

INTERNATIONAL HEALTH REGULATIONS (2005)

GUIDANCE DOCUMENT FOR THE STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL



World Health
Organization

GUIDANCE DOCUMENT FOR THE STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL



WHO/WHE/CPI/2018.17 © World Health Organization 2018

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. International Health Regulations (2005) GUIDANCE DOCUMENT FOR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

TABLE OF CONTENTS

1. PURPOSE OF THE DOCUMENT	7
2. AUDIENCE	7
3. RELEVANT GOVERNING BODIES DECISIONS AND RESOLUTIONS FOR REPORTING UNDER THE IHR (2005)	7
4. REVISION OF THE IHR (2005) STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL	8
5. PRINCIPLES APPLIED IN REVISING THE STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL	8
6. SUMMARY OF CHANGES TO THE STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL	9
7. STRUCTURE OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL	9
8. STRUCTURE OF THE INDICATORS AND ATTRIBUTES	10
• SCALE SCORING SYSTEM	11
9. ROLE OF VARIOUS SECTORS IN MULTISECTORAL ANNUAL REVIEW	11
10. COMPLETION OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL FOR COUNTRIES WITH DIFFERENT SETTINGS	12
• FEDERATED STATES	12
• SMALL ISLAND DEVELOPING STATES (SIDS)	12
• OVERSEAS TERRITORIES	12
• COUNTRIES IN CONFLICT	13
11. PROCESS FOR THE SUBMISSION OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL	13
12. PRESENTATION OF THE INFORMATION TO THE WORLD HEALTH ASSEMBLY	13
13. USE OF STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL BY THE WHO SECRETARIAT	14
ANNEX 1 – LIST OF CAPACITIES AND INDICATORS	15
• C1: LEGISLATION AND FINANCING	15
• C2: IHR COORDINATION AND NFP FUNCTIONS	15
• C3: ZOO NOTIC EVENTS AND THE HUMAN-ANIMAL INTERFACE	16
• C4. FOOD SAFETY	16
• C5. LABORATORY	16
• C6. SURVEILLANCE	16
• C7. HUMAN RESOURCES	16
• C8. NATIONAL HEALTH EMERGENCY FRAMEWORK	17
• C9. HEALTH SERVICE PROVISION	17
• C10. RISK COMMUNICATION	17
• C11. POINTS OF ENTRY (POE)	17
• C12. CHEMICAL EVENTS	18
• C13. RADIATION EMERGENCIES	18
ANNEX 2 - RELEVANT GOVERNING BODIES DECISIONS AND RESOLUTIONS FOR REPORTING UNDER THE IHR (2005)	19
ANNEX 3 - ACRONYMS AND GLOSSARY	21
• ACRONYMS	21
• GLOSSARY: WORKING DEFINITIONS	21

1. PURPOSE OF THE DOCUMENT

The main purpose of this document is to provide guidance on using the State Party Self-assessment Annual Reporting Tool, which is proposed to States Parties to fulfil their

obligations under Article 54 – Reporting and review of the IHR to report to the World Health Assembly (WHA).

2. AUDIENCE

The audiences of this guidance are the States Parties to the IHR) and the WHO Secretariat.

3. RELEVANT GOVERNING BODIES DECISIONS AND RESOLUTIONS FOR REPORTING UNDER THE IHR (2005)

The IHR represent the commitment of States Parties to collectively prepare for, and respond to events that may constitute a public health emergency of international concern according to a common set of rules. The IHR require States Parties to establish and maintain the capacity to detect, assess, notify and respond to public health risks and acute events, including those at points of entry, (Annex 1 of the Regulations). The relevance of the IHR as the legislative instrument to ensure global public health security lies in their full application, implementation, and compliance by all States Parties.

Article 54 of the IHR states that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”.

In 2008, the 61st World Health Assembly, through the adoption of Resolution WHA61.2 , decided that “States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually, with the next report to be submitted to the Sixty-second World Health Assembly”.

Between 2010 and 2017, the IHR Monitoring Questionnaire sent to National IHR Focal Points was used at least once by all 196 States Parties to report to the WHA. The summary of results from the questionnaire has been used to report to the Assembly since the 64th WHA in 2010, and

country profiles have been made available on the WHO Global Health Observatory (GHO) data web page¹ .

