International Health Regulations (2005)

SUMMARY OF STATES PARTIES 2013 REPORT ON IHR CORE CAPACITY IMPLEMENTATION

Regional Profiles
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NATIONAL CAPACITY MONITORING

With the coming into force of the International Health Regulations (2005) (hereinafter “IHR” or “the Regulations”) on June 15, 2007, all IHR States Parties are required to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response as specified in the IHR and to develop a plan of action to ensure that these capacities will be present and functioning throughout their territories by 2012. WHO is mandated to provide appropriate tools, guidance, and support to States Parties to achieve these goals. In accordance with Article 54 of the IHR and related resolution WHA61.2, States Parties and WHO are required to report annually to the World Health Assembly on the implementation of the Regulations. For this purpose, a monitoring framework was developed using technical expert views drawn globally from WHO Member States, technical institutions, and WHO partners, and from within WHO.

In 2013, 77% of countries (i.e. 36/47) in the African Region responded to the IHR Monitoring Questionnaire, which is lower than 2012 (46%) and 2011 (80%). Throughout this Regional Summary sheet, percentage values relate to responding countries only. Information extracted from the inputs provided by National Focal Points is reflected here to provide an overview of the progress achieved in the region as reported by State Parties in 2013. To obtain a full overview of progress of all the indicators please consult the individual Country Profiles 2013.

Analysis of the strengths and weaknesses in this regional profile is based on self-reported data submitted by States Parties with the IHR Monitoring Questionnaire 2013. Specific country contexts and other sources of information, if available, may also need to be considered in identifying priorities and needs and planning for future activities.

For further reference and information on individual elements (core capacities, indicators, attributes), please consult: http://www.who.int/ihr/IHR.Monitoring_Framework.Checklist.and.Indicators.pdf
For historical data, including maps, please visit the International Health Regulations section of the Global Health Observatory: http://www.who.int/gho/ihr/en/

This summary provides information on (i) eight core capacities, (ii) development of capacities at points of entry, and (iii) capacities for four IHR-relevant hazards: biological (including food safety and zoonoses), chemical, and radionuclear.

Regional Average Attribute Scores
Core Capacity 1: National legislation, policy, and financing

Legislation, regulations, administrative requirements, policies, or other government instruments, sufficient for implementation of the IHR.

- Legal requirements and instruments are assessed in 47% of countries and implemented in 26% of countries. National policies have been reviewed to facilitate the implementation of functions of the IHR National Focal point (IHR NFP) and of technical core capacities in 44% of countries. Key elements of national IHR legislation have been published in 21% of countries. Policies to facilitate IHR NFP core and expanded functions and to strengthen technical core capacities have been implemented in 32% of countries.

Core Capacity 2: Coordination and NFP Communications

Coordination mechanism between relevant sectors implementing the IHR

- The IHR NFP has been established in 88% of countries. Information on obligations of the NFP under IHR has been disseminated to relevant authorities and stakeholders in 65% of countries. Additional roles and responsibilities for the IHR NFP functions have been implemented in 53% of countries. The functions of the NFP have been evaluated for effectiveness in 15% of countries. The NFP provides WHO with updated contact information and confirmation of the NFP on an annual basis in 85% of countries.

- Use of the IHR Event Information Site as an integral information resource was reported by 59% of countries. An active IHR website or web page has been established in 9% of countries.

- 76% of countries report having a multisectoral, multidisciplinary committee, body or task force to address IHR requirements on surveillance and response for a PHEIC. Coordination between relevant ministries on events that may constitute a public health event of national or international concern (PHEIC) was reported by 79% of countries as being in place. Standard Operating Procedures
SOPs are available for coordination between IHR NFP and stakeholders of relevant sectors in 38% of countries. Coordination mechanisms have been tested in 32% of countries through an actual event occurrence or through exercises and 38% report these mechanisms have been updated as needed. Action plans have been developed to incorporate lessons learnt from multisectoral and multidisciplinary coordination and communication mechanisms in 24% of countries.

- National stakeholders involved in the implementation of IHR have been identified by 79% of countries and 21% disseminate annual updates on the status of IHR implementation to stakeholders across all sectors. Roles and responsibilities of various stakeholders under the IHR have been defined in 50% of countries and disseminated in 41%. Plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR have been implemented in 47% of countries.

