

INTERNATIONAL HEALTH REGULATIONS (2005)

STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

Second Edition



World Health
Organization

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CONTENTS

ACRONYMS	6
INTRODUCTION	7
• The SPAR tool	8
• Processing of data	8
• e-SPAR electronic platform for online reporting	8
RESPONDING THE SELF-ASSESSMENT AND REPORTING QUESTIONNAIRE	9
• Respondent identification	9
• Completion of annual report	9
• Reporting level of capacities using indicators and its attributes	10
• List of capacities and indicators	11
• Questionnaire for reporting level of capacities	12
• C1. Policy, legal and normative Instruments to implement IHR	12
• C2. IHR Coordination, National IHR Focal Point functions and advocacy	14
• C3. Financing	17
• C4. Laboratory	19
• C5. Surveillance	24
• C6. Human resources	26
• C7. Health emergency management	28
• C8. Health services provision	31
• C9. Infection prevention and control (IPC)	34
• C10. Risk communication and community engagement (RCCE)	38
• C11. Points of entry (PoEs) and border health	42
• Section 1. Information by type of PoE	42
• Section 2. Core capacities at PoEs and international travel-related measures	42
• C12. Zoonotic diseases	46
• C13. Food safety	48
• C14. Chemical events	50
• C15. Radiation emergencies	52
ANNEX 1. IMPROVEMENTS TO THE SPAR SECOND EDITION (2021)	54
ANNEX 2. EXAMPLES OF SELECTING LEVELS FOR CAPACITIES AND ITS INDICATORS	58
ANNEX 3. EXAMPLES OF THE USE OF COMMENT BOXES FOR INDICATORS AND CAPACITIES	59
ANNEX 4. GLOSSARY: WORKING DEFINITIONS	60

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 Party self-assessment annual reporting tool
SSC	Ship Sanitation Certificates
SSCC	Ship Sanitation Control Certificate
SSCEC	Ship Sanitation Control Exemption Certificate
WASH	Water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization

INTRODUCTION

Under the International Health Regulations (2005) – (IHR) (available at <https://www.who.int/publications/item/9789241580496>), States Parties are obliged to develop and maintain minimum core capacities for surveillance and response, including at points of entry, in order to detect, assess, notify and respond to any potential public health events of international concern.

Article 54 of the IHR request that States Parties and the Director-General shall report to the World Health Assembly (WHA) on the implementation of these Regulations as decided by the WHA. In 2008, the WHA, through the adoption of Resolution WHA61(2), and later on 2018 with the Resolution WHA71(15), confirmed that “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 Party self-assessment annual reporting tool (SPAR) is intended to support State Parties to fulfil these obligations. The submission of IHR Annual Reports using the SPAR tool allows the WHO Secretariat to compile a consistent report for the WHA.

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 Party self-assessment annual reporting tool (SPAR) was used for reporting from 2018 to 2020.

Beginning in 2021 the SPAR was reviewed and further improved, considering the initial experience of countries, to the COVID-19 pandemic. While improving the tool, these changes may mean limitations to the comparison of scores from previous years but will contribute to the better understanding of preparedness strengths and gaps based on the global experience of the COVID-19 pandemic. The second edition of SPAR (2021) has 15 capacities and 35 indicators compared to 13 capacities and 24 indicators in the first edition. Details of the changes are included in Annex 1.

The SPAR IHR annual report database is generated from information received from States Parties, based on national self-assessment and self-reporting. For that purpose WHO has made available an electronic platform for online reporting (e-SPAR, available at: <https://extranet.who.int/e-spar/>).

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

PROCESSING OF DATA

WHO receives the data send by each State Party, from the designated National IHR Focal Point or designated officers that 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 WHA. All data are recorded safely in the e-SPAR platform and available through the e-SPAR webpage at: <https://extranet.who.int/e-spar/>.

Production of statistics by WHO is processed as follows:¹

At the indicator level:

The e-SPAR tool is based on the assessment of a level of performance for each the indicator, on a "1 to 5" scale. When processed, the score of each indicator level is classified as a percentage of performance along the "1 to 5" scale, e.g., for a country selecting level 3 for indicator 2.1, the level of performance is expressed as: $3/5 \times 100 = 60\%$

At the capacity level:

The level of performance at the capacity level is expressed as the average of the indicators related to this capacity, e.g., for a country selecting Level 3 for indicator 2.1 and Level 4 for indicator 2.2. the level of performance of Capacity 2 will be expressed as: $[(3/5 \times 100) + (4/5 \times 100)] / 2 = 70\%$

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 IHR-NFP access to the restricted part of e-SPAR for a State Party, inclusive for online reporting and accessing detailed information of all annual reports since 2010, the designated national authorities responsible for IHR annual reporting are requested to update their contacts details in the WHO contact list for National IHR Focal Points, 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 to submit new report.

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 SPAR tool the users can send an email to ihrmonitoring@who.int.

¹ For the details on the analysis, please refer to International Health Regulations (2005): guidance document for the State Party self-assessment annual reporting tool (<https://www.who.int/publications/i/item/WHO-WHE-CPI-2018.17>, accessed 17 November 2021). *This document is being updated for SPAR Second Edition (2021).*

RESPONDING THE SELF-ASSESSMENT AND REPORTING QUESTIONNAIRE

This section details the different steps to use the online version of the SPAR

RESPONDENT IDENTIFICATION

Respondents must identify themselves according to the information fields below

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

3. Consultative process in compiling report:

- Via e-mail Virtual meeting
 Face-to-face 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 conduct a SimEx, an IAR or an AAR this year? If so, kindly check below the relevant box(es):

- 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 ITS ATTRIBUTES

The tool covers 15 capacities, each of which consists 1 to 5 indicators, with a total number 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 – For improvements to the SPAR Second edition (2021).

For each indicator, only one level of performance can be selected and should be 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 the attributes of Level 1 in order to examine the attributes in Level 2. If Level 2 is selected, this indicates that all attributes in Level 1 and Level 2 are fulfilled. Please see Annex 2 for examples of selecting levels for capacities.

It is recommended to respond to all the indicators, even if the final report will provide data at the capacity level. If no level is selected, it is regarded as the absence of performance and the score of zero is associated for statistics to this indicator, impacting the result for the capacity.

If a capacity is not applicable within a country context all the check boxes for that indicator should be left blank and it should be indicated, in the comments box as 'not applicable' and add any clarifications needed 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 in the implementation, can also added. Please see Annex 3 for examples on 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
- C3.3. 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 LEVEL OF CAPACITIES

C1. POLICY, LEGAL AND NORMATIVE INSTRUMENTS TO IMPLEMENT IHR²

States Parties should have an adequate legal framework in all relevant sectors³ to support and facilitate the effective and efficient implementation of all of 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 IHR in a more efficient, effective or beneficial manner. Through legal frameworks, the IHR should serve to institutionalize and strengthen essential public health functions to sustain improvements of overall health systems capacities. Policies for adopting health measures and IHR implementation should follow IHR principles (IHR Article 3) and should be applied in a transparent and non-discriminatory manner, including gender equality.⁴

		Indicators
Level	C1.1. Policy, legal and normative instruments ⁵	
Level 1	The country has not conducted a mapping ⁶ of relevant legal and normative instruments and policies for IHR implementation	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
Level 4	The country has identified and reviewed gaps in all sectors and across government levels ⁷ and developed and/or revised the necessary legal and normative instruments and policies for IHR implementation at the national and subnational levels, where applicable	<input type="checkbox"/>
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)	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation:		
<input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice		
<input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved:		
<input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication		
<input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation		
<input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others		

2 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.

3 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.