In 2015, the WHO Secretariat, along with States Parties, initiated the development of monitoring and evaluation approaches, focusing on national core capacities, that were consolidated, as a whole, in the IHR Monitoring and Evaluation Framework, to satisfactorily ensure mutual accountability among States Parties, while building trust and appreciation of the public health benefits resulting from the adoption of a common set of rules inspired by dialogue and transparency. The IHR Monitoring and Evaluation Framework consists of four complementary components: one mandatory; the State Party Self-assessment Annual Report, and three voluntary: joint external evaluation, after-action reviews, and simulation exercises. The State Party Self-assessment Annual Report and joint external evaluations, are based on quantitative measures, and can be regarded as a prerequisite of functional core capacities. After-action reviews and simulation exercises, are based on qualitative measures, and are aimed at gauging the functional status of core capacities. The IHR Monitoring and Evaluation Framework encourages transparency and mutual accountability between States Parties towards global public health security.

¹ - Global Health Observatory (accessed on 09 April, 2018 <http://www.who.int/gho/ihr/en/>)

4. REVISION OF THE IHR (2005) STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

In compliance with the recommendations of the *IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation*, and following formal global consultations with States Parties conducted in 2015, 2016 and 2017, and 2018, the WHO Secretariat has developed the “*IHR State Party Self-assessment Annual Reporting Tool*”. WHO drafted the new self-assessment

annual reporting tool based on inputs from all WHO regional focal points. The draft version of the new tool was shared with IHR focal points of State Parties for their inputs. In March 2018², WHO convened a meeting of IHR national focal points and all WHO Regional Offices to discuss the recommended changes. These recommendations were then incorporated into a revised version of the tool.

5. PRINCIPLES APPLIED IN REVISING THE STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

The revision of the IHR State Party Self-assessment Annual Reporting Tool (proposed to States Parties for reporting to the World Health Assembly) was based on the following principles:

- It constitutes the primary tool for ensuring mutual accountability between States Parties and the WHO Secretariat when reporting to the WHA;
- It is a self-assessment tool to be used by national authorities across government sectors, and focuses on national IHR capacities across relevant sectors for the detection and response to potential public health emergencies ;
- It considers ‘access’ to IHR capacities rather than in-country presence of IHR capacities;
- It explicitly captures the status of IHR for capacities at individual designated points of entry;
- It constitutes a revised interpretation of national IHR capacities detailed in Annex 1 of the Regulations, and, to the extent possible, it maintains consistency with the current IHR Monitoring Questionnaire proposed in 2010 by the WHO Secretariat;
- It based on a scale scoring system, that can be presented both, in percent and color-codes according to the level of capacity for each particular indicator;
- The score of each individual national IHR capacity continues to be based on the scores of indicators defining it;
- It is complementary with the other three voluntary components of the IHR Monitoring and Evaluation Framework;
- It attempts to increase the objectivity of the information reported by States Parties by focusing on the gathering information that can be documented; and by limiting the use of qualifiers and reducing redundancies.

² -The 2018 global consultative process with States Parties, based on a revision of the tool prepared by the WHO Secretariat, included a face-to-face meeting of selected States Parties from the six WHO Regions, open to all States Parties via internet connection, and an email consultation. WHO staff from headquarters and the six WHO Regional Offices were involved throughout the process.

6. SUMMARY OF CHANGES TO THE STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

The revised version is more concise than the current IHR Monitoring Questionnaire. The main changes between the previous tool used

for annual reporting and the proposed IHR State Party self-assessment Annual Reporting Tool are in the table below:

Change	Previous version	Proposed version
Name change	IHR monitoring questionnaire	IHR State Party self-assessment Annual Reporting Tool
Name change	Core capacity	Capacity
Addition of indicators	National legislation, policy and financing	C1. National legislation and financing => Addition of financing indicators (C1.2 and C1.3)
Name change	Zoonotic events	C3. Zoonotic events and the human–animal interface
Merging of capacities	Response Preparedness	C8. National health emergency framework
Addition of new capacity		C9. Health service provision
Structure	Yes/no/not known responses	Five progressive levels of capacity
Structure		Colour coded

7. STRUCTURE OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

The tool consists of 24 indicators for the thirteen IHR capacities needed to detect, assess, notify, report and respond, including at points of entry, to public health risk and acute events of domestic and international concern. For each of the 13 capacities, one to three indicators are used to measure the status of each capacity. Each indicator is based on five cumulative levels of capacity.

For each indicator, the reporting State Party is asked to select which of the five levels best describes the State Party's current status.

For each indicator, in order to move to the next level, all capacities described in previous levels should be in place.

