Refers to sex and gender gaps that are assessed in order to: 1) inhibit implementation effectiveness; 2) potentially affect a large proportion of the population of the disadvantaged sex (women and girls, or men and boys); and 3) act as a constraint on effective and full preparedness and response that the whole population can access. On the basis of the gender analysis conducted, each country will determine which elements of gender inequalities are high priority, with due consideration given to the differences in sociocultural contexts and gender norms across countries.
Ground crossing	A point of land entry in a State Party, including one utilized by road vehicles and trains.
Health-care facilities – water, sanitation and hygiene (WASH)	For global standards on WASH in health-care facilities, refer to: Adams J, Bartram J, Chartier Y. Essential environmental health standards in health care. Geneva: World Health Organization; 2008 (https://apps.who.int/iris/handle/10665/43767). WASH in health-care facilities should include: national WASH policy and standards; operational strategy and facility guidelines; education and training programmes; surveillance, monitoring and audit; and maintenance of essential WASH services (see the WHO website at: https://www.who.int/teams/environment-climate-change-and-health/).
Health-care worker	Any employee in a health care facility who has close contact with patients, patient care areas or patient care items; also referred to as health care personnel or a variety of professionals (such as medical practitioners, nurses, physical and occupational therapists, social workers, pharmacists, spiritual counsellors) who are involved in providing coordinated and comprehensive care (See: IPC of epidemic- and pandemic- prone acute respiratory diseases in health care, WHO Guidelines. Geneva: World Health Organization; 2014 (https://www.who.int/publications/i/item/infection-prevention-and-control-of-epidemic-and-pandemic-prone-acute-respiratory-infections-in-health-care).

Incidence	The "incidence" of a condition is the number of new cases in a period of time in a specified population (See: Murray CLJ, Lopez AD, Mathers CD, editors. The global epidemiology of infectious diseases. Geneva: World Health Organization; 2004 (https://apps.who.int/iris/handle/10665/43048).
Incident command system	See incident management system.
Incident management system	The emergency management structure and set of protocols that provide an approach to guiding government agencies, the private sector, nongovernmental organizations and other actors to work in a coordinated manner primarily to respond to and mitigate the effects of all types of emergencies. The incident management system may also be utilized to support other aspects of emergency management, including preparedness and recovery (also called incident command system).
Indicator	A variable that can be measured repeatedly (directly or indirectly) over time to reveal change in a system. It can be qualitative or quantitative, allowing the objective measurement of the progress of a programme or event. The quantitative measurements need to be interpreted in the broader context, taking other sources of information (e.g. supervisory reports and special studies) into consideration and supplemented with qualitative information.
Indicator-based surveillance	Routine reporting of cases of disease, including through notifiable diseases surveillance systems, sentinel surveillance, and laboratory-based surveillance. This routine reporting originates typically from a health-care facility where reports are submitted at weekly or monthly intervals.
Infection	Entry into, and development or multiplication of an infectious agent in, the body of humans and animals that may constitute a public health risk.
Infection control	Measures practised by health-care workers in health-care settings to limit the introduction, transmission and acquisition of infectious agents in health-care settings (e.g. proper hand hygiene, scrupulous work practices and the use of personal protective equipment, such as masks or particulate respirators, gloves, gowns and eye protection). Infection control measures are based on how an infectious agent is transmitted and include standard, contact, droplet and airborne precautions.
Infectious disease	See communicable disease.
Infection prevention and control (IPC) national programme	Ensemble of policies, goals, strategies, regulations, technical frameworks and monitoring of nosocomial infections. See: Core components for infection prevention and control programmes. Report of the Second Meeting. Informal network on infection prevention and control in health care. Geneva: World Health Organization; 2008 (https://apps.who.int/iris/bitstream/handle/10665/69982/WHO_HSE_EPR_2009.1_eng.pdf).
Infodemic	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. See: https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation).

