INTERNATIONAL HEALTH REGULATIONS (2005)

GUIDANCE DOCUMENT FOR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL
International Health Regulations (2005)
Guidance document for the State Party Self-assessment Annual Reporting Tool
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1. PURPOSE OF THE DOCUMENT

The main purpose of this document is to provide guidance on using the State Party Self-assessment Annual Reporting tool, which is proposed to States Parties to fulfil their obligations under Article 54 – Reporting and review of the IHR to report to the World Health Assembly (WHA).

2. AUDIENCE

The audiences of this guidance are the States Parties to the International Health Regulations (2005) (IHR (2005) or Regulations) and the WHO Secretariat.

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

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

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

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

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

In 2015, the WHO Secretariat, along with States Parties, initiated the development of monitoring and evaluation approaches, focusing on national core capacities, that were consolidated, as a whole, in the IHR Monitoring and Evaluation Framework, to satisfactorily ensure mutual accountability among States.

1 Global Health Observatory (accessed on 09 April, 2018 http://www.who.int/gho/ihr/en/)
Parties, while building trust and appreciation of public health benefits resulting from the adoption of a common set of rules inspired by dialogue and transparency. The IHR Monitoring and Evaluation Framework consists of four complementary components: one mandatory; the State Party Annual Report, and three voluntary: Joint External Evaluation, after-action reviews, and simulation exercises. The State Party Annual Report and joint external evaluations, based on quantitative measures, and regarded as a perquisite of functional core capacities. After-action reviews and simulation exercises, are based on qualitative measures, are aimed at gauging the functional status of core capacities. The IHRMEF This self-encourages transparency and mutual accountability between States Parties towards global public health security.

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

In compliance with the recommendations of the IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, following formal global consultations with States Parties conducted in 2015, 2016 and 2017, and 2018, the WHO Secretariat has developed the “IHR State Party Self-assessment Annual Reporting Tool”. WHO drafted the new annual reporting tool based on inputs from all WHO regional focal points. The draft version of the new tool was shared with IHR focal points of State Parties for their inputs. In March 2018, WHO convened a meeting of IHR national focal points and all WHO Regional Offices to discuss the recommended changes. These recommendations were then incorporated into a revised version of the tool.

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

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

- It constitutes the primary tool for ensuring mutual accountability between States Parties and the WHO Secretariat when reporting to the WHA
- It is a self-assessment tool be used by national authorities across government sectors, and focuses on national core capacities across relevant sectors for the prevention, detection and response to potential public health emergencies;
- It considers ‘access’ to core capacities rather than in-country presence of core capacities;
- It explicitly captures the status of core capacities at individual designated points of entry;

2 The 2018 global consultative process with States Parties, based on a revision of the tool prepared by the WHO Secretariat, included a face-to-face meeting selected States Parties from the six WHO Regions, open to all States Parties via internet connection, and an email consultation. WHO staff from headquarters and the six WHO Regional Offices were involved throughout the process.
• It constitutes a revised interpretation of national core capacities detailed in Annex 1 of the Regulations, and, to the extent possible, it maintains consistency with the current IHR Monitoring Questionnaire proposed in 2010 by the WHO Secretariat;

• It based on a scale scoring system, that can be presented both, in percent and color-codes according to the level of capacity for each particular indicator;

• The score of each individual national core capacities continues to be based on the scores of indicators defining it.

• It is complementary with the other three voluntary components of the IHR M&E framework

• It attempts to increase the objectivity of the information reported by States Parties by focusing on the gathering information that can be documented; and by limiting the use of qualifiers and reducing redundancies

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

The revised version is more concise than the current IHR Monitoring Questionnaire. The main changes between the previous tool used for annual reporting and the proposed IHR State Party self-assessment annual reporting tool are in the table below:

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

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

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

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

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

a. Respondent

<table>
<thead>
<tr>
<th>Date of Report</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Party</td>
<td></td>
</tr>
<tr>
<td>Name and title of contact officer for this report</td>
<td></td>
</tr>
<tr>
<td>E-mail address of the contact officer</td>
<td></td>
</tr>
<tr>
<td>Telephone number of contact officer for this report</td>
<td></td>
</tr>
</tbody>
</table>

b. Approach adopted for the completion of the tool

<table>
<thead>
<tr>
<th>Completed by an individual Government Official:</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, from what sector:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed by Government officials representing several sectors:</td>
<td>Yes</td>
<td>No</td>
<td>If Yes, the consultative process occurred:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Via email:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes         No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- At face-to-face meeting:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes         No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- All the above:</td>
</tr>
</tbody>
</table>
c. Application of the voluntary components of the IHR Monitoring and Evaluation Framework

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

The subsequent 13 sections of the tool capture information about the levels and indicators defining each capacity, and include a brief description of the capacity under scrutiny.