The **first section** of the tool captures information about the following:

a. Respondent

Date of Report	
State Party	
Name and title of contact officer for this report	
E-mail address of the contact officer for this report	
Telephone number of contact officer for this report	

b. Approach adopted for the completion of the tool

Completed by an individual Government Official:	Yes	No	If Yes, from what sector:
Completed by Government officials representing several sectors:	Yes	No	If Yes, the consultative process occurred: - Via email: Yes No - At face-to-face meeting: Yes No - All the above: Yes No - Other, describe

c. Application of the voluntary components of the IHR Monitoring and Evaluation Framework

While annual reporting is mandatory as per Article 54 of the IHR (2005), States Parties, if they so wish, can provide information on other voluntary IHR capacity M&E activities planned or completed in their country, such as after-action reviews, simulation exercises or joint external evaluations.

The subsequent 13 sections of the tool capture information about the levels and indicators defining each capacity, and include a brief description of the capacity under scrutiny. Acronyms and Glossary are provided at the end of the tool as Annex.

8. STRUCTURE OF THE INDICATOR AND ATTRIBUTES

The tool consists of 24 indicators for the thirteen IHR capacities needed to detect, assess, notify, report and respond to public health events of national and international concern. For each of the thirteen capacities, one to three indicators are used to measure the country's progress

towards implementation of IHR capacities. Indicators are further broken down to a number of elements called "attributes," which further define the indicator at each level.

The level of advancement or scoring with colour coding is described in the table below:

Level	Indicators
	Enabling environment, governance frameworks
Level 1	Policies, and strategies to support and facilitate the development and implementation of IHR capacities are not in place or under elaboration or available on an ad hoc basis.
Level 2	Policies and strategies to support and facilitate the development and implementation of IHR capacities are in place at the national level.
Level 3	Policies and strategies to support and facilitate the development and implementation of IHR capacities are in place in all relevant sectors
Level 4	Policies and strategies to support and facilitate the development and implementation of IHR capacities are in place at the national, intermediate and local levels by all relevant sectors
Level 5	Policies and strategies to support and facilitate the development and implementation of IHR capacities are revised and updated on a regular basis.

THE LIST OF CAPACITIES AND RELATED INDICATORS, OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL IS PRESENTED IN ANNEX 1.

SCALE SCORING SYSTEM

INDICATOR LEVEL

The score of each indicator level will be 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 indicator level will be expressed as:
 $3/5 \times 100 = 60\%$

CAPACITY LEVEL

The level of the capacity will be expressed as the average of all indicators.

e.g. for a country selecting level 3 for indicator 2.1 and level 4 for indicator 2.2

indicator level for 2.1 will be expressed as:
 $3/5 \times 100 = 60\%$

indicator level for 2.2 will be expressed as:
 $4/5 \times 100 = 80\%$

capacity level for 2 will be expressed as:
 $(60 + 80) / 2 = 70\%$

9. ROLE OF VARIOUS SECTORS IN MULTISECTORAL ANNUAL REVIEW

The WHO Secretariat recognizes that monitoring and evaluation constitutes essential national public health functions and that all States Parties should have monitoring and evaluation mechanisms at the national level as the foundation for their national strategic and operational planning within the health sector and between the other sectors responsible for health. Consequently, the IHR related monitoring and evaluation activities at international level should be well-articulated with existing national mechanisms to minimize the burden, and reduce the duplication of efforts by, national authorities.

To that end, the previous IHR Monitoring questionnaire was primarily intended to facilitate the States Parties' reporting obligations to the WHA. At the same time, at the national level, by promoting systematic intersectoral annual reviews, the IHR Monitoring Questionnaire was intended to consolidate the leadership of the public sector as well as to build strong partnerships among Government institutions, and across sectors with responsibilities concerning the application, implementation, and compliance with the IHR (2005).

Systematic multisectoral annual reviews can contribute to; (a) raising and maintaining heightened awareness regarding the rights and obligations of the country as whole in relation to the international community, including within

sub-regional mechanisms; (b) nurturing a culture of continual improvement; (c) establishing and strengthening national monitoring and evaluation mechanisms as part of the existing national planning processes and, consequently; (d) determining the costs and benefits resulting from investing in public health, according to exiting and/or newly identified national priorities.

The multi-sectoral approach remains the critical step for the completion of the IHR State Party Self-assessment Annual Report. The information reported by States Parties needs to be as reliable and objective as possible, and national inter-sectoral annual reviews, already promoted for the completion of the IHR Monitoring Questionnaire, are encouraged. Where applicable, the development of Biennial Work Plans by Member States and the WHO Secretariat can also be an opportunity for multisectoral reviews.

As public health preparedness is a dynamic and continuous process, maintaining functional IHR capacities entails investments and resource allocations, both for preventing their deterioration and, with more substantial resource implications, for re-establishing them in case of their regression or loss (e.g. in the case of catastrophic events).