**Core Capacity 3: Surveillance**

*Early warning function for detection of public health events in indicator-based (Routine) surveillance (IBS)*

- Lists of priority diseases or conditions for surveillance as well as case definitions for priority diseases are available in 94% of countries. Also, 91% of countries have designated specific units for surveillance of public health risks and 65% of countries indicate timely reporting from at least 80% of all reporting units.

- Surveillance data on epidemic prone and priority diseases is analyzed at least weekly at national and sub-national levels in 88% of countries. 85% of countries have defined baseline estimates, trends, and thresholds for alert and action for the local public health response level for priority diseases/events. In 79% of countries, reports or other documentation show that deviations or values exceeding thresholds are detected and used for action at the primary public health response level. Regular feedback of surveillance results is disseminated to all levels and relevant stakeholders in 82% of countries.
- Evaluations of the early warning function of the indicator-based surveillance have been carried out and country experiences, findings, and lessons learnt have been shared with the global community in 35% of countries. 47% have shared global experiences, findings, and lessons learnt on IBS with the global community.

**Event-Based Surveillance**

- SOPs and guidelines for event-based surveillance are available in 74% of countries. Designated unit(s) for event-based surveillance that may be part of an existing routine surveillance system were reported in 88% of countries. SOPs and guidelines for event capture, reporting, confirmation, verification, assessment, and notification have been developed and disseminated in 68% of countries.

- Information sources for public health events and risks have been identified in 76% of countries. A system at national and/or sub-national levels for capturing and registering public health events from a variety of sources, including media (print, broadcast, community, electronic, internet etc.), is in place in 76% of countries. 59% have actively engaged and sensitized community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events. In 62% of countries, arrangements have been established with neighboring countries to share data on surveillance and the control of public health events that may be of international concern. In 26% of countries, implementation of local community reporting has been evaluated and updated as needed.

- Country experiences and findings on implementation of event-based surveillance and the integration with indicator-based surveillance has been documented in 47% of countries and shared with the global community in 41% of countries.

- The decision instrument in Annex 2 of the IHR (2005) is used to notify WHO in 76% of countries and in 9% its use has been reviewed, with procedures for decision making updated on the basis of lessons learnt in 9%. Country experiences and findings in notification and use of Annex 2 of the IHR have been documented in 21% of countries. And shared with the global community in 21%. Events that meet the criteria for notification under Annex 2 of IHR have been notified by the IHR NFP to WHO within 24 hours of conducting risk assessments over the last 12 months in 56% of countries. All events identified as urgent within the past 12 months were assessed within 48 hours of reporting in 59% of countries reporting. The IHR NFP has responded to all verification requests from WHO within 24 hours in 56% of countries.
Core Capacity 4: Response

Public Health Emergency Response mechanisms

- 65% of countries report implementing response procedures for a real or simulated public health response in the past 12 months.

- Case management guidelines are in place for priority conditions in 94% of countries.

- In 71% of countries, management procedures have been established for command, communications, and control during public health emergency response operations. A functional, dedicated command and control operations centre at the national or other relevant level exists in 71% of countries. Emergency response management procedures have been evaluated after a real or simulated public health response in 32% of countries and updated in 26%. Assistance from 52% of countries has been offered to other States Parties for developing their response capacities or implementing control measures.

- Resources for rapid response during outbreaks of national or international concern are accessible in 71% of countries. Rapid Response Teams (RRT) are available in 79% of countries, and 50% have SOPs available for the deployment of RRT members. In 76% of countries, multidisciplinary RRT can be deployed within 48 hours from the time when the decision to respond is taken. Evaluations of response including the timeliness and quality of response are systematically carried out in 53% of countries. Staff (including RRT members) have been trained in specimen collection and transport was reported by 85% of countries.

Infection Prevention and Control (IPC) at national and hospital levels

- In 62% of countries, responsibilities are assigned for surveillance of health-care-associated infections and in 44% of countries for anti-microbial resistance. In 65% of countries, national infection prevention and control policies/guidelines, and an operational plan for infection control are available and have been implemented nationwide in 53% of countries.

- SOPs, guidelines, and protocols for IPC are available to all hospitals in 68% of countries, and defined norms or guidelines for protecting health-care workers have been developed in 65% of countries. Infection control measures and their effectiveness are regularly evaluated and published in 24% of countries. 65% report that tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions according to national or international guidelines. In 71% of countries, qualified IPC professionals are in place. 41% of countries carry out surveillance within high risk groups to promptly detect and investigate clusters of infectious disease patients, as well as unexplained illnesses in health workers. A national programme for protecting health-care workers has been implemented in 29% of countries.