Acronyms and Glossary are provided at the end of the tool as Annex.

### 8. STRUCTURE OF THE INDICATOR AND ATTRIBUTES

The tool consists of 24 indicators for the thirteen IHR capacities needed to detect, assess, notify, report and respond to public health events of national and international concern. For each of the thirteen capacities, one to three indicators are used to measure the country’s progress towards implementation of IHR capacities. Indicators are further broken down to a number of elements called “attributes,” which further define the indicator at each level.

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

<table>
<thead>
<tr>
<th>Level</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enabling environment, governance framework</td>
</tr>
<tr>
<td>Level 1</td>
<td>Policies, and strategies to support and facilitate the development and implementation of IHR capacities are not in place or under elaboration or available on an ad hoc basis.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Policies and strategies to support and facilitate the development and implementation of IHR capacities are in place at the national level.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Policies and strategies to support and facilitate the development and implementation of IHR capacities are in place in all relevant sectors</td>
</tr>
<tr>
<td>Level 4</td>
<td>Policies and strategies to support and facilitate the development and implementation of IHR capacities are in place at the national, intermediate and local levels by all relevant sectors</td>
</tr>
<tr>
<td>Level 5</td>
<td>Policies and strategies to support and facilitate the development and implementation of IHR capacities are revised and updated on a regular basis.</td>
</tr>
</tbody>
</table>

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

INDICATOR LEVEL

The score of each indicator level will be classified as a percentage of performance along the “1 to 5” scale.

e.g. for a country selecting level 3 for indicator 2.1,

the indicator level will be expressed as \(\frac{3}{5} \times 100 = 60\%\)

CAPACITY LEVEL

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

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

indicator level for 2.1 will be expressed as: \(\frac{3}{5} \times 100 = 60\%\)

indicator level for 2.2 will be expressed as: \(\frac{4}{5} \times 100 = 80\%\)

capacity level for 2 will be expressed as: \(\frac{60 + 80}{2} = 70\%\)

8. ROLE OF VARIOUS SECTORS IN MULTISECTORAL ANNUAL REVIEW

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

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

Systematic multisectoral annual reviews can contribute to; (a) raising and maintaining heightened awareness regarding the rights and obligations of the country as whole in relation to the international community, including within sub-regional mechanisms; (b) nurturing a culture of continual improvement; (c) establishing and strengthening national monitoring and evaluation mechanisms as part of the existing national planning processes and, consequently; (d) determining the costs and benefits resulting from investing in public health, according to exiting national priorities and/or newly identified ones.

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

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

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

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

**FEDERATED STATES**

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

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

National legal, administrative and operational arrangements to detect, assess, notify, report and respond, including at **points of entry**, to public health risks and/or acute events of domestic and international concern, should ideally be driven by frequent risk assessment activities that also keep national risk profiles up-to-date.
SMALL ISLAND DEVELOPING STATES (SIDS)

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

OVERSEAS TERRITORIES

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

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

COUNTRIES IN CONFLICT

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

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

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

- October of that year, in order to be presented to the WHO Executive Board at its January session of the following year;
- March of the following year, in order to be presented to the World Health Assembly in May of that year;
- June of the following year, in order for the results to be the relevant WHO Regional Committee of that year, depending on regional practices.

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

### 11. PRESENTATION OF THE INFORMATION TO THE WORLD HEALTH ASSEMBLY

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

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

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

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

The WHO Secretariat will use the information provided through the IHR State Party Self-assessment Annual Reporting tool to inform its planning in order to provide technical support as and when needed in the most effective manner.