10. COMPLETION OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL FOR COUNTRIES WITH DIFFERENT SETTINGS

In the application and implementation of the IHR, the WHO Secretariat recognizes that complying with the submission of the IHR State Party Self-assessment Annual Report to the World Health Assembly might pose different challenges to States Parties depending on their administrative (e.g. federal and decentralized states, presence of overseas territories) and geo-economic characteristics (e.g. Small Island Developing States).

FEDERATED STATES

Federated states may face challenges because the responsibility for establishing and maintaining national IHR capacities detailed in Annex 1 of the IHR lies with individual federated entities. Notwithstanding that the responsibility to submit the State Party Self-assessment Annual Report to the World Health Assembly ultimately lies with the central level, the following options can be considered for the completion of the IHR State Party Self-assessment Annual Reporting Tool:

1. An intersectoral annual review to compile the IHR State Party Self-assessment Annual Reporting Tool is conducted at the central level. For each capacity, the national estimation of its status is based on documents and knowledge available at central level, about the situation in the different federated entities;
2. An intersectoral annual review, based on the IHR State Party Self-assessment Annual Reporting Tool, can be conducted by each of the federated entities, and the completed tools are shared with the central level for the information to be consolidated in one single State Party Self-assessment Annual Report to the World Health Assembly.

National legal, administrative and operational arrangements to detect, assess, notify, report and respond, including at **points of entry**, to

public health risks and/or acute events of domestic and international concern, should ideally be driven by frequent risk assessment activities that also keep national risk profiles up-to-date.

SMALL ISLAND DEVELOPING STATES (SIDS)³

The format of the State Party Self-assessment Annual Reports submitted to the World Health Assembly, since the IHR Monitoring Questionnaire was proposed in 2010 was unable to capture the specific context of SIDS and in turn likely affected the scores of SIDS. This observation particularly applies to the capacities related to chemical and radiation-related hazards. Therefore, the IHR State Party Self-assessment Annual Reporting Tool is embedding the concept of 'access' (e.g. access to laboratory capacity implies the existence of agreements, Memoranda of Understanding, with one or more laboratories, including WHO Collaborating Centres, outside the country). However, given the geographical isolation of SIDS, these States Parties should have the capacity to independently detect and contain any health hazards during the first 48 to 72 hours from its occurrence, while additional capacities outside the country are being accessed.

OVERSEAS TERRITORIES

While recognizing the challenges faced by States Parties in supporting their overseas territories in establishing and maintaining IHR capacities detailed in Annex 1 of the Regulations, in those territories, with the limited documentation available, the WHO Secretariat is currently working with States Parties with overseas territories on more specific guidance on how to approach monitoring and evaluation of IHR capacities including the compilation of the IHR State Party Self-assessment Annual Reporting Tool.

3 - <https://sustainabledevelopment.un.org/topics/sids>

At this point in time, if some of the levels defining the indicators of the tool are not applicable to the State Party context, this can be indicated in the additional comment box provided at the end of each capacity, along with the reason why it is not applicable. Any additional comments or clarifications related to any given capacity may be accommodated in the same comment box.

COUNTRIES IN CONFLICT

Due to the impact on the public health system of a country during conflict, countries are often overburdened with a fragile health system, additional issues of displaced populations and the absence of, or inadequate, public health

services; all of which make these countries more vulnerable to public health threats. Despite these challenges, countries in this situation are urged to conduct the multisectoral annual review in completing their State Party Self-assessment Annual Reporting Tool as this exercise can be useful to establish a baseline for public health capacities; consolidate existing capacity building efforts; prioritize activities for capacity development within the backdrop of humanitarian action; inform decision making and mobilize available domestic resources; inform humanitarian response plans and plan for recovery.

11. PROCESS FOR THE SUBMISSION OF THE IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

Beginning in 2018, in June of each year, the WHO Secretariat, either through its headquarters or the relevant WHO Regional Offices depending on specific regional arrangements, will inform States Parties, by email through their National IHR Focal Points, about their obligation to submit their State Party Self-assessment Annual Report to the World Health Assembly, indicating that the information contained in State Party Self-assessment Annual Reports submitted by:

- October of that year, in order to be presented to the WHO Executive Board at its January session of the following year;

- February of the following year, in order to be presented to the World Health Assembly in May of that year;
- June of the following year, in order for the results to be the relevant WHO Regional Committee of that year, depending on regional practices.