- A monitoring system for antimicrobial resistance (AMR) has been established in 59% of countries. In 29% of countries have implemented an AMR monitoring system, and 26% have available data on the magnitude and trends in AMR.
Core Capacity 5: Preparedness

Multi-hazard National Public Health emergency Preparedness & Response Plan

- An assessment of the capacity of existing national structures and resources to meet IHR core capacities for the implementation of IHR have been conducted in 62% of countries.

- A national plan to meet the IHR core capacity requirements has been developed (Annex 1A Article 2) in 68% of countries and a national public health emergency response plan for IHR related hazards and Points of Entry (PoE) has been developed (Annex 1A, Article 6g) in 68% of countries. National public health emergency response plan(s) have been implemented or tested in 47% of countries in an actual emergency or simulation and updated as needed in 35%.

- In 62% of countries, a procedure or strategy is in place to reallocate or mobilize resources from national and sub-national levels to support action at community/primary response levels and the strategy has been implemented in 56% and reviewed and updated in 35%. Surge capacity is available in 53% of countries. Surge capacity has been tested either through response to a public health event or during an exercise in 29% of countries.

- Experiences and findings on emergency response and in mobilizing surge capacity have been documented in 29% of countries and shared with the global community in 18%.

Public health risk and resource mapping

- A national risk assessment to identify the most likely sources of “urgent public health event” has been conducted in 26% of countries. National resources have been mapped in 18% of countries to address priority risks with national profiles on risks and resources developed in 12%. The national risk profile is assessed regularly in 21% of countries. Regular assessment of the national resources for priority risks are performed by 12% of countries.

- A directory of experts in health and other sectors to support a response to IHR-related hazards is available in 41% of countries.

- A plan for management and distribution (if applicable) of national stockpiles is available in 35% of countries and 32% have stockpiles (critical stock levels) available and accessible for responding to the country’s priority biological, chemical, and radiological events and other emergencies. Contributions to international stockpiles are made by 12% of countries.
Core Capacity 6: Risk Communication

Mechanisms for effective risk communication during a public health emergency

- Risk communication partners and stakeholders have been identified in 74% of countries and a risk communication plan has been developed in 41%. Plans have been validated by 21% of countries through an actual emergency or simulation exercise in the past 12 months.

- Policies, SOPs, or guidelines on the clearance and release of information during a public health event have been developed in 44% of countries. In 68% of countries, regularly updated information sources are accessible to media and the public for information dissemination. Accessible and relevant IEC (Information, Education and Communications) materials are tailored to the needs of the population in 74% of countries.

- Evaluation of public health communication after emergencies, including for timeliness, transparency, and appropriateness of communications, and updating SOPs as needed following evaluation of the public health communication has taken place in 24% of countries. The results of evaluations have been used to update the risk communications plan in 12% of countries and 12% have shared the results of these evaluations with the global community.

- 76% of countries report informing populations and partners of a real or potential risk within 24 hours of confirmation in the last three national or international public health emergencies.
Core 7: Human Resource Capacity

Human resources available to implement IHR Core Capacity Requirements

- In 68% of countries, a unit has been identified to assess human resource capacities to meet the country’s IHR requirements. A needs assessment has been conducted to identify gaps in human resources and training (numbers and competencies) to meet IHR requirements in 38% of countries. A workforce development or training plan has been developed that includes human resource requirements for IHR in 35% of countries. Specific programs with allocated budgets to train workforces in IHR relevant hazards exist in 32% of countries. Progress for meeting workforce numbers and skills is consistent with training program milestones in 18% of countries.

- A strategy has been developed for the country to access field epidemiology training (one year or more) in-country, regionally, or internationally in 62% of countries and implemented in 59%.

Core Capacity 8: Laboratory

Laboratory services to test for priority health threats

- 74% of countries have policies in place to ensure the quality of laboratory diagnostic capacities. National laboratory quality standards/guidelines are available in 76% of countries.

- A network of national and international laboratories is in place to meet diagnostic and confirmatory requirements and support outbreak investigations for events specified in Annex 2 of the IHR in 76% of countries.
- National laboratory capacity is in place in 88% of countries to meet diagnostic and confirmatory requirements to support outbreak investigations for IHR events. An up-to-date inventory of public and private laboratories with relevant diagnostic capacity is available in 53% of countries and the inventory is accessible in 53%.