4 See definition of "Gender equality" in the Glossary.

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

6 Legal mapping helps to understand what a legal instrument says. Mapping provides a look at legal instruments across jurisdictions and/or 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 legal instruments, nor analyze its gaps. In the context of this indicator, legal mapping supports and facilitates the development, implementation, and strengthening preparedness for and response to public health risks (in accordance with Article 1 of IHR (2005), a likelihood of an event that may affect adversely 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 complimented by a legal assessment, as a functional review to evaluate the effectiveness of legal instruments, analyzing gaps with the country's legal system and context in mind.

7 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 ⁸ in any of the IHR capacities has been conducted <input type="checkbox"/>
Level 2	Systematic assessment ⁹ of gender gaps has been conducted in at least one IHR capacity <input type="checkbox"/>
Level 3	An action plan ¹⁰ to address identified high priority ¹¹ gender gaps in at least one IHR capacity is developed and incorporated in annual workplans <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	
Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

8 See definition of "Gender equality" in the Glossary.

9 See definition of "Gender systematic assessment" in the Glossary. For further guidance see the following document; WHO (2011) Gender Mainstreaming for Health Managers: A Practical Approach. Participant's Notes. (<https://www.who.int/publications/i/item/9789241501057>, accessed 3 November 2021).

10 See definition of "Gender action plan" in the Glossary.

11 See definition of "Gender high priority gaps" in the Glossary.

C2. IHR COORDINATION, NATIONAL IHR FOCAL POINT FUNCTIONS¹² AND ADVOCACY

Establishing and maintaining IHR capacities requires collaboration among all relevant sectors and ministries, agencies or other government bodies responsible for all aspects of the implementation of IHR capacities at the national, intermediate and local levels. Depending on the country and the capacity, all relevant sectors may include; human health, animal health, agriculture, environment, food safety, livestock, fisheries, finance, transport, trade, PoE, transport, travel, chemical safety, radiation safety, disaster management, emergency services, regulatory bodies, labour, education, foreign affairs, international treaties and convention, and the media. It can 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. Fundamental to this multisectoral approach is advocacy and coordination to bring all the relevant sectors together and the

recognition that risks to human health can emerge from various sources, such as other humans, domestic animals/livestock, wildlife, food, chemicals and/or radiation. Therefore, capacity to prevent, detect, report and respond to events or public health risks should exist within all relevant sectors.

The National IHR Focal Point, designated by each State Party, is the national centre for IHR communications with the WHO regional IHR contact points including notification of events¹³ and with all relevant sectors and bodies in the country. States Parties should provide their National IHR Focal Point with the necessary authority, capacity, training and resources (e.g., competent staff, adequate finances) to fulfil the functions required of them by the IHR. States Parties should provide WHO with contact details of the National IHR Focal Point, continuously update and annually confirm these contact details.

The updated contact details will allow National designated officers to sign into the e-SPAR platform and proceed 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 ¹⁴ 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	<input type="checkbox"/>
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	<input type="checkbox"/>
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 is inadequate to consolidate surveillance information or to obtain clearance from decision-makers in other domestic sectors	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>

¹² See IHR National Focal Point guide: Designation/establishment of national IHR focal points (<http://www.who.int/ihr/English2.pdf>, accessed 04 November 2021).

¹³ Under 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.

¹⁴ See National IHR Focal Point guide: Designation/establishment of National IHR Focal Points (<http://www.who.int/ihr/English2.pdf>, accessed 1 April 2018).

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 check boxes 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	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	<input type="checkbox"/>
Level 2	Multisectoral coordination mechanisms for IHR implementation are developed but not disseminated. Multisectoral coordination activities occur in ad hoc basis	<input type="checkbox"/>
Level 3	Multisectoral coordination mechanisms for IHR implementation are in place, disseminated and are being implemented at national level	<input type="checkbox"/>
Level 4	Multisectoral coordination mechanisms for IHR implementation are in place, disseminated and are being implemented at national and intermediate levels	<input type="checkbox"/>
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	<input type="checkbox"/>

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 check boxes 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	C2.3. Advocacy ¹⁵ for IHR implementation
Level 1	Advocacy mechanisms ¹⁶ for IHR implementation are not in place or under development. Advocacy activities are conducted on ad hoc basis <input type="checkbox"/>
Level 2	The advocacy mechanisms are developed but not disseminated. Advocacy activities are conducted on ad hoc basis <input type="checkbox"/>
Level 3	The advocacy mechanisms are in place, disseminated and being implemented at the national level <input type="checkbox"/>
Level 4	The advocacy mechanisms are in place, disseminated and being implemented at the national and intermediate levels <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	
Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

¹⁵ 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 Point 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, point of entry, public health services, clinics and hospital and other government departments (Article 4).

¹⁶ Advocacy mechanisms include strategic frameworks, guidelines, procedures and Standard operating procedures (SOPs), and plans.

C3. FINANCING

States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process.

Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers 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 ¹⁷ means	<input type="checkbox"/>
Level 2	Financial planning is limited with a budgetary allocation or substantial external financing ¹⁸ made for some of the relevant sectors ¹⁹ and their respective ministries to support the IHR implementation at the national level	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others		

¹⁷ Extrabudgetary means: accounts held by government bodies, but not included in the government budget.

¹⁸ External Financing: Financing from non-domestic sources towards the implementation of IHR capacities (that uses the (JEE); whose amounts make up a (SPAR)) majority of national financing for emergency preparedness, detection and response.

¹⁹ Relevant sectors including 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, 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 <input type="checkbox"/>
Level 2	Public financing exists that allows for structured reception, rapid distribution and use of funds for responding to public health emergencies <input type="checkbox"/>
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 <input type="checkbox"/>
Level 4	Public financing for responding to public health emergencies is place at national and intermediate levels and allows for the timely execution of funds ²⁰ by all relevant sectors during a public health emergency <input type="checkbox"/>
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 <input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>	
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>	
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>	
<p>Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity</p>	
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>	
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>	

²⁰ See definition of "Execution of budget" in the Glossary.

C4. LABORATORY

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

States Parties need to maintain mechanisms that ensure shipment of specimens to appropriate reference laboratories as necessary;²¹ reliable and timely laboratory testing; characterization of infectious agents and other hazards likely to cause public health emergencies of national and international concern; and timely sharing of results.

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 ²² is available <input type="checkbox"/>
Level 2	Referral and transport of specimens is organized ²³ for some priority diseases ²⁴ but may be restricted within districts or at the intermediate and national level <input type="checkbox"/>
Level 3	Referral and transport of specimens is organized for diagnostics and/or confirmation of most priority diseases from subnational to national level <input type="checkbox"/>
Level 4	Referral and transport of specimens is organized systematically for diagnostics and/or confirmation of all priority diseases at all levels <input type="checkbox"/>
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 ²⁵ and requests for the diagnosis, confirmation, characterization of all specimens with complete coverage at all levels <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

21 Reference laboratories could be national laboratories and/or international reference laboratory where the country has a formal memorandum of understanding for testing.

22 Ad hoc transportation: no SOP on how to transport samples.

23 This is an organized or established procedure within the country or outside. Some island countries may not require a system in place at the country level and can have access to regional or international laboratories.

24 Priority diseases are based on the local epidemiology and as defined in the national surveillance guidelines for priority diseases and/or notifiable diseases.

25 Define specimen types – include list of common specimen types.

Indicators	
Level	C4.2. Implementation of a laboratory biosafety ²⁶ and biosecurity ²⁷ regime
Level 1	National laboratory biosafety and biosecurity guidelines and/or regulations are under development <input type="checkbox"/>
Level 2	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by some laboratories at the national level <input type="checkbox"/>
Level 3	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by all laboratories at the national level <input type="checkbox"/>
Level 4	National laboratory biosafety and biosecurity guidelines and/or regulations are implemented by all laboratories at national, intermediate and local levels <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

²⁶ Laboratory biosafety refers to containment principles, technologies and practices that are implemented to prevent unintentional exposure to pathogens and toxins, or their accidental release.