### ANNEX 1 – LIST OF CAPACITIES AND INDICATORS

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

C1: LEGISLATION AND FINANCING

States Parties should have an adequate legal framework in all relevant sectors to support and facilitate the effective and efficient implementation of all of their obligations and rights under the IHR. In some States Parties, IHR implementation may require new or modified legislation. Even where new or revised legislation may not be specifically required under a State Party’s legal system, States Parties may still choose to revise some legislation, regulations or other instruments to facilitate their implementation and maintenance in a more efficient, effective or beneficial manner. Legislation could serve to institutionalize and strengthen the role of IHR within the State Party. It can also facilitate coordination among the different entities involved in their implementation. The IHR should serve to institutionalize through legislative frameworks, essential public health functions to sustain the continuous preparedness process for responding to public health events. States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers to money which a government or organization provides for a particular purpose. In other words, budget is what is planned for, and financing is what is actually provided.

INDICATORS

C1.1, LEGISLATION, LAWS, REGULATIONS, POLICY, ADMINISTRATIVE REQUIREMENTS OR OTHER GOVERNMENT INSTRUMENTS TO IMPLEMENT THE IHR (2005)

C.1.2 FINANCING FOR THE IMPLEMENTATION OF IHR CAPACITIES

C. 1.3 A FINANCING MECHANISM AND FUNDS FOR THE TIMELY RESPONSE TO PUBLIC HEALTH EMERGENCIES

C2: IHR COORDINATION AND NFP FUNCTIONS

Establishing and maintaining IHR capacities requires collaboration among all relevant sectors and ministries, agencies or other government bodies responsible for all aspects of 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

**C2.1 NFP  FUNCTIONS UNDER IHR**

**C. 2.2.MULTI-SECTORAL IHR COORDINATION MECHANISM**

**C3: ZOONOTIC EVENTS AND THE HUMAN-ANIMAL INTERFACE**

Mechanisms and documented procedures among all relevant sectors, 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

**C.3.1. COLLABORATIVE EFFORT ON ACTIVITIES TO ADDRESS ZOONOSES**

**C4. FOOD SAFETY**

States Parties have a capacity to timely detect, investigate and respond to food safety events involving foodborne diseases and/or food contamination that may constitute a public health emergency of national or international concern, through collaboration between the relevant
authorities. Food safety is multisectoral in nature and the agencies/sectors responsible for detection, investigation and response to a food safety emergency varies across Member States.

**INDICATORS**

**C4.1** A MULTISECTORAL COLLABORATION MECHANISM FOR FOOD SAFETY EVENTS

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**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; 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**

**C5.1. SPECIMEN REFERRAL AND TRANSPORT SYSTEM**

**C5.2** IMPLEMENTATION OF A LABORATORY BIOSAFETY AND BIOSECURITY REGIME

**C5.3 ACCESS TO LABORATORY TESTING CAPACITY FOR PRIORITY DISEASES**

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**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.

**INDICATORS**

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

**C6.2 MECHANISM FOR EVENT MANAGEMENT (VERIFICATION, RISK ASSESSMENT, ANALYSIS INVESTIGATION )**
C7. HUMAN RESOURCES

Strategies are in place to ensure that a multisectoral workforce is available and trained to enable early detection, prevention, preparedness and response to potential events of international concern at all levels of health systems, as required by the IHR. The availability and accessibility of quality health workforce is critical to build the resilience of communities and for continuity of health services.

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

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.

INDICATORS
C8.1. EMERGENCY PREPAREDNESS AND RESPONSE MECHANISM
C8.2 MANAGEMENT OF HEALTH EMERGENCY RESPONSE OPERATIONS
C8.3 EMERGENCY RESOURCE MOBILIZATION

C9. HEALTH SERVICE PROVISION

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

C9.1 CASE MANAGEMENT CAPACITY FOR IHR RELEVANT HAZARDS

C9.2 CAPACITY FOR INFECTION PREVENTION AND CONTROL (IPC) AND CHEMICAL AND RADIATION DECONTAMINATION.

C9.3: ACCESS TO ESSENTIAL HEALTH SERVICES

C10. RISK COMMUNICATION

Risk communication refers to real-time exchange of information, advice and opinion between experts or officials and people who face a threat (hazard) to their survival, health, or economic or social well-being. Its ultimate purpose is that everyone at risk is able to take informed decisions to mitigate the effects of the threat (hazard), such as a disease outbreak and take protective and preventive action.