- National reference laboratories successfully participate in External Quality Assessment schemes for diagnostic laboratories for major public health disciplines in 79% of countries. More than 10 non-AFP hazardous specimens per year were referred to national or international reference laboratories for examination in 68% of countries.

- All national reference laboratories are certified or accredited to international standards or to national standards adapted from international standards in 41% of countries.

- National regulations are in place which are compatible with international guidelines for packaging and transport of clinical specimens in 74% of countries, and a functional system for collection, packaging, and transport of clinical specimens is available in 88% of countries. Staff at national and other relevant levels have been trained on the safe shipment of infectious substances according to international standards in 82% of countries. 76% of countries reporting have pre-positioned collection and transportation kits at appropriate levels. Clinical specimens from investigation of urgent public health events can be delivered to appropriate laboratories within the appropriate timeframe in 88% of countries with 76% of countries reporting the shipment process consistently meets ICAO/IATA standards. At least 10 hazardous specimens are shipped by 53% of countries internationally per year as part of investigations or exercises.

**Laboratory biosafety and biosecurity practices**

- In 50% of countries, a responsible entity has been designated for laboratory biosafety and biosecurity. An institution or person responsible for inspection of laboratories for compliance with biosafety requirement has been identified in 62% of countries.

- Biosafety guidelines are accessible to laboratories in 65% of countries. Regulations, policies, or strategies for laboratory biosafety are available in 62% of countries. Relevant staff have been trained on biosafety guidelines in 71% of countries. A biorisk assessment in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste, has been conducted in 50% of countries.
Points of Entry

General obligations required at Points of Entry

- A review meeting (or other appropriate method) to designate Points of Entry (PoEs) has been conducted in 53% of countries and 56% have identified designated ports, ground crossings (as relevant), or airports for development of capacities specified in Annex 1. A list of ports authorized to offer ship sanitation certificates has been sent to WHO as applicable in 38% of countries.

- Relevant legislation, regulations, administrative acts, or other government instruments to implement IHR at designated PoEs has been updated as needed in 35% of countries. Updated IHR health documents have been implemented at designated PoEs in 53% of countries.

- 47% of countries report assessing all designated ports.

- Mechanisms for the exchange of information between designated PoEs and medical facilities are in place in 56% of countries. Procedures for coordination and communication between the IHR NFP and PoEs competent authority are in place in 41% of countries and have been tested in 26%. Procedures for communication internationally between PoEs competent authorities and other countries’ PoE competent authorities have been tested 18% of countries and updated as needed in 3% . Bilateral agreements concerning prevention or control of international transmission of disease at designated PoEs have been put in place in 35% of countries.

Effective surveillance at Points of Entry

- Priority conditions for surveillance at designated PoEs have been identified in 68% of countries and 50% have shared surveillance information at designated PoEs with the surveillance department/unit. A review of surveillance health threats at designated PoEs have been conducted in the last 12 months 18% of countries and published in 0%.

Effective response at Points of Entry

- SOPs for response at PoEs are available in 29% of countries. Results of the effectiveness of response to public health events at PoEs has been evaluated in 26% and published in 18% of countries.
Hazard: Zoonotic Events
Mechanisms for detecting and responding to zoonoses and potential zoonoses

- In 85% of countries, there is a coordination mechanism within the responsible government authority/ies for the detection of and response to zoonotic events. A national policy or strategy is in place for the surveillance and response to zoonotic events in 76% of countries. Focal points responsible for animal health for coordination with the MoH and/or IHR NFP have been designated in 74% of countries. 56% of countries have functional mechanisms for intersectoral collaboration which include animal and human health surveillance units and laboratories have been established and documented.

- In 68% of countries, there is a list of priority zoonotic diseases with case definitions available.

- Systematic and timely collection and collation of zoonotic disease data is performed in 56% of countries. A timely and systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks exists in 50% of countries. Zoonotic disease surveillance is implemented with a community component in 53% of countries.

- Laboratory capacity, nationally or internationally to confirm priority zoonotic events, is accessible in 88% of countries.

- A regularly updated roster (list) of experts that can respond to zoonotic events is available in 44% of countries.

- A mechanism for response to outbreaks of zoonotic diseases by human and animal health sectors has been established in 76% of countries. More than 80% of zoonotic events of potential national and international concern are responded to in a timely manner by 47% of countries.