²⁷ 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. Third edition. Geneva: World Health Organization; 2004 (<http://www.who.int/csr/resources/publications/biosafety/Biosafety7.pdf?ua=1>, accessed 1 April 2018).

Indicators	
Level	C4.3. Laboratory quality system ²⁸
Level 1	National laboratory quality standards are not available or under development <input type="checkbox"/>
Level 2	National quality standards have been developed but not implemented <input type="checkbox"/>
Level 3	National quality standards have been developed and implemented at national level. Activities include licensing of laboratories in conformity with national quality standard <input type="checkbox"/>
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 <input type="checkbox"/>
Level 5	National quality standards are implemented at all level including mandatory licensing of all laboratories in conformity with international quality standard and exercised, reviewed, evaluated and updated on a regular basis, as applicable <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

²⁸ 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>, accessed 1 April 2018).

Indicators	
Level	C4.4. Laboratory testing capacity ²⁹ 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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 ³⁰ <input type="checkbox"/>
Level 5	Laboratory system can perform in all capacities including access to whole genome sequencing; ³¹ identification of unknown and high consequence pathogens and has access to viral culture. Laboratory networks configured to support all diagnostic services ³² that are integrated ³³ are sustainable, with maximum population coverage, and exercised, reviewed, evaluated and updated on a regular basis as applicable <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

²⁹ 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).

³⁰ Priority diseases include, epidemic prone diseases, diseases earmarked for eradication/elimination and diseases of public health importance.

³¹ Access to whole genome sequencing may be through international collaboration including WHO collaborating centres.

³² This may include whole genomic sequencing and access to whole genome sequencing may be through international collaboration including WHO collaborating centres.

³³ Between the human, animal and environmental health sectors.

		Indicators
Level	C4.5. Effective national diagnostic network	
Level 1	Tier-specific diagnostic testing strategies ³⁴ are not available or under development.	<input type="checkbox"/>
Level 2	Tier-specific diagnostic testing strategies are developed.	<input type="checkbox"/>
Level 3	Tier-specific diagnostic testing strategies exist, but not fully implemented.	<input type="checkbox"/>
Level 4	Tier-specific diagnostic testing strategies are being implemented at national level.	<input type="checkbox"/>
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.	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		
<p>Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		

³⁴ Tier specific refers to the different administrative levels such as reference laboratories at national level, intermediate and local levels facility laboratories.

C5. SURVEILLANCE

IHR requires rapid detection of public health risks associated with biological, chemical and radiation events, as well as risk assessment, notification and response. A sensitive surveillance³⁵ system, including at PoE, is needed to ensure

the early warning function and provide information for an informed decision-making process during public health events and emergencies. This involves a multisectoral and integrated health system approach and may include sentinel surveillance systems 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	<input type="checkbox"/>
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	<input type="checkbox"/>
Level 3	National guidelines and/or SOPs for surveillance have been developed and are being implemented at the national level and provides immediate and weekly reporting of events and/or data	<input type="checkbox"/>
Level 4	National guidelines and/or SOPs for surveillance have been developed and are being implemented at the national and intermediate levels and provides immediate and weekly reporting of events and/or data	<input type="checkbox"/>
Level 5	National guidelines and/or SOPs for surveillance have been developed and implemented at national, intermediate and local ³⁶ levels; and the system is exercised (as applicable), reviewed, evaluated and updated on a regular basis, with improvement at all levels in the country	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others		

³⁵ See definition of "Surveillance" in the Glossary.

³⁶ 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, ³⁷ analysis, ³⁸ and dissemination of information)
Level 1	Process or mechanisms for managing detected events is not available or under development <input type="checkbox"/>
Level 2	Process or mechanisms for managing detected events has been developed but not implemented <input type="checkbox"/>
Level 3	Process or mechanisms for managing detected events has been developed and is being implemented at the national level <input type="checkbox"/>
Level 4	Process or mechanisms for managing detected events has been developed and is being implemented at the national and intermediate levels <input type="checkbox"/>
Level 5	Process or mechanisms 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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	
Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

³⁷ Investigation include contact tracing to identify all potential contacts and affected individuals.

³⁸ All surveillance data are systematically analysed for informed decision-making and dissemination.

C6. HUMAN RESOURCES

Strategies are in place to ensure that a multisectoral workforce is available and trained to enable early detection, prevention, preparedness and response to potential events of international concern at all levels of health systems, as required by the IHR.

The availability and accessibility of quality health workforce,³⁹ surge capacity in emergencies, including workforce for surveillance (e.g., field investigation and contact tracing teams) is critical to build the resilience of communities and for continuity of health services.

Indicators		
Level	C6.1. Human resources for implementation of IHR	
Level 1	Country does not have appropriate human resources ⁴⁰ capacity in relevant sectors ⁴¹ required, to detect, assess, notify, report and respond to events according to IHR provisions	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems		

³⁹ Attention to gender differentials in proportion of males to females holding decision making roles.

⁴⁰ 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.

⁴¹ Relevant sectors, including 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 ⁴² is not available or is under development	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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, as well may provide international collaboration for assisting emergency response.	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others		
Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others		

⁴² A national multisectoral workforce surge strategic plan in emergencies includes a gap analysis for 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 required surge workforce personnel with programmes for competency development, including procedures or policies for pre-deployment, deployment and post-deployment.

C7. HEALTH EMERGENCY MANAGEMENT

This capacity focuses on the national planning for health emergency management and systems for enabling countries to be prepared and operationally ready for response to any public health event, including emergencies, as per the requirement of IHR.

Ensuring risk-based plans for emergency preparedness and response, robust emergency management structures and mobilization of resources during an emergency is critical for a timely response to public health emergencies.

Indicators	
Level	C7.1. Planning for health emergencies
Level 1	A all-hazard risk informed ⁴³ health emergency plan ⁴⁴ is not available or under development <input type="checkbox"/>
Level 2	All-hazard risk informed health emergency plan is developed but not being implemented <input type="checkbox"/>
Level 3	All-hazard risk informed health emergency plan is developed and being implemented at the national level <input type="checkbox"/>
Level 4	All-hazard risk informed health emergency plan is developed and being implemented at the national and intermediate levels <input type="checkbox"/>
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 ⁴⁵ and lessons learned from real-world events, e.g., IARs ⁴⁶ or AARs ⁴⁷ <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

⁴³ Health emergency risk profiles should be based on a strategic multisectoral and multihazard health emergency risk assessment, and updated on a regular basis.

⁴⁴ 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.

⁴⁵ A SimEx can help develop, assess and test functional capabilities of emergency systems, procedures and mechanisms to be able to respond to outbreaks or public health emergencies. See definition of "SimEx" in the Glossary. For further information see <https://www.who.int/publications-detail-redirect/WHO-WHE-CPI-2017.10>, (accessed 3 November 2021).

⁴⁶ See definition of "IAR" in the Glossary. For information details see <https://apps.who.int/iris/handle/10665/341029>, (accessed 3 November 2021).

⁴⁷ An 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 definition of "AAR" in the Glossary for further information see <https://www.who.int/publications/i/item/WHO-WHE-CPI-2019.4>, (accessed 3 November 2021).