Risk communication includes a mix of communication and engagement strategies built on the basis of a sustainable system with dedicated resources to support the deployment of interventions that include public communication, media communication, social media communication, social mobilization, health promotion, health education, community engagement and operational and formative researches, before, during and after health emergencies.

INDICATORS

C10.1 CAPACITY FOR EMERGENCY RISK COMMUNICATION (ERC)

C11. POINTS OF ENTRY (POE)

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 IHR capacity requirements at designated airports, ports and ground crossings. Section 1 below, requests specific information on the States’ designated PoEs (the users should create an additional row in the table for each PoE).

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

INDICATORS

C11.1 CORE CAPACITY REQUIREMENTS AT ALL TIMES FOR DESIGNATED AIRPORTS, PORTS AND GROUND CROSSINGS

C11.2 EFFECTIVE PUBLIC HEALTH RESPONSE AT POINTS OF ENTRY (POE)

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.

INDICATORS

C12.1 RESOURCES FOR DETECTION AND ALERT

C13. RADIATION EMERGENCIES

“Radiological emergencies and nuclear accidents” (termed as radiation emergencies) are rare events, but depending on the scale of the event consequences, it can range from minor to catastrophic. Management of large events can be both exhausting in terms of resource use and human capacity, and 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.

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.114

INDICATORS

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

Article 54 of the IHR (2005) states that:

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

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

In order to facilitate States Parties’ reporting to the Health Assembly, in accordance with paragraph 1 of Article 54 of the Regulations, the Secretariat prepared questionnaires in 2008 and in 2009. A report on implementation of the Regulations, providing details of the initial responses to the questionnaire issued in 2009, was noted by the Sixty-second World Health Assembly⁵.

In 2010, the WHO Secretariat developed the document ‘IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties’⁶ and the related IHR Monitoring Questionnaire was proposed to States Parties for reporting annually to the World Health Assembly. The document constituted grouping of national core capacities detailed in Annex 1 of the Regulations – to prevent, detect, assess, notify, and respond, including at points of entry – in eight core capacities, four hazards (zoonotic, food safety, chemical, radiological) and capacities at points of entry. The results from IHR Monitoring Questionnaires were used in a summary form to report to the 64th⁷ World Health Assembly onwards (65th⁸, 66th⁹, 67th¹⁰, 68th¹¹, 69th¹² and

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⁵ http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_5-en.pdf
⁶ http://apps.who.int/iris/bitstream/handle/10665/84933/WHO_HSE_GCR_2013.2_eng.pdf;jsessionid=9BC13109AC86101DFA9554897F69A1EF?sequence=1
⁷ http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_9-en.pdf
70th World Health Assemblies.) and disaggregated data by State Party has been published in a table format since 66th Assembly. In addition, in 2016, disaggregated data from the IHR Monitoring Questionnaires submitted from 2010 to 2015 were made available by the WHO Secretariat on the WHO Global Health Observatory (GHO) data web page.

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

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

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

The recommendations from that IHR Review Committee were adopted by the 64th World Health Assembly through Resolution WHA64.1.

Resolution WHA65.2, adopted by the 65th World Health Assembly in 2012, requested the WHO Director-General: “to monitor the maintenance of the national core capacities required under the International Health Regulations (2005) in all States Parties not requesting extensions to the deadline, through the development of appropriate methods of assessing effective functioning of the established core capacities”.

http://www.who.int/gho/ihr/en/
http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10Add1-en.pdf
http://apps.who.int/gb/ebwha/pdf_files/WHA64-REC1/A64_REC1-en.pdf#page=21
In its report\(^{18}\), the *IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation*, convened in 2014\(^{19}\) pursuant to Articles 5 and 13, reiterated that, as States Parties envisioned the IHR (2005) as a long term process, and also one that should be seen and used, as an essential tool in contributing to global public health security. In addition, it would provide an important foundation upon which to build a long-term approach. Among other recommendations, The *IHR Review Committee* recommended:

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

The recommendations of that *IHR Review Committee* were adopted by the 68th World Health Assembly through Resolution WHA68.5\(^{20}\).