- Country experiences and findings related to zoonotic risks and events of potential national and international concern are shared with the global community by 32% of countries.
Hazard: Food Safety
Detecting and responding to foodborne disease and food contamination

- National or international food safety standards are available in 79% of countries. 71% have national food laws, regulations, or policies in place to facilitate food safety control. Laws are up to date in 38% of countries and implemented in 59%.

- An operational national multisectoral mechanism for food safety events is in place in 59% of countries. A functioning coordination mechanism has been established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP in 50% of countries and 50% are active members of the INFOSAN network.

- A list of priority food safety risks is available in 44% of countries.

- Guidelines or manuals on the surveillance, assessment, and management of priority food safety risks are available in 47% of countries and have been implemented in 41%. Epidemiological data related to food contamination are collected and systematically analyzed by 26% of countries. Epidemiological data is also shared in a timely and systematic manner with other relevant sectors in 38% of countries.

- Laboratory capacity to confirm priority food safety events of national or international concern, including molecular techniques, is accessible in 62% of countries.

- In 26% of countries, a roster of food safety experts is available for assessing and responding to food safety events.

- Plans for responding to Food Safety Events have been implemented 24% of countries and 14% of countries, tested in an exercise or actual emergency in 9%, and updated as needed in 12%. Risk based food inspection services are in place in 76% of countries. Mechanisms for tracing, recall, and disposal of contaminated products have been established in 56% of countries.

- Communication mechanisms and materials are in place in 41% of countries to inform, educate, and advise stakeholders across the farm-to-fork continuum.

- Food safety control management systems have been implemented in 68% of countries. In 56% of countries, information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards, and regulations. An analysis of food safety events, foodborne illness trends, and outbreaks, which integrate data across the food chain, has been published in 9% of countries.
Hazard: Chemical Events
Detection, alert, and response to chemical emergencies

- Experts for public health assessment and response to chemical incidents have been identified in 29% of countries.

- In 41%, national policies or plans are in place for chemical event surveillance, alert, and response. In 50% of countries, national authorities responsible for chemical events have designated a focal point for coordination with the MOH and/or the IHR NFP. Coordination mechanisms with relevant sectors are established in 29% of countries with 32% reporting a functional coordination mechanism implemented for surveillance and timely response across sectors. Surveillance is in place for chemical events, intoxication, or poisonings in 26% of countries. A list of priority chemical events/syndromes that may constitute a potential public health event of national and international concern is available in 24% of countries.

- An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies is available in 29% of countries and a national chemical profile has been developed in 29%.

- Manuals and SOPs for rapid assessment, case management, and control of chemical events are available in 18% and have been disseminated in 12% of countries. A timely and systematic information exchange is carried out between appropriate chemical units and surveillance units about urgent chemical events and potential chemical risks in 21% of countries.

- An emergency response plan that defines the roles and responsibilities of relevant agencies for chemical emergencies is available in 26% of countries.

- Laboratory capacity or access to laboratory capacity to confirm priority chemical events is available in 50% of countries.

- Chemical event response plans have been tested through the occurrence of a real event or through a simulation exercise in 9% of countries and updated as needed in 6% of countries.

- 15% of countries report an adequately-resourced Poison Centre(s) is in place.

- Country experience and findings regarding chemical events and risk of national and international concern have been shared with the global community by 18% of countries.
Hazard: Radiological Events

Detecting and responding to radiological and nuclear emergencies

- Experts have been identified for public health assessment and response to radiological and nuclear events in 41% of countries.

- A national policy or plan for the detection, assessment and response to radiation emergencies is in place in 35%. Plans have been implemented in 24%. A national policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and medical services, is in place in 29% of countries.

- A functional coordination and communication mechanism has been established between relevant national competent authorities responsible for nuclear regulatory control/safety and relevant sectors in 26% of countries. Focal points for radiological and nuclear events for coordination and communication with the MOH and/or the NFP have been established in 41% of countries.

- Monitoring for radiation emergencies is in place in 32% of countries. A systematic information exchange between radiological-competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public health emergency of international concern is in place in 21% of countries.

- Technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation, and management of radiation emergencies have been developed in 18% of countries and have been evaluated and update in 15%. A radiation emergency response plan is in place in 24% of countries. Radiation emergency response drills are carried out regularly at national level, including requesting international assistance (as needed) and international notification, in 12% of countries.