Indicators		
Level	C7.2. Management of health emergency response ⁴⁸	
Level 1	An incident management system ⁴⁹ integrated with a national public health emergency operations centre ⁵⁰ or equivalent structure is not available or under development	<input type="checkbox"/>
Level 2	An incident management system integrated with a national public health emergency operations centre, or equivalent structure is developed but not operational	<input type="checkbox"/>
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	<input type="checkbox"/>
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 and able to support intermediate levels	<input type="checkbox"/>
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 levels and exercised, reviewed, evaluated and updated, with improvements based on SimEx and lessons learned from real-world events, e.g., IARs or AARs	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems </p>		

48 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 health sector response with other sectors. Coordination mechanisms may apply incident management systems to fulfil the coordination function.

49 See definition of "Incident management system" (or incident command system) in the Glossary.

50 See definition of "EOC" in the Glossary.

Indicators	
Level	C7.3. Emergency logistic and supply chain management ⁵¹
Level 1	Emergency logistics and supply chain management system/mechanism ⁵² is under development and/or not able to provide adequate support for health emergencies <input type="checkbox"/>
Level 2	Emergency logistics and supply chain management system/mechanism is developed but not able to provide adequate support for health emergencies ⁵³ <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	
Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

51 To maintain updated emergency logistic and supply chain management system/mechanism may include 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.

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

53 Emergency logistics and supply chain system and mechanism includes the capacity to purchase, store and deliver essentials 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' transportations means, 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 both event-related case management and routine health services are and equally as important. Moreover, ensuring minimal disruption in health service utilization before, during and beyond an emergency and across the varied contexts within a country is also a critical aspect of a resilient health system.

Indicators		
Level	C8.1. Case management	
Level 1	National clinical case management guideline for priority health events ⁵⁴ are not available or under development	<input type="checkbox"/>
Level 2	National clinical case management guidelines for priority health events are developed but not being implemented ⁵⁵	<input type="checkbox"/>
Level 3	National clinical case management guidelines for priority health events are developed and being implemented at national level	<input type="checkbox"/>
Level 4	National clinical case management guidelines for priority health events are developed and being implemented at national and subnational levels	<input type="checkbox"/>
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	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		

⁵⁴ These should include SOPs with a list of designated referral health care facilities, referral procedures, field triage, safe transportation and case management guidelines to 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.).

⁵⁵ 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. Utilization of health services ⁵⁶
Level 1	Very low levels of service utilization (number of outpatient department visits per person per year < 1.00 visit/person/year in both urban and rural areas) <input type="checkbox"/>
Level 2	Low levels of service utilization (number of outpatient department visits per person per year $1.0 \leq X < 2.0$ visit/person/year, in both urban and rural areas) <input type="checkbox"/>
Level 3	Satisfactory levels of service utilization in tertiary health care facilities at national level (number of outpatient department visits per person per year ≥ 2.0 visit/person/year, in both urban and rural areas) <input type="checkbox"/>
Level 4	Strong levels of service utilization at all tertiary and secondary health care facilities at intermediate and national level and geographical contexts (number of outpatient department visits per person per year ≥ 3.0 visit/person/year, in both urban and rural areas) <input type="checkbox"/>
Level 5	Strong levels of service utilization at all tertiary, secondary and primary health care facilities at national, intermediate and local level and geographical contexts (number of outpatient department visits per person per year ≥ 3.0 visit/person/year, in both urban and rural areas) and information on service utilization is reviewed, evaluated and updated on a regular basis to inform policy and planning <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

⁵⁶ 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 (https://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_ServiceDelivery.pdf). 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. Reference source for Health Service Utilization indicator – Global Reference List of 100 Core Health Indicators (plus health-related SDGs). (<https://apps.who.int/iris/handle/10665/259951>, accessed 3 November 2021).

Indicators		
Level	C8.3. Continuity of essential health services (EHS)	
Level 1	A package of EHS ⁵⁷ is not defined and there are no plans or guidelines for continuity EHS during emergency	<input type="checkbox"/>
Level 2	A package of EHS is defined but plans/guidelines on continuity of EHS in emergencies is not developed	<input type="checkbox"/>
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 are in place at national level	<input type="checkbox"/>
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 are in place at national and intermediate levels	<input type="checkbox"/>
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 ⁵⁸ levels and exercised, reviewed, evaluated and updated, with improvements based on SimEx and lessons learned from real-world events, e.g., IARs or AARs	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		
<p>Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		

⁵⁷ Essential services: 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. (<http://apps.who.int/medicinedocs/documents/s19808en/s19808en.pdf>, accessed 3 November 2021).

⁵⁸ ALL levels include national, intermediate and local levels.

C9. INFECTION PREVENTION AND CONTROL (IPC)

Preventing harm to patients, health workers and visitors due to HCAs contributes to achieve quality care, patient safety, health security and the reduction of antimicrobial resistance (AMR). Strong, effective IPC programmes allows safe health care and essential services delivery and prevention and control of outbreaks throughout the health system. It is critical to initially ensure that at least the minimum requirements for IPC are in place, both at the national and facility level, and to gradually

progress to the full achievement of all requirements within the WHO IPC core components recommendations.

IPC minimum requirements are defined as IPC standards 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 core components for IPC programmes.

The existence of these requirements constitutes the initial starting point for building additional critical components of IPC programmes, according to a stepwise approach based on assessments of the local situation.

		Indicators
Level	C9.1. IPC programmes	
Level 1	An active ⁵⁹ national IPC programme ⁶⁰ or operational plan according to the WHO minimum requirements ⁶¹ is not available or is under development	<input type="checkbox"/>
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	<input type="checkbox"/>
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, ⁶² including health workers' training and monitoring and feedback	<input type="checkbox"/>
Level 4	An active national IPC programme is available according to WHO IPC core components guidelines ⁶³ 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	<input type="checkbox"/>
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	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems		

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

60 IPC programmes should have clearly defined objectives based on local epidemiology and priorities according to risk assessment, and 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. See the WHO Guidelines on core components of IPC programmes at the national and acute health care facility level for more information (<https://www.who.int/publications/i/item/9789241549929>, accessed 3 November 2021).

61 IPC minimum requirements are minimum standards identified by WHO and 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. See the WHO minimum requirements for IPC programmes for more information: <https://www.who.int/publications/i/item/9789241516945>, accessed 3 November 2021.

62 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: (i) system change (availability of the appropriate infrastructure and supplies to enable IPC good practices); (ii) education and training of health care workers and key players (for example, managers); (iii) monitoring infrastructures, practices, processes, outcomes and providing data feedback; (iv) reminders in the workplace/communications; and (v) culture change within the establishment or the strengthening of a safety climate, see: <https://www.who.int/publications/m/item/who-multimodal-improvement-strategy>.

63 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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>	
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>	
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>	

Indicators	
Level	C9.3. Safe environment in health facilities
Level 1	National standards and resources for safe built environment, ⁶⁴ e.g., water, sanitation and hygiene (WASH) in health care facilities, ⁶⁵ 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 <input type="checkbox"/>
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 <input type="checkbox"/>
Level 3	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 and are implemented in health care facilities at national level through a national plan <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

⁶⁴ See definition of "Safe environment" in the Glossary.

⁶⁵ 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 (http://www.who.int/water_sanitation_health/publications/ehs_hc/en/, accessed 2 April 2018). 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 WHO website: http://www.who.int/water_sanitation_health/facilities/en/, accessed 2 April 2018).