The completed State Party Self-assessment Annual Reports should be sent by email either to WHO headquarters or to the WHO Regional Offices depending on specific regional arrangements

12. PRESENTATION OF THE INFORMATION TO THE WORLD HEALTH ASSEMBLY

The summary of implementation status of IHR capacities will be included in the report by the WHO Secretariat to the WHO Executive Board, to the World Health Assembly, and, depending on regional practices, to the WHO Regional Committees. The scores by State Party (by capacity/indicator) will be presented in the IHR global health observatory (GHO) and strategic partnership portal (SPP) and links will be provided in the above mentioned report. These will be presented in a tabular format both in percent and colour coded. Once States Parties' specific baselines are established, information about progress made by capacity and by State Party will also be presented in the table.

A country profile will be developed using the information provided by the country. These data will be used to report to WHO governing bodies and published on WHO website, on the IHR homepage at the WHO Global Health Observatory (GHO).

Considering that the IHR constitute the international framework for States Parties to collectively prepare for and respond to events that may constitute a public health emergency of international concern, information on the status of capacities at specific designated points of entry will be published, and annually updated, on the WHO web site.

13.USE OF STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL BY THE WHO SECRETARIAT

The WHO Secretariat will use the information provided through the IHR State Party Self-assessment Annual Reporting tool to inform its

planning in order to provide technical support as and when needed in the most effective manner.

ANNEX 1 – LIST OF CAPACITIES AND INDICATORS

The 13 capacities of the IHR are based on the interpretation of the IHR capacity requirements in Annex 1A and 1B of IHR (2005). For each capacity, a number of indicators are used to measure the country's progress towards fully developed and functional IHR capacities. The 13 capacities and 24 indicators are listed below:

C1: LEGISLATION AND FINANCING

States Parties should have an adequate legal framework in all relevant sectors 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 legislation. Even where new or revised legislation 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 in a more efficient, effective or beneficial manner. Legislation could serve to institutionalize and strengthen the role of IHR within the State Party. It can also facilitate coordination among the different entities involved in their implementation. The IHR should serve to institutionalize through legislative frameworks, essential public health functions to sustain the continuous preparedness process for responding to public health events. 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. In other words, budget is what is planned for, and financing is what is actually provided.

INDICATORS

- C.1.1 LEGISLATION, LAWS, REGULATIONS, POLICY, ADMINISTRATIVE REQUIREMENTS OR OTHER GOVERNMENT INSTRUMENTS TO IMPLEMENT THE IHR (2005)
- C.1.2 FINANCING FOR THE IMPLEMENTATION OF IHR CAPACITIES
- C.1.3 FINANCING MECHANISM AND FUNDS FOR THE TIMELY RESPONSE TO PUBLIC HEALTH EMERGENCIES

C2: IHR COORDINATION AND NFP FUNCTIONS

Establishing and maintaining IHR capacities requires collaboration among all relevant sectors and ministries, agencies or other government bodies responsible for all aspects of implementation of capacities required under the IHR at the national, intermediate and local levels. Depending on the country and the capacity, all relevant sectors may include, in addition to human health, animal health, agriculture, environment, food safety, livestock, fisheries, finance, transport, trade/points of entry (PoEs), 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. Fundamental to this multisectoral approach is 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, the 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 IHR contact points. The National IHR Focal Point should be accessible at all times to communicate with the WHO IHR Contact Point(s) and with all relevant sectors and other stakeholders in the country. States Parties should provide their National IHR Focal Point with the necessary resources (competent staff, adequate finances and level of authority) to fulfil the functions required of them by the IHR. States Parties should provide WHO with contact details of their National IHR Focal Point, continuously update and annually confirm them.

INDICATORS

- C.2.1 NFP FUNCTIONS UNDER IHR
- C.2.2 MULTI-SECTORAL IHR COORDINATION MECHANISMS

C3: ZONOTIC EVENTS AND THE HUMAN-ANIMAL INTERFACE

Mechanisms and documented procedures among all relevant sectors, particularly those responsible for human health and animal health, should be in place to ensure that operational coordination in preparedness, planning, surveillance and response for zoonotic diseases and other health events existing or emerging at the human–animal interface, functional collaboration, and taking a multisectoral One Health approach, is currently ongoing.

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 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 requiring a multisectoral assessment of potential zoonotic risk. Similarly, investigation of the epidemiology of a new disease identified in humans should include consideration of a possible livestock or wildlife source.

INDICATORS

C 3.1 COLLABORATIVE EFFORT ON ACTIVITIES TO ADDRESS ZOOSES

C4. FOOD SAFETY

States Parties have the capacity to timely detect, investigate and respond 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. Food safety is multisectoral in nature and the agencies/sectors responsible for detection, investigation and response to a food safety emergency vary across Member States

INDICATORS

C 4.1 A MULTISECTORAL COLLABORATION MECHANISM FOR FOOD SAFETY EVENTS

C5. LABORATORY

Laboratory capacity is part of surveillance, preparedness and response. It includes detection, investigation and response with laboratory analysis of samples performed either domestically or through international referral, such as collaborating centres. States Parties need to maintain mechanisms that ensure: shipment of specimens to appropriate reference laboratories; reliable and timely laboratory testing; characterization of infectious agents and other hazards likely to cause public health emergencies of national and international concern; and sharing of results on time.

