INTERNATIONAL HEALTH REGULATIONS (2005)

STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

World Health Organization

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RESPONDENT IDENTIFICATION

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State party	Choose a country
Name of the contact officer for this report	
Title of the contact officer for this report	
E-mail address of the contact officer for this report	
Telephone number of the contact officer for this report	

APPROACH ADOPTED BY STATES PARTIES FOR THE COMPLETION OF THE TOOL

1. Compiled by:

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

2. Sectors involved in compiling report:

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

3. Consultative process:

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

The submission of IHR Annual Reports using this tool will allow the WHO Secretariat to compile a consistent report for the WHA. Submission of reports in other formats will not be considered for statistics of capacities, since it will not allow WHO Secretariat to retrieve correctly the data and produce standardized scores. However, the use of this tool by States Parties is entirely voluntary.

APPLICATION OF THE VOLUNTARY COMPONENTS OF THE IHR MONITORING AND EVALUATION FRAMEWORK

While annual reporting is mandatory under IHR (2005), States Parties that had undergone the voluntary components of the IHR Monitoring and Evaluation Framework, such as after-action reviews, simulation exercises or joint external evaluations, may use the results of it, to provide complementary information for their Annual Report, while using the SPAR Tool.

INSTRUCTIONS

SELECTION OF LEVEL FOR EACH INDICATOR

The tool has 13 capacities, each of which consists of a number of indicators. Each indicator is graded into five levels of performance to choose from in the continuum of progress. Actions or elements, called "attributes", required for each level are described, and where possible the difference from one level to the next is highlighted. Explanatory notes are given as footnotes for further clarification, as necessary, so that each attribute and the indicator as a whole are fully explained and well defined. Further information may be obtained under Annex 1 Acronyms and glossary. Therefore, ***it is important that the respondents read the explanatory notes carefully before determining the level.***

For each indicator, please select one of the five levels that best describes your State Party's implementation status. To obtain the most accurate view of national capacities, it is recommended to respond to all the indicators and select one level per indicator. ***If two or more levels are selected, the lowest level will be regarded as your implementation status. If you do not select any, it is regarded as no capacity exists and your final score for this indicator will be calculated as zero[1].***

All attributes in one level must be in place in order to move to the next level. This means that it is a prerequisite to have all the attributes for level 1 in order to examine the attributes in level 2. If level 2 is selected, it indicates that all the attributes in level 1 and level 2 are fulfilled.

ADDITIONAL COMMENTS

If there is no capacity at all and the answer to level 1 attribute is 'no', then all the check boxes for that indicator should be left blank and it should be indicated as 'no capacity and score to be considered zero for this indicator' and add rationale for this choice in the additional comments box.

If any attribute is not applicable in your country's context, please indicate this in the comment box provided at the end of each section along with the reason for it not being applicable. Other additional comments or contributions you may wish to make, describing actual situation, such as strengths and weaknesses , as well actions planned or on-going to improve each specific capacity, to help plan and monitor progress in the implementation, can also be considered in the comment box. Additional pages may also be added, if required.

EXAMPLES

Some of the examples are given below:

Example	Your country's implementation status	The level that should 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 indicate no capacity and score to be considered zero for this indicator' and add rationale for this choice in Additional Comments box.
Example 2	Level 1 – yes to all elements Level 2 – yes to some elements but not all	Level 1 ***Irrespective of*** the status of elements in levels 3, 4 and 5
Example 2 - A	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**
Example 2 - B	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**

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 (available at: https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.16/en/).

IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

C1. LEGISLATION AND FINANCING[2]

States Parties should have an adequate legal framework in all relevant sectors[3] 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. This may include a regulatory pathway for emergency research, licensing process, marketing authorization of products and procurement procedures during health emergencies and pandemics. 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	
Level	**C1.1 Legislation, laws, regulations, policy, administrative requirements or other government instruments[4] to implement the IHR**	
Level 1	Legislation, laws, regulations, policy, administrative requirements or other government instruments to support and facilitate the development and implementation of IHR capacities **for infectious diseases are under development**	❑
Level 2	Legislation, laws, regulations, policy, administrative requirements or other government instruments to support and facilitate the development and implementation of IHR capacities **for infectious diseases are in place**[5]	❑
Level 3	Legislation, laws, regulations, policy, administrative requirements or other government instruments to support and facilitate the development and implementation of IHR capacities **for food safety are in place**[6]	❑
Level 4	Country is party to key **chemical** multilateral agreements[7] AND **Chemical safety** laws, regulations and policies[8] that contribute to chemical event prevention, preparedness, detection and response **are in place at the national, intermediate and local levels** as appropriate to the structure of the country	❑
Level 5	Legislation addressing the needs of **radiation emergency** preparedness and response (according to the radiation risk profiles of the country)[9] **are in place**, specifying the roles and responsibilities of relevant stakeholders	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