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

Status of implementation:

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> planned | <input type="checkbox"/> achieved | <input type="checkbox"/> strength/best practice |
| <input type="checkbox"/> ongoing | <input type="checkbox"/> challenges/gaps | <input type="checkbox"/> other |

Area Involved:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> financing | <input type="checkbox"/> policy | <input type="checkbox"/> leadership & governance | <input type="checkbox"/> risk communication |
| <input type="checkbox"/> guidelines & SOPs | <input type="checkbox"/> infrastructure & logistics | <input type="checkbox"/> assessments | <input type="checkbox"/> legislation |
| <input type="checkbox"/> coordination & collaboration mechanisms | <input type="checkbox"/> workforce | <input type="checkbox"/> health information systems | <input type="checkbox"/> others |

C10. RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

RCCE have proven 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 ultimate purpose is that everyone at risk is

able to take informed decisions to mitigate the effects of the threat and take protective and preventive action. Community engagement is a more focused series of activities intended to bring communities to the centre of preparedness, readiness and response, providing 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 ⁶⁶ for coordination of RCCE functions ⁶⁷ and resources ⁶⁸ are under development, or coordination of RCCE functions and resources is conducted on an ad hoc basis	<input type="checkbox"/>
Level 2	Mechanisms for coordination of RCCE functions and resources, including plans, SOPs and formal government arrangements are developed	<input type="checkbox"/>
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 ⁶⁹	<input type="checkbox"/>
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 ⁷⁰	<input type="checkbox"/>
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 ⁷¹	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems		

⁶⁶ 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.

⁶⁷ 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 design of communications, interventions, and programmatic improvements; infodemic monitoring.

⁶⁸ Resources include, finance; skilled staff (e.g., at least a risk communication specialist sitting in the emergency response team, adequate number of qualified staff, a trained spokespersons) and arrangements for workforce surge; equipment and materials (e.g., IEC materials); communication platforms for coordination of RCCE functions.

⁶⁹ 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.

⁷⁰ 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.

⁷¹ 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 on 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 ⁷²	<input type="checkbox"/>
Level 2	Mechanisms for public communication and/or media relations, including infodemics, are developed but not fully implemented with significant gaps ⁷³	<input type="checkbox"/>
Level 3	Mechanisms for public communication and/or media relations, including infodemics, are developed and activities are being implemented at the national level	<input type="checkbox"/>
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	<input type="checkbox"/>
Level 5	Mechanisms for public communication and/or media relations, including infodemics, are developed and activities are being implemented and coordinated across sectors ⁷⁴ at national, intermediate and local levels, and information is shared in a timely manner. ⁷⁵ The mechanisms and related activities are exercised (as applicable), reviewed, evaluated and updated on a regular basis	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		

72 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. Please see infodemic definition at Annex 4.

73 Gaps may include limited implementation of best practices and community listening activities to inform design of 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.

74 Coordination of RCCE involve the whole of government and sectors; 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 design of communications, interventions, and programmatic improvements.

75 Information provided regarding the emergency situation should be up to date, timely and should include government response and health recommendations. The messages address people's concerns and rumours, as well as misinformation, and provide actionable advice.⁷⁶ Communities are equal partners in the risk communication and emergency response process and co-design interventions.

Indicators		
Level	C10.3. Community engagement ⁷⁶	
Level 1	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, are under development or community engagement activities ⁷⁷ are implemented on an ad hoc basis ⁷⁸	<input type="checkbox"/>
Level 2	Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed but not implemented	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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; ⁷⁹ and mechanisms and activities for community engagement are exercised (as applicable), reviewed, evaluated and updated on a regular basis	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		

⁷⁶ Communities are equal partners in the risk communication and emergency response process and co-design interventions.

⁷⁷ 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, or vaccine distribution); training social mobilization and community engagement teams including volunteers regularly; scaling-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.

⁷⁸ 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.

⁷⁹ 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 check boxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> planned | <input type="checkbox"/> achieved | <input type="checkbox"/> strength/best practice |
| <input type="checkbox"/> ongoing | <input type="checkbox"/> challenges/gaps | <input type="checkbox"/> other |

Area Involved:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> financing | <input type="checkbox"/> policy | <input type="checkbox"/> leadership & governance | <input type="checkbox"/> risk communication |
| <input type="checkbox"/> guidelines & SOPs | <input type="checkbox"/> infrastructure & logistics | <input type="checkbox"/> assessments | <input type="checkbox"/> legislation |
| <input type="checkbox"/> coordination & collaboration mechanisms | <input type="checkbox"/> workforce | <input type="checkbox"/> health information systems | <input type="checkbox"/> others |

C11. POINT OF ENTRY (PoE) AND BORDER HEALTH

PoE are 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 agencies and areas providing services to them on entry or exit. A PoE is an integral part of surveillance and response systems and helps support public health functions in a country.


Factors to be considered while designating PoE for developing IHR capacities are found in the introductory chapter of the WHO

document on core capacity requirements at designated airports, ports and ground crossings.⁸⁰ Section 1 below requests specific information on the States' designated PoE (the users should create an additional row in the table for each PoE). The scoring table for this core capacity in Section 2 should be based on the results of an in- depth assessment of each designated PoE, as well as some non-designated PoE that are of public health significance, using the detailed WHO document on core capacity requirements at designated airports, ports and ground crossings, as well as the document on coordinated public health surveillance between PoE and national health surveillance systems.⁸¹

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
Number of designated airports
Number of designated ground crossings ⁸²
2. Please list the names of designated PoE (ports, airports and ground crossings as applicable) and indicate the information required related 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 ⁸³	ICAO airport or other code for ports and ground crossings ⁸⁴	United Nations Code for Trade and Transport Locations (UNLOCODE) ⁸⁵	Competent authorities identified at designated PoE level (Y/N)	Level ⁸⁶ 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 ⁸⁷ of effective public health response at each designated PoE (capacities to respond to emergencies, Annex 1B)	PoE public health emergency contingency plan ⁸⁸ (Y/N)
Type	Name of designated PoE								
Airports									
Ports									
Ground crossings									

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

Yes No Not applicable

80 See: Introduction of assessment tool for core capacity requirements at designated airports, ports and ground crossings. Geneva: World Health Organization; 2009 (<http://www.who.int/ihr/publications/PoE/en/>, accessed 2 April 2018). See also definition of designated point of entry at Annex 4.

81 See: Coordinated public health surveillance between points of entry and national health surveillance systems: advising principles. Geneva: World Health Organization; 2014 (http://www.who.int/ihr/publications/WHO_HSE_GCR_LYO_2014.12/en/, accessed 2 April 2018).

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

83 IATA Airport codes can be found at IATA/International Air Transport Association site (<https://www.iata.org/en/publications/directories/code-search/>, accessed 21 October 2021)). For port facilities and ground crossings countries may use their national location codes for geo-reference.

84 ICAO Airport code is a four letter code designating aerodromes globally as defined by the ICAO and published in ICAO documents 7910 <https://www.icao.int>. For port facilities and ground crossings countries may use their national location codes for geo-reference.

85 UN/LOCODE is the United Nations Code for Trade and Transport Location it is published by United Nations Economic Commission for Europe (<https://www.unece.org/cefact/locode/service/location>, accessed 3 November 2021).

86 Please refer to the Assessment tool for core capacity requirements at designated airports, ports and ground crossings (<http://www.who.int/ihr/publications/PoE/en/>) 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.

87 Please refer to the assessment tool for core capacity requirements at designated airports, ports and ground crossings (<https://www.who.int/publications/i/item/WHO-HSEIHR-LYO-2009-9>, accessed 3 November 2021) 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.

88 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 PoEs, see WHO WPRO document: Guide for public health emergency contingency planning at designated points of entry. Geneva: World Health Organization; 2012 (<http://www.who.int/ihr/publications/9789290615668/en/>, accessed 2 April 2018).