INDICATORS

C 5. 1 SPECIMEN REFERRAL AND TRANSPORT SYSTEM

C 5. 2 IMPLEMENTATION OF A LABORATORY BIO-SAFETY AND BIOSECURITY REGIME

C 5. 3 ACCESS TO LABORATORY TESTING CAPACITY FOR PRIORITY DISEASES

C6. SURVEILLANCE

The IHR requires rapid detection of public health risks associated with biological, chemical and radiation, as well as risk assessment, notification and response. To this end, a sensitive surveillance system, including at points of entry, is needed to ensure the early warning function and provide information for an informed decision making process during public health events and emergencies.

INDICATORS

C6.1 EARLY WARNING FUNCTION : INDICATOR- AND EVENT-BASED SURVEILLANCE

C6.2 MECHANISM FOR EVENT MANAGEMENT (VERIFICATION, RISK ASSESSMENT ANALYSIS, INVESTIGATION)

C7. 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 a quality health workforce is critical to build the resilience of communities and for continuity of health services.

INDICATORS

C7.1 HUMAN RESOURCES TO IMPLEMENT IHR (2005) CAPACITIES

C8. NATIONAL HEALTH EMERGENCY FRAMEWORK

This capacity focuses on the overall national health emergency framework and system for enabling countries to be prepared and operationally ready for response to any public health event, including emergencies, as per the requirement of the 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

C 8. 1 PLANNING FOR EMERGENCY PREPAREDNESS AND RESPONSE MECHANISM

C 8. 2 MANAGEMENT OF HEALTH EMERGENCY RESPONSE OPERATION

C 8. 3 EMERGENCY RESOURCE MOBILIZATION

C9. HEALTH SERVICE PROVISION

Resilient national health systems and intermediate and local level health service delivery are essential for countries to prevent, detect, respond to and recover from public health events. Particularly in emergencies, health services should ensure capacities for event-related case management in addition to the provision of routine health services. To minimize the risk of onward transmission, clinical care should at all times adhere to optimum infection prevention and control (IPC) practices. Health care providers should ensure: IPC with an adequate water, sanitation and hygiene (WASH) programme; safe waste management and decontamination of hazardous substances, including chemical and radiation decontamination; and a functioning referral system.

INDICATORS

C 9.1 CASE MANAGEMENT CAPACITY FOR IHR RELEVANT HAZARDS

C 9.2 CAPACITY FOR INFECTION PREVENTION AND CONTROL (IPC) AND CHEMICAL AND RADIATION DECONTAMINATION.

C 9.3 ACCESS TO ESSENTIAL HEALTH SERVICES

C10. RISK COMMUNICATION

Risk communication refers to real-time exchange of information, advice and opinion between experts or officials and people who face a threat

(hazard) to their survival, health, or economic or social well-being. Its ultimate purpose is that everyone at risk is able to take informed decisions to mitigate the effects of the threat (hazard), such as a disease outbreak and take 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.

INDICATORS

C 10.1 CAPACITY FOR EMERGENCY RISK COMMUNICATIONS

C11. POINTS OF ENTRY (POE)

Points of entry (PoEs) are defined in the IHR as a passage for international entry or exit of travelers, baggage, cargo, containers, conveyances, goods and postal parcels; as well as agencies and areas providing services to them on entry or exit. 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 PoEs for developing IHR capacities are found in the introductory chapter of the WHO document on IHR capacity requirements at designated airports, ports and ground crossings. Section 1 below, requests specific information on the States' designated PoEs (the users should create an additional row in the table for each PoE).

The scoring table for this IHR capacity in Section 2 below should be based on the results of an in-depth assessment of each designated PoE, using the detailed WHO document on IHR capacity requirements at designated airports, ports and ground crossings, as well as the document on coordinated public health surveillance between PoEs and national health surveillance systems.

INDICATORS

C 11.1 CORE CAPACITY REQUIREMENTS AT ALL TIMES FOR DESIGNATED AIRPORTS, PORTS AND GROUND CROSSINGS

C 11.2 EFFECTIVE PUBLIC HEALTH RESPONSE AT POINTS OF ENTRY

C12. CHEMICAL EVENTS

Chemical events, including emergencies arising from technological incidents, natural disasters, deliberate events and contaminated foods and products, are common and occur worldwide. This section describes resources for detection and alert. Other capacities, i.e. for legislation and policies, preparedness planning and response for chemical events including emergencies, and strategic coordination are incorporated into relevant indicators above. It is important to note that some of the responsibilities for these capacities fall outside of the health sector, such as in the sectors for environment, labour, agriculture, civil protection, transport and 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.