Intra-action review (IAR)	Country-led facilitated discussion that allows national and subnational stakeholders of the COVID-19 response to reflect on actions being undertaken to prepare for and respond to the COVID-19 outbreak at the country level in order to identify current best practices, gaps and lessons learned, and propose corrective actions to improve and strengthen the continued response to COVID-19. Additionally, IAR findings and recommendations may contribute to improving the management of concurrent emergencies and to long-term health security. See: Guidance for conducting a country COVID-19 intra-action review (IAR). Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Country_IAR-2020.1).
Intermediate level	The administrative level next to the national level and below, but above the local community level/primary public health response level, such as state, district, province or region (From: International Health Regulations (2005). Second edition. Annex 1. Geneva: World Health Organization; 2008 (https://www.who.int/publications/i/item/9789241580410).
Legislation	Range of legal, administrative or other governmental instruments which may be available to States Parties for the implementation of IHR. This includes legally binding instruments, such as state constitutions, laws, acts, decrees, orders, regulations and ordinances; legally non-binding instruments, such as guidelines, standards, operating rules, administrative procedures or rules; and other types of instruments, such as protocols, resolutions, and multisectoral or interministerial agreements. This encompasses legislation in all relevant sectors (i.e. health, agriculture, transportation, environment, ports and airports) and at all applicable governmental levels, such as national, intermediate, community and primary.
Legal instrument	Measures enacted and implemented by national or subnational levels of government that are legally binding and enforceable. The types of legal instruments vary depending on the country's legal system. Legal instruments include, but are not limited to, constitutions, legislation, arête, decrees, regulations, administrative requirements and applicable international agreements. The type and number of legal documents which make up a legal system vary from country to country. As a result, the rules, rights and obligations of the government, its citizens and other entities also vary across countries. For further details see this WHO guidance document: (https://www.who.int/publications/m/item/international-health-regulations-(2005)-toolkit-for-implementation-in-national-legislation).
Local level	The local community level/primary public health response level (from International Health Regulations (2005). Second edition. Annex 1. Geneva: World Health Organization; 2008 (https://www.who.int/publications/i/item/9789241580410).
Member States (WHO)	The 194 current Member States of WHO, in accordance with Chapter III of the WHO Constitution (https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf) and currently identified on the WHO website (https://www.who.int/countries) and any States which may hereafter become a Member State of WHO in accordance with the WHO constitution.

Monitoring	The process of regular planning for and oversight of the implementation of activities, which seeks to ensure that inputs, work schedules, targeted outputs and other required actions are progressing as planned. The intermittent performance and analysis of routine measurements, aimed at detecting changes in the environment and health status of populations (adapted from: Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001). Monitoring in the context of surveillance and response refers to the routine and continuous tracking of the implementation of planned activities and of the overall performance of surveillance and response systems. It allows for tracking of progress in implementation of planned activities, ensuring that planned targets are achieved in a timely manner, identifying problems in the system that require corrective measures, providing a basis for readjustment of resource allocation based on ongoing needs and priorities, and ensuring responsibility and accountability for defined activities.
National legislation	See Legislation.
National IHR Focal Point (NFP)	National centre, designated by each State Party, which shall be accessible at all times for communications with WHO's IHR contact points in accordance with IHR.
Notifiable disease	Disease that, by statutory/legal requirements, must be reported to the public health or other authority in the pertinent jurisdiction when the diagnosis is made (adapted from: Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001).
Notification	Official communication of a disease/health event to the WHO by the health administration of the Member State affected by the disease/health event or national notification of an event to the national surveillance system, occurring at the country level, and not subject to notification to WHO.
One Health approach	In the context of WHO's IHR monitoring and evaluation framework, this means including, from all relevant sectors, national information, expertise, perspectives and experience necessary to conduct the assessments, evaluations and reporting.
Outbreak	An outbreak is defined as more cases of a disease than expected in a specific location over a specific time period. (Houlihan CF, Whitworth JA. Outbreak science: recent progress in the detection and response to outbreaks of infectious diseases. Clin Med (Lond). 2019;19(2):140–4. doi:10.7861/clinmedicine.19-2-140.)
Personal protective equipment	Specialized clothing and equipment designed to create a barrier against health and safety hazards; examples include eye protection (such as goggles or face shields), gloves, surgical masks and particulate respirators.
Point of entry (PoE)	Passage for international entry or exit of travellers, baggage, cargo, containers, conveyances, goods and postal parcels as well as agencies and areas providing services to them on entry or exit.
Port	Seaport or a port on an inland body of water where ships on an international voyage arrive or depart.
Priority diseases	Diseases of concern for a country with set criteria for the identification of these diseases.