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	<input type="checkbox"/>
Level 2	Some designated PoE are implementing routine core capacities based on a completed associated strategic risk assessment	<input type="checkbox"/>
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)	<input type="checkbox"/>
Level 4	All designated PoE are implementing routine core capacities with an all-hazard and multisectoral approach integrated into the national surveillance system	<input type="checkbox"/>
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	<input type="checkbox"/>
<p>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 check boxes according to the status of implementation and the area related to your comments</p>		
<p>Status of implementation:</p> <p> <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other </p>		
<p>Area Involved:</p> <p> <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others </p>		

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 ⁸⁹ <input type="checkbox"/>
Level 2	Some designated PoE have developed a PoE public health emergency contingency plan for events caused by biological hazards <input type="checkbox"/>
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 ⁹⁰ <input type="checkbox"/>
Level 4	All designated PoE have developed PoE public health emergency contingency plans for events caused by all hazards ⁹¹ and integrated into national emergency response plans <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems	

89 PoE public health emergency contingency plan (IHR (2005)) for public health events, including potential PHEIC.

90 See: Coordinated public health surveillance between points of entry and national health surveillance systems: advising principles. Geneva: World Health Organization; 2014 (http://www.who.int/ihr/publications/WHO_HSE_GCR_LYO_2014.12/en/, accessed 2 April 2018).

91 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, ⁹² on a risk-based manner, is not available or under development <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	
Please add any additional comments for this capacity as applicable. Choose all applicable check boxes according to the status of implementation and the area related to your comment on this capacity	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

⁹² 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. ZONOTIC DISEASES

Mechanisms and documented procedures among all relevant sectors,⁹³ particularly those responsible for human, animal (livestock, pets, wild animals)⁹⁴ and environmental health are in place to ensure operational coordination in preparedness, planning, surveillance and response to zoonotic diseases and other health events existing or emerging at the human–animal–environment interface.

This capacity includes the ability of the country 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”. For example, diseases circulating in animals that may not be known zoonoses but have characteristics that strongly suggest some potential zoonotic threat in the future. Similarly, investigation of the epidemiology of a new disease identified in humans should include consideration of a possible livestock or wildlife source.

Indicators	
Level	C12.1. One Health ⁹⁵ 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 <input type="checkbox"/>
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 <input type="checkbox"/>
Level 3	The animal, human and environment health sectors collaborate regularly and coordinate their activities ⁹⁶ 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 <input type="checkbox"/>
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 <input type="checkbox"/>
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) <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

⁹³ See C2. IHR coordination and National IHR Focal Point functions.

⁹⁴ Technical note on definition of “animal” includes wildlife, domestic, and livestock.

⁹⁵ “One Health” is an approach for designing and implementing programs, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes. The areas of work which are One Health approach is particularly relevant include food safety, the control of zoonosis and combating antibiotic (WHO 2017. <https://www.who.int/news-room/q-a-detail/one-health>, accessed 3 November 2021).

⁹⁶ 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 check boxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> planned | <input type="checkbox"/> achieved | <input type="checkbox"/> strength/best practice |
| <input type="checkbox"/> ongoing | <input type="checkbox"/> challenges/gaps | <input type="checkbox"/> other |

Area Involved:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> financing | <input type="checkbox"/> policy | <input type="checkbox"/> leadership & governance | <input type="checkbox"/> risk communication |
| <input type="checkbox"/> guidelines & SOPs | <input type="checkbox"/> infrastructure & logistics | <input type="checkbox"/> assessments | <input type="checkbox"/> legislation |
| <input type="checkbox"/> coordination & collaboration mechanisms | <input type="checkbox"/> workforce | <input type="checkbox"/> health information systems | <input type="checkbox"/> others |

C13. FOOD SAFETY

States Parties have the adequate capacity for timely detection, investigation and response to food safety events involving foodborne diseases and/or food contamination that may constitute a public health emergency of national or international concern, through collaboration between

the relevant authorities at national level and through active membership in the International Food Safety Authorities Network (INFOSAN) network. Food safety is multisectoral in nature and the agencies/sectors responsible for detection, investigation and response to a food safety emergency adopt a One Health approach.

Indicators	
Level	C13.1 Multisectoral collaboration mechanism ⁹⁷ for food safety ⁹⁸ events
Level 1	A multisectoral collaboration mechanism that includes an INFOSAN ⁹⁹ Emergency Contact Point ¹⁰⁰ is under development, activated on an ad hoc basis. <input type="checkbox"/>
Level 2	A multisectoral collaboration mechanism that includes the INFOSAN Emergency Contact Point is in place at the national level AND Communication channels ¹⁰¹ 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. <input type="checkbox"/>
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. <input type="checkbox"/>
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. <input type="checkbox"/>
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. <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

97 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 stakeholders documented. Documented procedures for the detection of and response to food safety emergencies should also be specified.

98 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 dependant on the structure of the respective Member State.

99 INFOSAN (http://www.who.int/foodsafety/areas_work/infosan/en/, accessed 1 April 2018).

100 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.).

101 Communication channels refer to the way information flows within and between organizations and stakeholders. This can be informal (i.e., person-to-person, undocumented phone 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 check boxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> planned | <input type="checkbox"/> achieved | <input type="checkbox"/> strength/best practice |
| <input type="checkbox"/> ongoing | <input type="checkbox"/> challenges/gaps | <input type="checkbox"/> other |

Area Involved:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> financing | <input type="checkbox"/> policy | <input type="checkbox"/> leadership & governance | <input type="checkbox"/> risk communication |
| <input type="checkbox"/> guidelines & SOPs | <input type="checkbox"/> infrastructure & logistics | <input type="checkbox"/> assessments | <input type="checkbox"/> legislation |
| <input type="checkbox"/> coordination & collaboration mechanisms | <input type="checkbox"/> workforce | <input type="checkbox"/> health information systems | <input type="checkbox"/> others |

C14. CHEMICAL EVENTS

Chemical events, including emergencies arising from technological incidents, natural disasters, deliberate events or contaminated foods and products, are common and occur worldwide. This capacities refers to the resources for detection and alert of those events. Other capacities requested for this sort of events, i.e., legislation and policies, preparedness planning and response, strategic coordination, are incorporated

into relevant capacities covered above. It is important to note that some of the responsibilities for this capacity fall on other sectors than the health sector, such as in the sectors for environment, labour, agriculture, civil protection, transport or customs. Coordination and collaboration between these sectors is therefore important to ensure the timely detection of, and effective response to, potential chemical risks and/or events.¹⁰²

Indicators	
Level	C14.1 Resources for detection and alert
Level 1	Surveillance mechanisms and resources ¹⁰³ for chemical events or poisoning are under development <input type="checkbox"/>
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 ¹⁰⁴ for identifying and quantifying exposures to key chemicals of concern ¹⁰⁵ is available on an ad hoc basis <input type="checkbox"/>
Level 3	A poisons information service ¹⁰⁶ or equivalent national service that performs surveillance for chemical exposures, and for communication of alerts is in place on a 24/7 basis <input type="checkbox"/>
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 <input type="checkbox"/>
Level 5	An integrated system of public health surveillance linked with environmental monitoring, ¹⁰⁷ that captures and assesses data on chemical exposures from multiple sources, is under development or in place <input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments	
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other	
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems <input type="checkbox"/> others	

¹⁰² See also: International Health Regulations (2005) and chemical events. Geneva: World Health Organization; 2015 (<http://apps.who.int/iris/bitstream/10665/249532/1/9789241509589-eng.pdf>, accessed 2 April 2018).

¹⁰³ Mechanisms for surveillance include policies, guidelines and systems for reporting actual or potential chemical events to a central authority, and also 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.

¹⁰⁴ 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.

¹⁰⁵ List to be determined by the responding State Party.

¹⁰⁶ 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 (http://www.who.int/ipcs/poisons/centre/poisons_centres/en/, accessed 2 April 2018).