Level	C1.2 Financing[10] for the implementation of IHR capacities[11]	
Level 1	**Budgetary allocations**[12] for the implementation of IHR capacities are made **only by extra-budgetary means**[13]	❑
Level 2	**Budgetary allocation or external financing**[14] are made for the implementation of IHR capacities **for biological hazards**[15] **at the national, intermediate and local levels**	❑
Level 3	**Budgetary allocations or external financing** are made for the implementation of IHR capacities **for all IHR hazards**[16] **at the national, intermediate and local levels**	❑
Level 4	**Budgets** for the implementation of IHR capacities for all IHR hazards **are distributed**[17] **in a timely manner at the national, intermediate and local levels in all relevant sectors**	❑
Level 5	**Budgets** for the implementation of IHR capacities for all IHR hazards **are executed in a coordinated manner**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

2 Questions on these should be answered by legal or legislative advisers, experts at the Ministry of Health or other relevant ministries with supporting evidence and documents.
3 See C2. IHR coordination and National IHR Focal Point functions.
4 These include strategies and national plans to support the implementation of IHR capacities.
5 This should be at national, intermediate and local levels, as appropriate to the structure of the country.
6 This should be at national, intermediate and local levels, as appropriate to the structure of the country.
7 Key chemical multilateral agreements, such as the Rotterdam Convention, Stockholm Convention, Basel Convention, Minamata Convention, Bamako Convention (African countries), Chemical Weapons Convention, Convention on the Transboundary Effects of Industrial Accidents (European countries), International Labour Organization (ILO) Convention 174 on Prevention of Major Industrial Accidents, International Labour Organization (ILO) Convention 170 on Safety in the Use of Chemicals at Work.
8 These include requirements for: land-use planning, licensing of hazardous sites, building regulations, control of chemical storage and transportation, control of waste disposal sites, occupational health and safety, emergency plans on hazardous sites, local authorities to have emergency plans, implementation of the Globally Harmonised System of Classification and Labelling of Chemicals (GHS) (see: WHO manual - the public health management of chemical incidents. Geneva: World Health Organization; 2009 (http://www.who.int/environmental_health_emergencies/publications/Manual_Chemical_Incidents/en/, accessed 1 April 2018).
9 If there is no need for legislation to address the requirements of radiation emergency preparedness and response according to the radiation risk profiles, then the answer is automatically 'yes'.
10 These are 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.
11 These include all IHR related hazards, i.e. infectious diseases, zoonoses, food safety, chemical events and radiation emergencies, and National IHR Focal Point functions (see C2.1).
12 This refers to access to funds by relevant ministries or government bodies for the implementation of all IHR capacities.
13 Accounts held by government bodies, but not included in the government budget.
14 Financing from non-domestic sources towards the implementation of IHR capacities whose amounts make up a majority of national financing for emergency preparedness, detection and response.
15 Comprises infectious disease events, including zoonotic and food safety events.
16 HR capacities for all IHR related hazards, i.e. infectious diseases, zoonoses, food safety, chemical events and radiation emergencies.
17 A release of annual appropriation of financing, usually on a quarterly or monthly basis, for the meeting of financial obligations.

Level	C1.3 Financing mechanism and funds for timely response[18] to public health emergencies[19]	
Level 1	**An emergency public financing mechanism**[20] that allows structured reception and rapid distribution of funds for responding to public health emergencies is **under development**	❑
Level 2	**An emergency public financing mechanism** that allows structured reception and rapid distribution of funds for responding to public health emergencies **is in place at the national level**	❑
Level 3	**An emergency public financing mechanism** that allows structured reception and rapid distribution of funds for responding to public health emergencies **is in place at the national level for all relevant sectors**[21]	❑
Level 4	**An emergency public financing mechanism** that allows structured reception and rapid distribution of funds for responding to public health emergencies **is in place at the national, intermediate and local levels**	❑
Level 5	**Monitoring and feedback system** for an emergency public financing mechanism is in place and functional AND **Access to an emergency contingency fund** [22] for public health emergency **is in place**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

18 Funding and a financing mechanism for responding to public health emergencies focuses on providing resources to facilitate the surge capacity of the health system and the deployment of interventions that go beyond the routine structure of the health system. This could include legislation in place such as a public health act or state emergency act.

19 A set of triggers (as defined by the country) helps identify and declare a situation as a public health emergency.

20 These could include a special set of processes or channels in place that activate a special emergency public financing mechanism and allows for rapid reception and distribution of funds, which may circumvent (in a defined way) certain financing rules or slower mechanisms in the short-term with appropriate review and oversight provisions after the event is under control.