Public health	The science and art of preventing disease, prolonging life and promoting health through organized efforts of society. Public health is a combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all people through collective or social actions. The goals are to reduce the amount of disease, premature death and disease-produced discomfort and disability in the population (summarized from: Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001).
Public health emergency of international concern (PHEIC)	An extraordinary event which is determined to: 1) constitute a public health risk to other States through the international spread of disease; and 2) potentially requires a coordinated international response public health risk. See the definition of "public health risk" in the IHR (2005) (https://www.who.int/publications/i/item/9789241580410).
Public health risk	The likelihood that an event may adversely affect the health of human populations, with an emphasis in the IHR on events that may spread internationally or may present a serious and direct danger.
Relevant sector	Ministries or agencies that are key to the technical area. Depending on the country and the technical area, these may include human health, animal health, agriculture, environment, food safety, finance, transport, trade/ports of entry, chemical safety, radiation safety, disaster management, emergency services, regulatory bodies and the media. Sectors and agencies responsible for aspects of the technical area but not key, such as private stakeholders (e.g. industry, medical associations, farmers associations) and academia may be included as needed.
Reservoir	Animal, plant or substance in which an infectious agent normally lives and whose presence may constitute a public health risk.
Risk	Situation in which there is a probability that the use of, or exposure to an agent or contaminated product will cause adverse health consequences or death.
Risk assessment	Qualitative or quantitative estimation of the likelihood of adverse effects that may result from exposure to specified health hazards or the absence of beneficial influences (adapted from: Last JM, Spasoff RA, Harris SS, editors. A dictionary of epidemiology. Fourth edition. New York (NY): Oxford University Press; 2001).
Risk communication	Real-time exchange of information, advice and opinion between experts or officials and people who are faced with a health risk or threat. Its purpose is to enable everyone at risk to take informed decisions for protective and preventive action. Risk communication includes a mix of communication and engagement strategies built on the basis of a sustainable system with dedicated resources to support the deployment of interventions that include public communication, media communication, social media communication, social mobilization, health promotion, health education, community engagement and operational and formative researches before, during and after health emergencies.
Safe environment	Also called the "built environment", is a core component for IPC programmes which enables delivery of patient care activities in a clean and/or hygienic environment that facilitates practices related to the prevention and control of HCAI, as well as AMR, including all elements around WASH infrastructure and services and the availability of appropriate IPC materials and equipment (i.e. personal protective equipment, hand hygiene-related products etc.).

Ship Sanitation Certificates (SSC)	When the IHR came into force on 15 June 2007, competent authorities could require from international ships the IHR SSC (IHR Annex 3), which covers public health risks on board and the necessary inspections and control measures taken in accordance with the IHR (2005). Competent authorities are required to use the IHR Annex 3 – SSC to identify and record all evidence of contamination or infection and other risks to human health in different areas, facilities or systems, together with any required control measures that must be applied (as authorized by the IHR) to control public health risks. The SSCs may be required from all ships, whether seagoing or inland navigation ships, on international voyages that call at a port of a State Party. See: Handbook for inspection of ships and issuance of ship sanitation certificates. Geneva: World Health Organization; 2011 (https://www.who.int/publications/i/item/9789241548199).
Simulation exercise (SimEx)	Operational tool for continuous learning and system improvements as it tests and enhances emergency preparedness and response functions. SimEx include discussion- based table-top exercises as well as operations-based exercises such as drills, functional exercises and field/full-scale exercises (See: https://www.who.int/publications/i/item/WHO-WHE-CPI-2017.10).
States Parties	These are the 194 WHO Member States, and the Holy See and Liechtenstein, currently identified by IHR (see website: https://www.who.int/health-topics/international-health-regulations#tab=tab_1, accessed 19 October 2021) and any States which may hereafter accede to the IHR in accordance with the terms of the Regulations and the WHO Constitution.
Surveillance	Systematic ongoing collection, collation and analysis of data for public health purposes and the timely dissemination of public health information for assessment and public health response, as necessary. Key components of surveillance include indicator-based surveillance and event-based surveillance.
Trained staff	Individuals who have gained the necessary educational credentials and/or have received appropriate instruction on how to deal with a specific task or situation.
Urgent event	Manifestation of a disease or an occurrence that creates a potential for disease which may have a serious public health impact and/or is of an unusual or unexpected nature, with a high potential for spread. The term “urgent” has been used in combination with other terms (e.g. infectious event or chemical event) in order simultaneously to convey both the nature of the event and the characteristics that make it “urgent” (i.e. serious public health impact and/or an unusual or unexpected nature with high potential for spread).
Vector	Insect or other animal which normally transports an infectious agent that constitutes a public health risk.
Verification	Provision of information by a State Party to WHO confirming the status of an event within the territory or territories of that State Party.
WHO IHR Contact Point	The IHR contact points are located at regional offices in all six WHO regions and are accessible at all times for communication with the National IHR Focal Point.
Zoonosis	Infection or disease that is transmissible between animals and humans.

CONTACT DETAILS

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