¹⁰⁷ 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 check boxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> planned | <input type="checkbox"/> achieved | <input type="checkbox"/> strength/best practice |
| <input type="checkbox"/> ongoing | <input type="checkbox"/> challenges/gaps | <input type="checkbox"/> other |

Area Involved:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> financing | <input type="checkbox"/> policy | <input type="checkbox"/> leadership & governance | <input type="checkbox"/> risk communication |
| <input type="checkbox"/> guidelines & SOPs | <input type="checkbox"/> infrastructure & logistics | <input type="checkbox"/> assessments | <input type="checkbox"/> legislation |
| <input type="checkbox"/> coordination & collaboration mechanisms | <input type="checkbox"/> workforce | <input type="checkbox"/> health information systems | <input type="checkbox"/> others |

C15. RADIATION EMERGENCIES

Radiological emergencies and nuclear accidents, termed as radiation emergencies,¹⁰⁸ are rare events, but can range from minor to catastrophic. Management of large events can be both exhausting in terms of resource and human capacity, and its consequences may last for decades. Response to such emergencies is multisectoral and requires specific infrastructure and expertise that is different from responding to outbreaks; support of specific legislation; and cross-sector coordination. In most countries, the competence and responsibility for response to radiation emergencies are outside the national health authorities. Therefore, coordination between national radiation authorities, health and non-health sectors

(e.g., meteorological services, environmental protection, trade and travel, law-enforcement, etc.) is required at all stages of preparedness, surveillance, response and long-term consequence management after radiation emergencies.¹⁰⁹ Relevant core capacities are different for countries with dissimilar risk profiles – required core capacities for countries with limited use of radioactive sources, will differ from those in possession of nuclear technologies in industry, medicine and research. The international radiation safety standards published by IAEA and co-sponsored by WHO and other international organizations provides guidance for 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 ¹¹⁰ for radiation emergencies are under development.	<input type="checkbox"/>
Level 2	Radiation sources have been inventoried and radiation risk mapping ¹¹¹ has been conducted and documented.	<input type="checkbox"/>
Level 3	Access to specialized health care for radiation injuries ¹¹² is in place AND access to laboratory testing capacity for monitoring, identification and assessment of radiation exposure is in place.	<input type="checkbox"/>
Level 4	Access to technical expertise for managing radiation emergencies, ¹¹³ including guidelines, protocols and regularly trained experts, is in place AND access to stockpile to support radiation emergency preparedness and response is in place.	<input type="checkbox"/>
Level 5	Radiation emergency arrangements are formally exercised (as applicable), reviewed, evaluated on a regular basis, and improvements are made accordingly.	<input type="checkbox"/>
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 check boxes according to the status of implementation and the area related to your comments		
Status of implementation: <input type="checkbox"/> planned <input type="checkbox"/> achieved <input type="checkbox"/> strength/best practice <input type="checkbox"/> ongoing <input type="checkbox"/> challenges/gaps <input type="checkbox"/> other		
Area Involved: <input type="checkbox"/> financing <input type="checkbox"/> policy <input type="checkbox"/> leadership & governance <input type="checkbox"/> risk communication <input type="checkbox"/> guidelines & SOPs <input type="checkbox"/> infrastructure & logistics <input type="checkbox"/> assessments <input type="checkbox"/> legislation <input type="checkbox"/> coordination & collaboration mechanisms <input type="checkbox"/> workforce <input type="checkbox"/> health information systems		

108 For the purpose of this document the terms radiological emergencies and nuclear accidents are shortened to "radiation emergencies" that encompasses both types of emergencies.
 109 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>, accessed 3 November 2021).

110 Mechanisms for surveillance include policies, guidelines and systems for reporting actual or potential radiation emergencies to a central authority, and also guidance for assessing and acting on these events. The resources needed include infrastructure for monitoring, identification and assessment of radiation exposure.

111 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.

112 This refers to facilities and case management of individuals with radiation injuries.

113 This refers to 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 check boxes according to the status of implementation and the area related to your comment on this capacity

Status of implementation:

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> planned | <input type="checkbox"/> achieved | <input type="checkbox"/> strength/best practice |
| <input type="checkbox"/> ongoing | <input type="checkbox"/> challenges/gaps | <input type="checkbox"/> other |

Area Involved:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> financing | <input type="checkbox"/> policy | <input type="checkbox"/> leadership & governance | <input type="checkbox"/> risk communication |
| <input type="checkbox"/> guidelines & SOPs | <input type="checkbox"/> infrastructure & logistics | <input type="checkbox"/> assessments | <input type="checkbox"/> legislation |
| <input type="checkbox"/> coordination & collaboration mechanisms | <input type="checkbox"/> workforce | <input type="checkbox"/> health information systems | <input type="checkbox"/> 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.

Summary of changes between version one and two of the SPAR		
New capacities	SPAR 1st ed. 2018-2020	SPAR 2nd ed. 2021
Splitting capacity, with name change and creating 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
Creating 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
Name change of capacities and new indicator	C1. – Legislation and financing	C1. – Policy, Legislation and normative instruments to implement the IHR
Name change 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 for 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 for indicator	C4.1. Multisectoral collaboration mechanism for food safety events	C4.1. Specimen referral and transport system
Change of place for 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 for 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 for indicator	C5.1. Specimen referral and transport systems	C5.1. Early warning surveillance function
Change of place for indicator	C5.2. Implementation of a laboratory biosafety and biosecurity regime	C5.2. Event management
Change of place for 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 place and name for Health emergency management with new names for indicators	C7. Human resources	C7. Health emergency management
Change of place and name for indicator	C7.1 Human resources for the implementation of IHR capacities	C7.1. Planning for health emergencies
Change of place and name for indicator	-----	C7.2. Management of health emergency response
Change of place and name for indicator	-----	C7.3. Emergency logistic 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 for indicator	C8.1. Planning for emergency preparedness and response mechanism	C8.1. Case management
Change of place and name for indicator	C8.2. Management of health emergency response operations	C8.2. Utilization of health services
Change of place and name for 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. RCCE
Change of name for 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 crossings codes for geo-information systems to use it and produce maps	Section 1. Information by type of points of entry	Section 1. Information by type of PoEs
No change	Section 2. Overall national profile of the implementation of core capacities at points of entry	Section 2. Implementation of core capacities at PoEs 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 PoEs
No change	C11.2 Effective public health response at PoEs	C11.2. Public health response at PoEs
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 ITS INDICATORS**

	Country implementation status	The level to be selected
Example 1	Level 1 – yes to some elements but not all	No selection (no capacity and score will be "zero") Irrespective of the status of elements in levels 2, 3, 4 and 5 => Please add rationale for this choice in the Comments Box
Example 2	Level 1 – yes to all elements Level 2 – yes to some elements but not all Level 3 – yes to all elements Level 4 – yes to all elements Level 5 – yes to all elements	Level 1 Irrespective of the status of elements in levels 3, 4 and 5
Example 3	Level 1 – yes to all elements Level 2 – no information Level 3 – yes to all elements Level 4 – yes to all elements Level 5 – yes to all elements	Level 1

ANNEX 3

EXAMPLE OF THE USE OF COMMENT BOXES FOR INDICATORS AND CAPACITIES

Example of country comments related to the indicator C10.			
Indicator Comment box			
Risk communication strategic plan and RCCE policy are developed; however, they are not endorsed yet and emergency risk communications are done on ad hoc bases.			
Status of implementation:			
<input type="checkbox"/> planned	<input type="checkbox"/> achieved	<input type="checkbox"/> strength/best practice	
<input checked="" type="checkbox"/> ongoing	<input type="checkbox"/> challenges/gaps	<input type="checkbox"/> other	
Area Involved:			
<input type="checkbox"/> financing	<input type="checkbox"/> policy	<input type="checkbox"/> leadership & governance	<input checked="" type="checkbox"/> risk communication
<input type="checkbox"/> guidelines & SOPs	<input type="checkbox"/> infrastructure & logistics	<input type="checkbox"/> assessments	<input type="checkbox"/> legislation
<input type="checkbox"/> coordination & collaboration mechanisms	<input type="checkbox"/> workforce	<input type="checkbox"/> health information systems	<input type="checkbox"/> others