INDICATORS

C 12.1 RESOURCES FOR DETECTION AND ALERT

C13. RADIATION EMERGENCIES

"Radiological emergencies and nuclear accidents" (termed as radiation emergencies) are rare events, but depending on the scale of the event consequences, it can range from minor to catastrophic. Management of large events can be both exhausting in terms of resource use and human capacity, and their 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 (these requirements are included in C1, C2 and C8 sections of this document and should be addressed by radiation-specific authorities as well). In most countries, the competence and responsibility for response to radiation emergencies are outside of 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.

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 International Atomic Energy Agency (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

13.1 CAPACITY AND RESOURCES

ANNEX 2 – RELEVANT GOVERNING BODIES DECISIONS AND RESOLUTIONS FOR REPORTING UNDER THE IHR (2005)

The IHR (2005) represent the commitment of States Parties to collectively prepare for, and respond to events that may constitute a public health emergency of international concern according to a common set of rules. The IHR (2005) therefore constitute an instrument, meant to ensure and improve the capacity of all States Parties, as per Annex 1 of the Regulations, to detect, assess, notify, respond to public health risks and acute events, including those at points of entry, as a continuous process. The relevance of the IHR (2005) as the legislative instrument to ensure global public health security lies in their full application, implementation, and compliance with the IHR (2005), by all States Parties.

Article 54 of the IHR (2005) states that:

1. States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly.

In 2008, the 61st World Health Assembly, through the adoption of Resolution WHA61.2⁴, decided that "States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually, with the next report to be submitted to the Sixty-second World Health Assembly"⁵.

In order to facilitate States Parties' reporting to the Health Assembly, in accordance with paragraph 1 of Article 54 of the Regulations, the Secretariat prepared questionnaires in 2008 and in 2009. A report on implementation of the Regulations, providing details of the initial responses to the questionnaire issued in 2009, was noted by the Sixty-second World Health Assembly .

In 2010, the WHO Secretariat developed the document '*IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties*⁶' and the related IHR Monitoring Questionnaire was proposed to States Parties for reporting annually to the World Health Assembly. The document constituted grouping of national core capacities detailed in Annex 1 of the Regulations – to prevent, detect, assess, notify, and respond, including at points of entry – in eight core capacities, four hazards (zoonotic, food safety, chemical, radiological) and capacities at points of entries. The results from IHR Monitoring Questionnaires were used in a summary form to report to the 64th⁷ World Health Assembly onwards (65th⁸, 66th⁹, 67th¹⁰, 68th¹¹, 69th¹² and 70th¹³ World Health Assemblies.) and disaggregated data by State Party has been published in a table format since 66th Assembly. In addition, in 2016, disaggregated data from the IHR Monitoring Questionnaires submitted from 2010 to 2015 were made available by the WHO Secretariat on the WHO Global Health Observatory (GHO) data web page¹⁴.

Between 2010 and 2017, the IHR Monitoring Questionnaire sent to National IHR Focal Points were used at least once by all 196 States Parties to report to the WHA. The summary of results from the questionnaire have been used to report to the Assembly since 64th WHA, capacity scores by country and country profiles have been made available on the WHO Global Health Observatory (GHO) data web page.

4 - http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_Rec1-part2-en.pdf

5 - http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_5-en.pdf

6 - http://apps.who.int/iris/bitstream/handle/10665/84933/WHO_HSE_GCR_2013.2_eng.pdf;jsessionid=9BC13109AC86101DFA9554897F69A1EF?sequence=1

7 - http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_9-en.pdf

8 - http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_17-en.pdf

9 - http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_16-en.pdf

10 - http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_35Add1-en.pdf

11 - http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22-en.pdf

12 - http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_20-en.pdf

13 - http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_15-en.pdf

14 - <http://www.who.int/gho/ihr/en/>

In 2011, the report of the *IHR Review Committee on the functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009*¹⁵ was presented by the WHO Director-General to the 64th World Health Assembly. The summary conclusions were:

"The IHR helped make the world better prepared to cope with public-health emergencies...but core capacities are not yet fully operational and not on a path to timely implementation worldwide".