21 Different hazards or public emergencies involve different sectors, e.g. avian influenza involves, agriculture, health and the home ministry. Those sectors identified as relevant in the emergency response plans for each type of hazard have budget lines in place to receive and execute emergency funding.

22 An emergency contingency fund exists at the national, regional or international level, with which a national authority can coordinate the reception and distribution of funds.

C2. IHR COORDINATION AND NATIONAL IHR FOCAL POINT FUNCTIONS

Establishing and maintaining IHR capacities requires collaboration among all relevant sectors and ministries, agencies or other government bodies responsible for all aspects of IHR capacities' implementation 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	
Level	**C2.1 National IHR Focal Point functions[23] under IHR**	
Level 1	**National IHR Focal Point** that is accessible (at all times) for communications with WHO IHR contact points in accordance with IHR is **designated by the State Party** (issues pertaining to the application, implementation, and compliance with the IHR).	❑
Level 2	National IHR Focal Point **is accessible at all times** for communications with WHO IHR contact points in accordance with IHR	❑
Level 3	**Terms of reference** describing the roles and responsibilities of the National IHR Focal Point **is in place**[24]	❑
Level 4	National IHR Focal Point **functions are carried out** according to the terms of reference	❑
Level 5	National IHR Focal Point **functions are tested on a regular basis** and actions have been taken to strengthen their capacities	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

23 See National IHR Focal Point guide: Designation/establishment of national IHR focal points (http://www.who.int/ihr/English2.pdf, accessed 1 April 2018).

24 See National IHR Focal Point guide: Designation/establishment of national IHR focal points (http://www.who.int/ihr/English2.pdf, accessed 1 April 2018)

Level	C2.2 Multisectoral IHR coordination mechanisms[25]	
Level 1	Multisectoral coordination mechanisms **for infectious diseases** between stakeholders from all relevant sectors to address IHR strategies **are in place**	❑
Level 2	Multisectoral coordination mechanisms to address **zoonoses** and other existing or new health events at the human–animal interface [26] **are in place**	❑
Level 3	Multisectoral coordination mechanisms for **food safety** between stakeholders from all relevant sectors[27] to fulfil the obligations under IHR **are in place**	❑
Level 4	Multisectoral[28] coordination mechanisms for **chemical safety are in place**	❑
Level 5	Coordination and communication mechanisms[29] for **radiation emergencies** between all stakeholders from all relevant sectors, including national radiation safety authorities, **are in place**[30]	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

25 Multisectoral coordination mechanism should include clearly defined roles and responsibilities for each stakeholder, appropriate hierarchical levels within each sector and formalized documented procedures to support the implementation of IHR capacities in a sustainable approach.
26 This does not refer to coordination mechanisms in place for individual zoonotic diseases or for national emergencies.
27 This can include health, agriculture and fishery, law enforcement, independent food regulation authority, tourism, transportation and service industry, among others.
28 Relevant sectors and entities can include: emergency services, public health authorities, secondary and tertiary medical facilities, ministries of industry, trade and agriculture, relevant regulatory authorities, government chemist laboratory, mass media and industry.
29 Coordination for risk assessments, risk communications, planning, exercising, monitoring and including coordination during urgent radiological events and potential risks that may constitute a public health emergency of international concern (PHEIC), and should include information-sharing, communication procedures, regular meetings, and standard operating procedures (SOPs) for a coordinated response.
30 For countries with low radiation risk profiles, arrangements are in place for accessing technical expertise abroad – in neighbouring states, regional or international networks, such as WHO's REMPAN and BioDoseNet and International Atomic Energy Agency's (IAEA's) RANET.

C3. ZOONOTIC EVENTS AND THE HUMAN–ANIMAL INTERFACE

Mechanisms and documented procedures among all relevant sectors[31], particularly those responsible for human health and animal health, are 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	
Level	**C3.1. Collaborative effort on activities to address zoonoses**	
Level 1	The animal and public health sectors **work together** on zoonoses only **on an ad hoc basis**	❑
Level 2	The animal and public health sectors have jointly mapped, prioritized and agreed on priority zoonoses	❑
Level 3	The animal and public health sectors work in collaboration regularly on specific activities[32] to prevent, detect and respond to **one or more agreed priority zoonoses**	❑
Level 4	The animal and public health sectors work in collaboration regularly on specific activities to prevent, detect and respond **to the majority of priority zoonoses at national, intermediate and local levels**	❑
Level 5	Collaborative efforts to prevent, detect and respond to priority zoonoses are **tested or evaluated and updated regularly**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

31 See C2. IHR coordination and National IHR Focal Point functions.
32 Specific activities could include surveillance (epidemiology and laboratory), data sharing, situation or risk assessments, planning, risk reduction and risk communication.