- A mechanism is in place in 26% of countries for access to health facilities (inside or outside of the country) with capacity to manage patients of radiation emergencies.

- Laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards is available in 26% of countries. Regularly updated collaborative mechanisms are in place in 21% of countries for access to specialized laboratories that are able to perform bioassays, biological dosimetry by cytogenetic analysis, and ESR (electron-spin resonance technique). These mechanisms have been evaluated in 18% of countries.

- 18%, of countries have documented and shared experiences with the detection and response to radiological risks and events with the global community.
IHR CAPACITY ANALYSIS REGIONAL SUMMARY 2013 – Region of the Americas

NATIONAL CAPACITY MONITORING

With the coming into force of the International Health Regulations (2005) (hereinafter “IHR” or “the Regulations”) on June 15, 2007, all IHR States Parties are required to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response as specified in the IHR and to develop a plan of action to ensure that these capacities will be present and functioning throughout their territories by 2012. WHO is mandated to provide appropriate tools, guidance, and support to States Parties to achieve these goals. In accordance with Article 54 of the IHR and related resolution WHA61.2, States Parties and WHO are required to report annually to the World Health Assembly on the implementation of the Regulations. For this purpose, a monitoring framework was developed using technical expert views drawn globally from WHO Member States, technical institutions, and WHO partners, and from within WHO.

In 2013, 94% of countries (i.e. 33/35) in the Region of the Americas responded to the IHR Monitoring Questionnaire, which is higher than 2012 (85%) and 2011 (82%). Throughout this Regional Summary sheet, percentage values relate to responding countries only. Information extracted from the inputs provided by National Focal Points is reflected here to provide an overview of the progress achieved in the region as reported by State Parties in 2013. To obtain a full overview of progress of all the indicators please consult the individual Country Profiles 2013.

Analysis of the strengths and weaknesses in this regional profile is based on self-reported data submitted by States Parties with the IHR Monitoring Questionnaire 2013. Specific country contexts and other sources of information, if available, may also need to be considered in identifying priorities and needs and planning for future activities.

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Regional Average Attribute Scores
Core Capacity 1: National legislation, policy, and financing

Legislation, regulations, administrative requirements, policies, or other government instruments, sufficient for implementation of the IHR.

- Legal requirements and instruments are assessed in 86% of countries and implemented in 66% of countries. National policies have been reviewed to facilitate the implementation of functions of the IHR National Focal point (IHR NFP) and of technical core capacities in 86% of countries. Key elements of national IHR legislation have been published in 49% of countries. Policies to facilitate IHR NFP core and expanded functions and to strengthen technical core capacities have been implemented in 69% of countries.

![Legislation Map](image)

Core Capacity 2: Coordination and NFP Communications

Coordination mechanism between relevant sectors implementing the IHR

- The IHR NFP has been established in 100% of countries. Information on obligations of the NFP under IHR has been disseminated to relevant authorities and stakeholders in 91% of countries. Additional roles and responsibilities for the IHR NFP functions have been implemented in 89% of countries. The functions of the NFP have been evaluated for effectiveness in 57% of countries. The NFP provides WHO with updated contact information and confirmation of the NFP on an annual basis in 97% of countries.

- Use of the IHR Event Information Site as an integral information resource was reported by 100% of countries. An active IHR website or web page has been established in 46% of countries.

- 89% of countries report having a multisectoral, multidisciplinary committee, body or task force to address IHR requirements on surveillance and response for a PHEIC. Coordination between relevant ministries on events that may constitute a public health event...
of national or international concern (PHEIC) was reported by 100% of countries as being in place. Standard Operating Procedures (SOPs) are available for coordination between IHR NFP and stakeholders of relevant sectors in 71% of countries. Coordination mechanisms have been tested in 69% of countries through an actual event occurrence or through exercises and 63% report these mechanisms have been updated as needed. Action plans have been developed to incorporate lessons learnt from multisectoral and multidisciplinary coordination and communication mechanisms in 57% of countries.

- National stakeholders involved in the implementation of IHR have been identified by 100% of countries and 57% disseminate annual updates on the status of IHR implementation to stakeholders across all sectors. Roles and responsibilities of various stakeholders under the IHR have been defined in 74% of countries and disseminated in 66%. Plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR have been implemented in 74% of countries.