The recommendations from that IHR Review Committee were adopted by the 64th World Health Assembly through Resolution WHA64.1¹⁶. Resolution WHA65.23¹⁷, adopted by the 65th World Health Assembly in 2012, requested the WHO Director-General: "to monitor the maintenance of the national core capacities required under the International Health Regulations (2005) in all States Parties not requesting extensions to the deadline, through the development of appropriate methods of assessing effective functioning of the established core capacities".

In its report¹⁸, the *IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation*, convened in 2014¹⁹ pursuant to Articles 5 and 13, reiterated that, as States Parties envisioned the IHR (2005) as a long term process, and also one that should be seen and used, as an essential tool in contributing to global public health security. In addition, it would provide an important foundation upon which to build a long-term approach. Among other recommendations, The *IHR Review Committee recommended*:

"The Director General should consider a variety of approaches for the shorter-and longer-term

assessment and development of IHR core capacities. [...] with a longer term vision, the [WHO] Secretariat should develop through regional consultative mechanisms options to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations [...] Any new monitoring and evaluation scheme should be developed with the active involvement of WHO regional offices and subsequently proposed to all States Parties through the WHO governing bodies' process."

The recommendations of that *IHR Review Committee* were adopted by the 68th World Health Assembly through Resolution WHA68.5²⁰.

In 2015, the WHO Secretariat, along with States Parties, initiated the development of monitoring and evaluation approaches, focusing on national core capacities, that were consolidated, as a whole, in the IHR Monitoring and Evaluation Framework, to satisfactorily ensure mutual accountability among States Parties, while building trust and appreciation of public health benefits resulting from the adoption of a common set of rules inspired by dialogue and transparency²¹. The IHR Monitoring and Evaluation Framework consists of four complementary components: one mandatory; the State Party Self-assessment Annual Report, and three voluntary: Joint External Evaluation, after-action reviews, and simulation exercises. The State Party Self-assessment Annual Report and joint external evaluations attempt at quantitative assessment of existence of IHR capacities. After-action reviews and simulation exercises, based on qualitative measures, are aimed at gauging the functional status of IHR capacities.

15 - http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10Add1-en.pdf

16 - http://apps.who.int/gb/ebwha/pdf_files/WHA64-REC1/A64_REC1-en.pdf#page=21

17 - http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf#page=25

18 - http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf

19 - http://apps.who.int/gb/ebwha/pdf_files/EB136/B136_22Add1-en.pdf

20 - http://apps.who.int/gb/ebwha/pdf_files/WHA68-REC1/A68_R1_REC1-en.pdf#page=27

21 - http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_20-en.pdf

ANNEX 3. ACRONYMS AND GLOSSARY

ACRONYMS

EOC	Emergency operation centre
FAO	Food and Agriculture Organization of the United Nations
IHR	International Health Regulations (2005)
IAEA	International Atomic Energy Agency
INFOSAN	International Food Safety Authorities Network
IPC	infection prevention and control
MoH	Ministry of Health
NFP	National IHR Focal Point
NGO	nongovernmental organization
PHEIC	public health emergency of international concern
PoEs	points of entry
SOP	standard operating procedure
WASH	water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization

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 guidance 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.
attribute	One of a set of specific elements or characteristics that reflect the level of performance or achievement of a specific indicator.
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.
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).
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).
facility-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).
financing	Funds and resources identified, allocated, distributed and executed on activities and interventions. It does not take into account 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.
ground crossing	Point of land entry in a State Party, including one utilized by road vehicles and trains.
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: Infection prevention and control 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	Number of instances of illness commencing, or of persons falling ill during a given period in a specified population (Prevalence and incidence. Bull World Health Organ. 1966; 35(5): 783–787).
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).
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.
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/ , accessed 2 April 2018) 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 re-adjustment 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	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.
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	Epidemic limited to localized increase in the incidence of a disease, such as in a village, town or closed institution (adapted from Last JM, Spasoff RA, Harris SS, ed. A dictionary of epidemiology. Fourth edition. New York: Oxford University Press;2001).
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	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	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 to the international community.
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.

States Parties	These are the 194 WHO Member States, and the Holy See and Lichtenstein, currently identified by IHR (see website: www.who.int/ihr/ , accessed 2 April 2018) 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.
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).
WASH	In this document, WASH refers to facility-WASH.
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	Unit within WHO that shall be accessible at all times for communication with the National IHR Focal Point. The IHR contact points are located at regional offices in all six WHO regions.
zoonosis	Infection or disease that is transmissible between animals and humans.



CONTACT DETAILS

COUNTRY CAPACITY MONITORING AND EVALUATION UNIT
Country Health Emergency Preparedness and IHR
World Health Organization
20 Avenue Appia
CH-1211 Geneva
Switzerland

E-MAIL
cme@who.int