C4. FOOD SAFETY

States Parties have the capacity for the 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 of the INFOSAN network. Food safety is multisectoral in nature and the agencies/sectors responsible for detection, investigation and response to a food safety emergency varies across r States Parties.

	Indicators	
Level	**C4.1 Multisectoral collaboration mechanism[33] for food safety[34] events**	
Level 1	A multisectoral collaboration mechanism that includes an International Food Safety Authorities Network (INFOSAN)[35] Emergency Contact Point[36] **is under development,** or the existing multisectoral collaboration mechanism is outdated.	❑
Level 2	A multisectoral collaboration mechanism that includes an INFOSAN Emergency Contact Point **is in place at the national level** AND **Communication channels**[37] between the INFOSAN Emergency Contact Point, the National IHR Focal Point and all relevant sectors for food safety events including emergencies have been **established at the national level.**	❑
Level 3	A multisectoral collaboration mechanism that includes at least one INFOSAN Focal Point[38] **is in place at the national, intermediate and local levels,** as appropriate to the structure of the country.	❑
Level 4	**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,** if applicable, have been established.	❑
Level 5	A multisectoral collaboration mechanism has been **assessed, monitored and reviewed on a regular basis** in order to strengthen capacities AND **Formalized** communication channels between the INFOSAN Emergency Contact Point, the National IHR Focal Point, INFOSAN focal points and other relevant sectors for food safety events including emergencies at national and international level **have been tested, reviewed and updated**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

33 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.

34 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.

35 International Food Safety Authorities Network (http://www.who.int/foodsafety/areas_work/infosan/en/, accessed 1 April 2018).

36 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 Focal Point.)

37 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).

38 An INFOSAN Focal Point is a member of a national authority with a stake in food safety, such as ministries of agriculture, trade, fisheries, etc.

C5. LABORATORY

Laboratory 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[39]; 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	
Level	**C5.1. Specimen referral and transport system**	
Level 1	Transportation[40] of specimens from health facilities to reference laboratories for confirmatory diagnostics could be available **on an ad hoc basis**	❑
Level 2	Systems[41] are in place **for less than 50% of all health facilities** to transport specimens to reference laboratories for confirmatory diagnostics	❑
Level 3	Systems are in place for **50–80% of all health facilities** to transport specimens to reference laboratories for confirmatory diagnostics	❑
Level 4	Systems are in place **for at least 80% of all health facilities** to transport specimens to reference laboratories for confirmatory diagnostics	❑
Level 5	Systems are in place to transport specimens to reference laboratories for confirmatory diagnostics **from all health facilities**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

39 Reference laboratories could be national laboratories and/or international reference laboratory where the country has a formal memorandum of understanding for testing.
40 Ad hoc transportation: no SOP on how to transport samples.
41 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.

Level	C5.2 Implementation of a laboratory biosafety[42] and biosecurity[43] regime	
Level 1	National laboratory biosafety and biosecurity guidelines and/or regulations **are under development**	❑
Level 2	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented **by some laboratories at the national level**	❑
Level 3	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented **by all laboratories at the national level**	❑
Level 4	National laboratory biosafety and biosecurity guidelines and/or regulations are implemented **by all laboratories at national, intermediate and local levels**	❑
Level 5	National laboratory biosafety and biosecurity guidelines and/or **regulations are regularly reviewed and updated as needed**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

Level	C5.3 Access to laboratory testing capacity[44] for priority diseases[45]	
Level 1	Access to laboratory testing capacity with quality assured results[46] **is in place only for a minority of the priority diseases**	❑
Level 2	Access to laboratory testing capacity with quality assured results **is in place for at least five priority epidemic-prone diseases or other public health events**	❑
Level 3	Access to laboratory testing capacity with quality assured results **is in place for at least 10 priority epidemic-prone diseases or other public health events**	❑
Level 4	Access to laboratory testing capacity with quality assured results **is in place for at least 15 priority epidemic-prone diseases or other public health events**	❑
Level 5	Access to laboratory testing capacity with quality assured results **is in place for all priority epidemic-prone diseases or other public health events**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)

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

43 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).

44 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).

45 Priority diseases are based on the local epidemiology and as defined in the national surveillance guidelines for priority diseases and/or notifiable diseases, including for emerging or novel pathogens.

46 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).

C6. SURVEILLANCE

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. This involves a multisectoral and integrated health system approach and may include sentinel surveillance systems and contact tracing during health emergencies.