Example of country comments related to the capacity C5. Surveillance			
Capacity Comment box			
Currently there is a need to finalize SOP for surveillance teams. Surveillance teams have been established to rapid response of public health events/risk. There are SOPs for certain diseases under surveillance but needs to be inclusive of multisector agencies (One Health Approach).			
Status of implementation:			
<input type="checkbox"/> planned	<input checked="" type="checkbox"/> achieved	<input type="checkbox"/> strength/best practice	
<input checked="" type="checkbox"/> ongoing	<input checked="" type="checkbox"/> challenges/gaps	<input type="checkbox"/> other	
Area Involved:			
<input type="checkbox"/> financing	<input type="checkbox"/> policy	<input type="checkbox"/> leadership & governance	<input type="checkbox"/> risk communication
<input checked="" type="checkbox"/> guidelines & SOPs	<input type="checkbox"/> infrastructure & logistics	<input type="checkbox"/> assessments	<input type="checkbox"/> legislation
<input type="checkbox"/> coordination & collaboration mechanisms	<input checked="" type="checkbox"/> workforce	<input type="checkbox"/> health information systems	<input type="checkbox"/> others

ANNEX 4

GLOSSARY: WORKING DEFINITIONS

Terms and 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 those used in other documents.

affected	Persons, baggage, cargo, containers, conveyances, goods, postal parcels or human remains that are infected or contaminated, or 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 (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)	<p>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 can 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 the WHO the list of their ports authorized to:</p> <ul style="list-style-type: none"> • 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. <p>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 the WHO IHR website (http://www.who.int/ihr/ports_airports/en) and further information on the Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates – Available at: https://www.who.int/ihr/publications/handbook_ships_inspection/en/.</p>
biological hazards	Infectious disease events, including zoonotic and food safety events.
biosafety	Maintenance of safe conditions in storing, handling and disposing 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. WHO laboratory biosafety manual. Third edition. Geneva: World Health Organization; 2004 (http://www.who.int/csr/resources/publications/biosafety/Biosafety7.pdf?ua=1 , accessed 2 April 2018).
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 the WHO, regardless of circumstances, are published on the WHO website under "Annex 2 of the International Health Regulations (IHR) (2005)" (http://www.who.int/ihr/annex_2/en/ , accessed 2 April 2018).
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, ed. A dictionary of epidemiology. Fourth edition. New York: Oxford University Press; 2001).
competent authority	Authority responsible for the implementation and application of health measures under the IHR. See WHA58.3 Revision of the International Health Regulations. Article 22 Role of competent authorities. (http://www.who.int/csr/ihr/WHA58-en.pdf , pages 24, 25; accessed 2 April 2018).
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 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 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 only useful if it is linked to mechanisms for early response (adapted from Last JM, Spasoff RA, Harris SS, ed. A dictionary of epidemiology. Fourth edition. New York: Oxford University Press; 2001).

Emergency Operation Centre (EOC)	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> – 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, ed. A dictionary of epidemiology. Fourth edition. New York: 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., media, health workers and nongovernmental organizations reports). It is a component of early warning surveillance.
execution of budget	A national authority that has coordinated the allocation and execution of financing for activities and interventions to implement IHR capacities.
external financing	Financing from non-domestic sources towards the implementation of IHR capacities; whose amounts make up a majority or complements 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. It 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, WHO and Gender: 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 to understand the causes of that gender gap (sometimes referred to as gender analysis): without knowing the causes of a 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; WHO (2011) Gender mainstreaming for health managers: a practical approach. participant's notes. https://www.who.int/publications/i/item/9789241501057 .
gender action plan	Refers to a planning document that includes: <ul style="list-style-type: none"> • 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	Means sex and gender gaps that are assessed to (i) inhibit implementation effectiveness, (ii) potentially affect a large proportion of the population of the disadvantaged sex (women and girls, or men and boys) and (iii) act as a constraint to effective and full preparedness and response that the whole population can access. Based on the gender analysis conducted, each country will determine which elements of gender inequalities are high priority, with due consideration given to the differences across countries in sociocultural contexts and gender norms.
ground crossing	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 (http://www.who.int/water_sanitation_health/publications/ehs_hc/en/ , accessed 2 April 2018). 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 WHO website: http://www.who.int/water_sanitation_health/facilities/en/ , accessed 2 April 2018).
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 (http://apps.who.int/iris/bitstream/handle/10665/112656/9789241507134_eng.pdf?sequence=1 , accessed 2 April 2018)).

incidence	The “incidence” of a condition is the number of new cases in a period of time in a specified population (World Health Organization. (2004). <i>The global epidemiology of infectious diseases</i> / edited by Christopher J. L. Murray, Alan D. Lopez, Colin D. Mathers. World Health Organization. https://apps.who.int/iris/handle/10665/43048) incident command system. See Incident management system.
incident command system	See incident management system.
incident management system	Emergency management structure and set of protocols that provides 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, laboratory based surveillance, etc. This routine reporting originates typically from a health care facility where reports are submitted at weekly or monthly intervals.
infection	Entry 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 practiced 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, legal, technical framework and monitoring of nosocomial infections (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 (http://apps.who.int/iris/bitstream/handle/10665/69982/WHO_HSE_EPR_2009.1_eng.pdf?sequence=1 , accessed 2 April 2018).
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. (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. (https://cms.who.int/publications-detail-redirect/WHO-2019-nCoV-Country_IAR-2020.1).
intermediate level	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, region (from International Health Regulations (2005). Second edition. Annex 1. Geneva: World Health Organization; 2008 (http://www.who.int/ihr/9789241596664/en/ , accessed 2 April 2018).
legislation	Range of legal, administrative or other governmental instruments which may be available for 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 inter-ministerial 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, arrêté, 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; Toolkit_Legislative_Implementation_2009.pdf 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 (http://www.who.int/ihr/9789241596664/en/ , accessed 2 April 2018).
Member States (WHO)	194 current Member States of the WHO, in accordance with Chapter III of the WHO Constitution and currently identified on the WHO website "IHR Committees" (http://www.who.int/ihr/) and any States which may hereafter become a Member State of the WHO in accordance with the WHO constitution.

monitoring	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, ed. A dictionary of epidemiology. Fourth edition. New York: 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 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, ed. A dictionary of epidemiology. Fourth edition. New York: 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 the WHO IHR monitoring and evaluation framework 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):140-144. 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	Science and art of preventing disease, prolonging life and promoting health through organized efforts of society. It 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, ed. A dictionary of epidemiology. Fourth edition. New York: Oxford University Press; 2001).
public health emergency of international concern (PHEIC)	Extraordinary event which is determined to: (i) constitute a public health risk to other States through the international spread of disease, and (ii) potentially requires a coordinated international response public health risk (See definition of “public health risk” in IHR (2005) (http://www.who.int/ihr/ , accessed 2 April 2018)).
public health risk	Likelihood that an event may adversely affect the health of human populations, with an emphasis in the IHR for 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, ed. A dictionary of epidemiology. Fourth edition. New York: 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. (Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates, available at: https://www.who.int/ihr/publications/handbook_ships_inspection/en/).
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 (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 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 to simultaneously convey both the nature of the event and the characteristics that make it 'urgent' (i.e., serious public health impact and/or 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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