In 2015, the WHO Secretariat, along with States Parties, initiated the development of monitoring and evaluation approaches, focusing on national core capacities, that were consolidated, as a whole, in the IHR Monitoring and Evaluation Framework, to satisfactorily ensure mutual accountability among States Parties, while building trust and appreciation of public health benefits resulting from the adoption of a common set of rules inspired by dialogue and transparency\(^{21}\). The IHR Monitoring and Evaluation Framework consists of four complementary components: one mandatory; the State Party Self-assessment Annual Report, and three voluntary: Joint External Evaluation, after-action reviews, and simulation exercises. The State Party Self-assessment Annual Report and joint external evaluations attempt at quantitative assessment of existence of IHR capacities. After-action reviews and simulation exercises, based on qualitative measures, are aimed at gauging the functional status of IHR capacities.

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## ANNEX 3 ACRONYMS AND GLOSSARY

### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>EOC</td>
<td>Emergency operation centre</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<tr>
<td>IHR</td>
<td>International Health Regulations (2005)</td>
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<tr>
<td>IAEA</td>
<td>International Atomic Energy Agency</td>
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<tr>
<td>INFOSAN</td>
<td>International Food Safety Authorities Network</td>
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<tr>
<td>IPC</td>
<td>Infection prevention and control</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NFP</td>
<td>National IHR Focal Point</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>PHEIC</td>
<td>public health emergency of international concern</td>
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<tr>
<td>PoEs</td>
<td>points of entry</td>
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<tr>
<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
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<tr>
<td>WHA</td>
<td>World Health Assembly</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>affected</td>
<td>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.</td>
</tr>
<tr>
<td>attribute</td>
<td>One of a set of specific elements or characteristics that reflect the level of performance or achievement of a specific indicator.</td>
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<tr>
<td>biological hazards</td>
<td>Infectious disease events, including zoonotic and food safety events.</td>
</tr>
<tr>
<td>biosafety</td>
<td>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.</td>
</tr>
<tr>
<td>budget</td>
<td>Itemized summary of expected income and expenditure of a country, company, etc., over a specified period, usually a financial year.</td>
</tr>
<tr>
<td>case definition</td>
<td>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)” (<a href="http://www.who.int/ihr/annex_2/en/">http://www.who.int/ihr/annex_2/en/</a>, accessed 2 April 2018).</td>
</tr>
<tr>
<td>communicable disease or infectious disease</td>
<td>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).</td>
</tr>
<tr>
<td>competent authority</td>
<td>Authority responsible for the implementation and application of health measures under the IHR (2005). See WHA58.3 Revision of the International Health Regulations. Article</td>
</tr>
</tbody>
</table>

**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 systemically 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**

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)).


**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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>indicator-based surveillance</td>
<td>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.</td>
</tr>
<tr>
<td>infection</td>
<td>Entry and development or multiplication of an infectious agent in the body of humans and animals that may constitute a public health risk.</td>
</tr>
<tr>
<td>infection control</td>
<td>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.</td>
</tr>
<tr>
<td>infectious disease</td>
<td>See communicable disease.</td>
</tr>
<tr>
<td>legislation</td>
<td>Range of legal, administrative or other governmental instruments which may be available for States Parties for the implementation of IHR (2005). 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.</td>
</tr>
</tbody>
</table>
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 (2005).

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 (2005) 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  Qualitative or quantitative estimation of the likelihood of adverse effects that may
**assessment**

result from exposure to specified health hazards or the absence of beneficial influences (adapted from Last JM, Spasoff RA, Harris SS, ed. A dictionary of epidemiology. Fourth edition. New York: Oxford University Press; 2001)

**risk communication**

Real time exchange of information, advice and opinion between experts or officials and people who are faced with a health risk or threat. Its purpose is to enable everyone at risk to take informed decisions for protective and preventive action. Risk communication includes a mix of communication and engagement strategies built on the basis of a sustainable system with dedicated resources to support the deployment of interventions that include public communication, media communication, social media communication, social mobilization, health promotion, health education, community engagement and operational and formative researches, before, during and after health emergencies.

**States Parties**

These are the 194 WHO Member States, and the Holy See and Lichtenstein, currently identified by IHR (2005) (see website: www.who.int/ihr/, accessed 2 April 2018) and any States which may hereafter accede to the IHR (2005) 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.