	Indicators	
Level	**C6.1 Early warning function: indicator-and event-based surveillance**	
Level 1	The surveillance system for diseases/syndromes/events (reporting, feedback, communication) **is under development**	❑
Level 2	Standard operating procedures (SOPs) and/or other written technical guidelines for surveillance have been **developed and implemented at the national, intermediate and local levels of the surveillance system**	❑
Level 3	Surveillance data/information are collected via **either** indicator-based[47] **or** event-based[48] surveillance **on ad hoc basis**	❑
Level 4	Surveillance data/information are collected via **both** indicator-and event-based surveillance with regular reporting and immediate notification taking place **in a systematic manner**	❑
Level 5	Surveillance system is **regularly evaluated and updated**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

47 Indicator-based surveillance is the systematic (regular) collection, monitoring, analysis and interpretation of structured data, i.e. of indicators produced by a number of well-identified, mostly health-based, formal sources, such as when healthcare facilities regularly report the numbers of cases and deaths caused certain priority diseases that are predefined and mandated.

48 Event-based surveillance is the organized collection, monitoring, assessment and interpretation of mainly unstructured ad hoc information regarding health events or risks, which may represent an acute risk to human health. It is a functional component of the early warning and response system (such as media screening that is conducted in a systematized manner to identify events of public health interest).

Level	C6.2 Mechanism for event management (verification, risk assessment, analysis[49] investigation)	
Level 1	There is **unstructured** mechanism for event management	❑
Level 2	SOPs and/or other written technical guidelines for event management are **developed and disseminated to national, intermediate and local levels**	❑
Level 3	Event verification, risk assessment, investigation and analysis are **systematically performed and guide a response by national and intermediate levels** **AND** Findings are disseminated by production of periodical epidemiological reports	❑
Level 4	Event verification, risk assessment, investigation and analysis are systematically performed and guide a response by national, intermediate and local levels **AND** Results of all events that may constitute potential public health events of international concern **are communicated to WHO and epidemiological reports are shared with all relevant sectors,** [50] **and partners**	❑
Level 5	Event management system **is evaluated and updated on a regular basis**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

49 All surveillance data are systematically analysed for informed decision-making and dissemination.
50 See C2. IHR coordination and National IHR Focal Point functions.

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

	Indicators	
Level	**C7.1 Human resources[51] for the implementation of IHR capacities**	
Level 1	Human resources for the implementation of IHR capacities[52] **are available on an ad hoc basis**	❑
Level 2	Human resources for the implementation of IHR capacities **are mapped and available only at the national level**	❑
Level 3	Human resources for the implementation of IHR capacities **are available at the national level in all relevant sectors**[53]	❑
Level 4	Human resources for the implementation of IHR capacities **are available**[54] **at national, intermediate and local levels**	❑
Level 5	Human resources for the implementation of IHR capacities **are reviewed and updated on a regular basis**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

51 Human resources to apply, implement, and comply with the IHR. Examples 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, 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.

52 This includes human resources required at the human resources unit/department responsible for planning, mapping, development and distribution of the public health and emergency workforce as well as those required at the operational level.

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

54 This includes the distribution of personnel, quality of services, competencies, safety and systems required to respond to health emergencies with regards to the IHR specific regulations.

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 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 and surge capacity for scaling up for large national events and pandemics.

	Indicators	
Level	**C8.1 Planning for emergency preparedness and response mechanism**	
Level 1	A public health emergency risk profile[55] and plans[56] for emergency preparedness and response **are under development**	❑
Level 2	Public health emergency risk profiles have been developed and emergency preparedness measures[57] for priority public health risks[58] **is available at the national level**	❑
Level 3	Based on the all-hazard health emergency risk profile, plans for **multisectoral allhazard**[59] public health emergency preparedness and response **are in place at the national level**	❑
Level 4	Based on the all-hazard health emergency risk profile, plans for **multisectoral all-hazard** public health emergency preparedness and response are in place **at national, intermediate and local levels**	❑
Level 5	Based on updated **all-hazard** health emergency risk profile and resource mapping, plans for **multisectoral all-hazard** public health emergency preparedness and response plan **are regularly tested and updated**	❑
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

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

56 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.

57 Emergency preparedness measures include strategic risk assessments, emergency response planning, contingency planning, training for emergency response, exercising and surge capacity development.

58 Risks are identified by strategic emergency risk assessments, and should include those that have the potential to cause PHEICs as per the IHR.