### Core Capacity 3: Surveillance
*Early warning function for detection of public health events in indicator-based (Routine) surveillance (IBS)*

- Lists of priority diseases or conditions for surveillance as well as case definitions for priority diseases are available in 100% of countries. Also, 97% of countries have designated specific units for surveillance of public health risks and 91% of countries indicate timely reporting from at least 80% of all reporting units.

- Surveillance data on epidemic prone and priority diseases is analyzed at least weekly at national and sub-national levels in 97% of countries. 94% of countries have defined baseline estimates, trends, and thresholds for alert and action for the local public health response level for priority diseases/events. In 91% of countries, reports or other documentation show that deviations or values
exceeding thresholds are detected and used for action at the primary public health response level. Regular feedback of surveillance results is disseminated to all levels and relevant stakeholders in 100% of countries.

- Evaluations of the early warning function of the indicator-based surveillance have been carried out and country experiences, findings, and lessons learnt have been shared with the global community in 63% of countries. 60% have shared global experiences, findings, and lessons learnt on IBS with the global community.

**Event-Based Surveillance**

- SOPs and guidelines for event-based surveillance are available in 91% of countries. Designated unit(s) for event-based surveillance that may be part of an existing routine surveillance system were reported in 94% of countries. SOPs and guidelines for event capture, reporting, confirmation, verification, assessment, and notification have been developed and disseminated in 89% of countries.

- Information sources for public health events and risks have been identified in 91% of countries. A system at national and/or sub-national levels for capturing and registering public health events from a variety of sources, including media (print, broadcast, community, electronic, internet etc.), is in place in 97% of countries. 77% have actively engaged and sensitized community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events. In 89% of countries, arrangements have been established with neighboring countries to share data on surveillance and the control of public health events that may be of international concern. In 54% of countries, implementation of local community reporting has been evaluated and updated as needed.

- Country experiences and findings on implementation of event-based surveillance and the integration with indicator-based surveillance has been documented in 66% of countries and shared with the global community in 43% of countries.

- The decision instrument in Annex 2 of the IHR (2005) is used to notify WHO in 97% of countries and in 69% its use has been reviewed, with procedures for decision making updated on the basis of lessons learnt in 66%. Country experiences and findings in notification and use of Annex 2 of the IHR have been documented in 60% of countries. And shared with the global community in 40%. Events that meet the criteria for notification under Annex 2 of IHR have been notified by the IHR NFP to WHO within 24 hours of conducting risk assessments over the last 12 months in 74% of countries. All events identified as urgent within the past 12 months were assessed within 48 hours of reporting in 80% of countries reporting. The IHR NFP has responded to all verification requests from WHO within 24 hours in 77% of countries.
Core Capacity 4: Response

Public Health Emergency Response mechanisms

- 89% of countries report implementing response procedures for a real or simulated public health response in the past 12 months.

- Case management guidelines are in place for priority conditions in 97% of countries.

- In 94% of countries, management procedures have been established for command, communications, and control during public health emergency response operations. A functional, dedicated command and control operations centre at the national or other relevant level exists in 89% of countries. Emergency response management procedures have been evaluated after a real or simulated public health response in 77% of countries and updated in 74%. Assistance from 52% of countries has been offered to other States Parties for developing their response capacities or implementing control measures.

- Resources for rapid response during outbreaks of national or international concern are accessible in 94% of countries. Rapid Response Teams (RRT) are available in 91% of countries, and 86% have SOPs available for the deployment of RRT members. In 94% of countries, multidisciplinary RRT can be deployed within 48 hours from the time the decision to respond is taken. Evaluations of response including the timeliness and quality of response are systematically carried out in 51% of countries. Staff (including RRT members) have been trained in specimen collection and transport was reported by 91% of countries.

Infection Prevention and Control (IPC) at national and hospital levels

- In 100% of countries, responsibilities are assigned for surveillance of health-care-associated infections and in 86% of countries for anti-microbial resistance. In 91% of countries, national infection prevention and control policies/guidelines, and an operational plan for infection control are available and have been implemented nationwide in 89% of countries.

- SOPs, guidelines, and protocols for IPC are available to all hospitals in 94% of countries, and defined norms or guidelines for protecting health-care workers have been developed in 91% of countries. Infection control measures and their effectiveness are regularly evaluated and published in 51% of countries. 71% report that tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions according to national or international guidelines. In 77% of countries, qualified IPC professionals are in place. 69% of countries carry out surveillance within high risk groups to promptly detect and investigate clusters of infectious disease patients, as well as unexplained illnesses in health workers. A national programme for protecting health-care workers has been implemented in 60% of countries.