59 This should include all IHR hazards (zoonoses, food safety, chemical and radiation).

Level	C8.2 Management of health emergency response operations	
Level 1	A health sector emergency response coordination mechanism[60] **or** incident management system[61] linked with a national emergency operation centre **is under development**	❑
Level 2	A health sector emergency response coordination mechanism **or** incident management system linked with a national emergency operation centre **are in place at the primary level of response**[62]	❑
Level 3	Health sector emergency response coordination mechanisms **and** incident management system linked with a national emergency operation centre **are in place at the primary level of response**	❑
Level 4	Health sector emergency response coordination mechanisms **and** incident management system linked with a national emergency operation centre **are in place at national, intermediate and local levels**	❑
Level 5	A health sector emergency response coordination mechanism and incident management system linked with a national emergency operation centre **have been tested and updated regularly**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

Level	C8.3 Emergency resource mobilization	
Level 1	**Inventories and maps of existing** health sector resources[63] for emergency response **are under development**	❑
Level 2	Inventories and maps of existing health sector resources for emergency response **are in place at the national level**	❑
Level 3	**Inventories and maps** of existing health sector resources for emergency response **are in place at the national, intermediate and local levels** AND A mechanism to send and/or receive international assistance **is in place**	❑
Level 4	**Access** to existing health sector resources for emergency response **is in place at national, intermediate and local levels**	❑
Level 5	Resource mapping and mobilization mechanisms are **regularly tested and updated**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)

60 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.

61 Incident management system (or incident command system) refers to an 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.

62 Depending on the emergency response plan of the country, the primary responsibility of emergency response lies at a different administrative level. In general, it is at the national level in centralized governments, and at the intermediate level in federal governments.

63 Human (experts), financial, logistics (medical countermeasures, stockpiles, product deployment plans), and health facilities (beds, equipment, etc.).

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 assure capacities for event-related case management in addition to the provision of routine health services. To minimize the risk of onward[64] 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[65]; safe waste management and decontamination of hazardous substances, including chemical and radiation decontamination; and a functioning referral system.

	Indicators	
Level	**C9.1 Case management capacity for IHR relevant hazards**	
Level 1	Nationally recognized (issued) case management guidelines[66] **for priority epidemic-prone diseases are under development**	❑
Level 2	Access to case management services according to nationally recognized guidelines **for priority epidemic-prone diseases are available at national, intermediate and local levels**	❑
Level 3	Access to case management services[67] according to nationally recognized guidelines for **all-hazards[68] are in place at the national level**	❑
Level 4	Access to case management services according to nationally recognized guidelines **for all-hazards are in place at national, intermediate and local levels**	❑
Level 5	Access to case management services according to nationally recognized guidelines **for all-hazards are reviewed and updated on a regular basis**	❑
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

64 See: Guideline on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/handle/10665/251730/9789241549929-eng.pdf?sequence=1, accessed 2 April 2018).
65 Within this document, WASH refers to facility-WASH only.
66 These should include SOP 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 risks.
67 Including procedures for referral and evacuation.
68 Nuclear, chemical, zoonoses and food safety, based on the national risk profile.

Level	C9.2 Capacity for infection prevention and control and chemical and radiation decontamination	
Level 1	A national IPC programme and WASH standard for infectious diseases are **under development**	❑
Level 2	Access to health services according to national IPC programme and national WASH standards for infectious diseases are in **place at major hospital centres**	❑
Level 3	Access to health services according to national IPC programme and national WASH standards for infectious diseases **are in place at all health care facilities**	❑
Level 4	Designated health care facilities for chemical events **have access** to the capacity to decontaminate	❑
Level 5	Designated health care facilities for radiation emergencies **have access** to the capacity to decontaminate	❑
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

Level	C9.3:Access[69] to essential health services[70]	
Level 1	Less than 50% of catchment areas have access to **essential health services**.	❑
Level 2	At least 75% of catchment areas have access to **essential health services.**	❑
Level 3	All of catchment areas have access to **essential health services.**	❑
Level 4	Level of service utilization[71]: number of outpatient contacts per person per year **≥ 2.0 visit/person/ year.**	❑
Level 5	Level of service utilization: number of outpatient contacts per person per year **≥ 3.0 visit/person/ year.** AND Delivery of essential health services **is evaluated and updated on a regular basis.**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

69 Access to health services means «the timely use of health services to achieve the best health outcomes». Attaining access to care requires three discrete steps:
Gaining entry into the health care system.
Getting access to sites of care where patients can receive required services.
Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.

70 Essential services: maternal and child health services, health promotion, reproductive health services, prevention and control of communicable and prevention and treatment of non-communicable diseases, emergency health services, mental health services http://apps.who.int/medicinedocs/documents/s19808en/s19808en.pdf

71 http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf?ua=1; http://apps.who.int/iris/bitstream/10665/173589/1/WHO_HIS_HSI_2015.3_eng.pdf?ua=1

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. This may include management of risk perceptions, knowledge, attitudes and behaviors of population and infodemics.

	Indicators	
Level	**C10.1 Capacity for emergency risk communications**	
Level 1	Mechanisms[72] for emergency risk communication are implemented **on an ad hoc basis**[73]	❑
Level 2	Formalized[74] all-hazard emergency risk communication mechanisms **are in place at the national level** with the ability to proactively engage with the public and affected communities **through different channels (including the media and social media)**	❑
Level 3	Formalized all-hazard emergency risk communication mechanisms **are in place at the national, intermediate and local levels,** with the ability to proactively engage with the public and affected communities in **local languages**	❑
Level 4	All-hazard emergency risk communication mechanisms **are operational at the national, intermediate and local levels** with the ability to proactively engage with affected communities in local languages **and incorporate their feedback**[75] **into the emergency response system**	❑
Level 5	Formalized all-hazard emergency risk communication mechanisms[76] **are consistently implemented and regularly reviewed, evaluated and updated**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

72 Coordination and planning mechanisms across all relevant response agencies.
73 Uncoordinated and not systematic.
74 Coordinated with all relevant sectors.
75 Perceptions, concerns, misinformation, rumours, etc.
76 As indicated in level 4.

C11. POINTS OF ENTRY

Points of entry (PoEs) 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 PoEs 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[77]. 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 core 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 core 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[78].

SECTION 1. INFORMATION BY TYPE OF POINTS OF ENTRY

1. Please indicate the number of designated PoEs that shall develop the capacities provided in Annex 1 of the IHR (n/a if not applicable)	
Number of designated ports	Choose a number
Number of designated airports	Choose a number
Number of designated ground crossings[79]	Choose a number

2. Please list the names of designated PoEs (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.

Download		United Nations Code for Trade and Transport Locations (UNLOCODE)[80]	Competent authorities identified at designated PoE level (Y/N)	Level[81] 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[82]of effective public health response at each designated PoE (capacities to respond to emergencies, Annex 1B)	PoE public health emergency contingency plan[83] (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 ❑

77 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).

78 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).

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

80 UNLOCODE published by United Nations Economic Commission for Europe (https://www.unece.org/cefact/locode/service/location).

81 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 the section 2, whereas the "all" and "some" should be replaced by the Specific individual PoE that has been assessed. e.g level 1: PoE to develop routine capacities is identified based on risk assessment; level 2: PoE is implementing some of the routine capacities and competent authorities are identified at this specific PoE; level 3: PoE is implementing all routine core capacities and PoE is integrated to national surveillance system for biological hazards; level 4: the PoE is implementing routine core capacities with an all- hazard and multi sectoral approach; level 5, routine capacities at this specific PoE is evaluated and actions are taken to improve on a regular basis.

82 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 effective public health response capacities at each specific point of entry, utilizing the criteria in the section 2, whereas the "all" and "some" should be replaced by the Specific individual PoE that has been assessed. e. g level 1: PoE is in the process of developing a PoE public health emergency contingency plan; level 2: PoE has developed a PoE public health emergency contingency plan for events caused by biological hazards; level 3: PoE has developed PoE public health emergency contingency plans for events caused by biological hazards AND this PoE is integrated into national emergency response plans; level 4: the PoE has developed PoE public health emergency contingency plan for events caused by all hazards; level 5, the PoE routinely tests, reviews and updates PoE public health emergency contingency plans for events caused by all hazards.

83 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).

SECTION 2. OVERALL NATIONAL PROFILE OF THE IMPLEMENTATION OF CORE CAPACITIES AT POINTS OF ENTRY

	Indicators	
Level	**C11.1 Core capacity requirements at all times for designated airports, ports and ground crossings**	
Level 1	PoEs to develop routine core capacities **are** identified for designation based on associated public risk assessment	❑
Level 2	**Some** designated PoEs are implementing routine core capacities at all times AND Competent authorities are identified in each designated PoE	❑
Level 3	**All** designated PoEs are implementing routine core capacities at all times AND **All** designated PoEs are integrated into the national surveillance system **for biological hazards**	❑
Level 4	**All** designated PoEs are implementing routine core capacities with an **all-hazard and multisectoral approach**	❑
Level 5	Routine core capacities at all designated PoEs are **evaluated and actions are taken to improve on a regular basis**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Level	**C11.2 Effective public health response at points of entry**	
Level 1	PoEs identified for designation are in the process of **developing a PoE public health emergency contingency plan**[84]	❑
Level 2	**Some** designated PoEs have developed a PoE public health emergency contingency plan for events caused by **biological hazards**	❑
Level 3	**All** designated PoEs have developed PoE public health emergency contingency plans for events caused by **biological hazards** AND **All** designated PoEs are **integrated into** national emergency response plans	❑
Level 4	**All** designated PoEs have developed PoE public health emergency contingency plans for events caused **by all hazards**	❑
Level 5	**All** designated PoEs **routinely**[85] **test, review and update** PoE public health emergency contingency plans for events caused **by all hazards**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

84 PoE public health emergency contingency plan (IHR (2005) Annex 1B) should be part of the aerodome emergency plan of each individual PoE, for public health events, including potential PHEIC. This should be developed using a multisectoral and all-hazards approach and harmonized with national emergency response plans. Detailed recommended approach, structure and logical set of considerations can be found at: Guide for public health emergency contingency planning at designated points of entry (http://www.who.int/ihr/publications/9789290615668/en/, accessed 2 April 2018).

85 Consistent with any applicable international agreements.

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 sections 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[86].

	Indicators	
Level	**C12.1 Resources for detection and alert**	
Level 1	Surveillance mechanisms and resources[87] for chemical events or poisoning **are under development**	❑
Level 2	**Surveillance capacity for chemical exposures is available on an ad hoc basis,** e.g. a poison information service that operates only during office hours or that only serves part of the country AND **Access to laboratory capacity**[88] for identifying and quantifying exposures to key chemicals of concern[89] **is available on an ad hoc basis**	❑
Level 3	A poisons information service[90] or equivalent national service that performs surveillance for chemical exposures, and for communication of alerts **is in place on a 24/7 basis**	❑
Level 4	Access to laboratory that conforms to national quality standard for identifying and quantifying chemical exposures to key chemicals of concern **is in place**	❑
Level 5	An integrated system of public health surveillance linked with environmental monitoring[91], that captures and assesses data on chemical exposures from multiple sources, **is under development or in place**	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

86 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).

87 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.

88 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.

89 List to be determined by the responding State Party.

90 The poisons information service (which may comprise one oр 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).

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

C13. RADIATION EMERGENCIES

"Radiological emergencies and nuclear accidents" (termed as radiation emergencies)[92] 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 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 (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[93].

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	
Level	**C13.1 Capacity and resources**	
Level 1	Surveillance mechanisms and resources[94] for radiation emergencies **are under development**	❑
Level 2	Radiation sources have been inventoried and radiation risk mapping[95] **has been conducted and documented**	❑
Level 3	Access to specialized health care for radiation injuries[96] is in place AND Access to laboratory testing capacity for monitoring, identification and assessment of radiation exposure is in place	❑
Level 4	Access to technical expertise for managing radiation emergencies[97], including guidelines, protocols and regularly trained experts, is in place. AND Access to stockpile to support radiation emergency preparedness and response is in place	❑
Level 5	Radiation emergency arrangements are formally evaluated and tested on a regular basis, and improvements are made accordingly	❑
Add your comments for this indicator here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		
Add your additional comments for this capacity here (e.g. rationale for choosing the checked level and summary of the actual situation, such as weakness, strengths, planned or on-going actions and recommendation to improve level of this capacity)		

92 For the purpose of this document the terms radiological emergencies and nuclear accidents are shortened to "radiation emergencies" that encompasses both types of emergencies.
93 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 (http://www-pub.iaea.org/MTCD/Publications/PDF/P_1708_web.pdf, accessed 2 April 2018)
94 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 taking action on these events. The resources needed include infrastructure for monitoring, identification and assessment of radiation exposure.
95 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.
96 This refers to facilities and case management of individuals with radiation injuries.
97 This refers to public health response to radiation emergencies, such as resource mobilization and risk communication

ANNEX 1. ACRONYMS AND GLOSSARY

ACRONYMS

EOC	Emergency operation centre
FAO	Food and Agriculture Organization
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 FOR IHR ANNUAL REPORTING

Terms and NB: The definitions provided below for words and phrases found in the text relate to their use in the context of this tool 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.
Authorized Port to issue Ship Sanitation Certificates – SSC	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 World Health Organization (WHO) the list of their ports authorized to: • issue SSCCs and provide the related services referred to in IHR Annex 3 (Requirements for the SSC) and Annex 1B (Core capacity requirements for designated ports);

	• issue SSCECs only and extend a valid SSCEC or SSCC for one month until the ship arrives in a port at which the certificate may be issued. Each State Party must inform WHO of any changes that occur in the status of the listed ports. WHO publishes and updates a list of these authorized ports, with related information. This list is available on 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/
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.
Ship Sanitation Certificates	When the International Health Regulations (IHR) (2005) came into force on 15 June 2007, competent authorities could require from international ships the IHR ship sanitation certificate (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 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/)
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

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