- A monitoring system for antimicrobial resistance (AMR) has been established in 83% of countries. In 66% of countries have implemented an AMR monitoring system, and 69% have available data on the magnitude and trends in AMR.
Core Capacity 5: Preparedness

Multi-hazard National Public Health emergency Preparedness & Response Plan

- An assessment of the capacity of existing national structures and resources to meet IHR core capacities for the implementation of IHR have been conducted in 94% of countries.

- A national plan to meet the IHR core capacity requirements has been developed (Annex 1A Article 2) in 100% of countries and a national public health emergency response plan for IHR related hazards and Points of Entry (PoE) has been developed (Annex 1A, Article 6g) in 66% of countries. National public health emergency response plan(s) have been developed or tested in 71% of countries in an actual emergency or simulation and updated as needed in 71%.

- In 86% of countries, a procedure or strategy is in place to reallocate or mobilize resources from national and sub-national levels to support action at community/primary response levels and the strategy has been implemented in 83% and reviewed and updated in 63%. Surge capacity is available in 77% of countries. Surge capacity has been tested either through response to a public health event or during an exercise in 69% of countries.

- Experiences and findings on emergency response and in mobilizing surge capacity have been documented in 51% of countries and shared with the global community in 43%.

Public health risk and resource mapping

- A national risk assessment to identify the most likely sources of “urgent public health event” has been conducted in 60% of countries. National resources have been mapped in 57% of countries to address priority risks with national profiles on risks and resources developed in 60%. The national risk profile is assessed regularly in 51% of countries. Regular assessment of the national resources for priority risks are performed by 46% of countries.

- A directory of experts in health and other sectors to support a response to IHR-related hazards is available in 91% of countries.

- A plan for management and distribution (if applicable) of national stockpiles is available in 60% of countries and 43% have stockpiles (critical stock levels) available and accessible for responding to the country’s priority biological, chemical, and radiological events and other emergencies. Contributions to international stockpiles are made by 31% of countries.
Core Capacity 6: Risk Communication

Mechanisms for effective risk communication during a public health emergency

- Risk communication partners and stakeholders have been identified in 97% of countries and a risk communication plan has been developed in 71%. Plans have been validated by 49% of countries through an actual emergency or simulation exercise in the past 12 months.

- Policies, SOPs, or guidelines on the clearance and release of information during a public health event have been developed in 80% of countries. In 91% of countries, regularly updated information sources are accessible to media and the public for information dissemination. Accessible and relevant IEC (Information, Education and Communications) materials are tailored to the needs of the population in 86% of countries.

- Evaluation of public health communication after emergencies, including for timeliness, transparency, and appropriateness of communications, and updating SOPs as needed following evaluation of the public health communication has taken place in 60% of countries. The results of evaluations have been used to update the risk communications plan in 34% of countries and 34% have shared the results of these evaluations with the global community.

- 94% of countries report informing populations and partners of a real or potential risk within 24 hours of confirmation in the last three national or international public health emergencies.
Core 7: Human Resource Capacity

*Human resources available to implement IHR Core Capacity Requirements*

- In 91% of countries, a unit has been identified to assess human resource capacities to meet the country’s IHR requirements. A needs assessment has been conducted to identify gaps in human resources and training (numbers and competencies) to meet IHR requirements in 74% of countries. A workforce development or training plan has been developed that includes human resource requirements for IHR in 51% of countries. Specific programs with allocated budgets to train workforces in IHR relevant hazards exist in 40% of countries. Progress for meeting workforce numbers and skills is consistent with training program milestones in 34% of countries.

- A strategy has been developed for the country to access field epidemiology training (one year or more) in-country, regionally, or internationally in 91% of countries and implemented in 74%.

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**Human Resources**

![Map of Human Resources](image)

**Implementation status (%)**
- 0–24
- 25–49
- 50–74
- 75–100
- Data not available
- Not part of WHO Region of the Americas

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Core Capacity 8: Laboratory

*Laboratory services to test for priority health threats*

- 77% of countries have policies in place to ensure the quality of laboratory diagnostic capacities. National laboratory quality standards/guidelines are available in 97% of countries.

- A network of national and international laboratories is in place to meet diagnostic and confirmatory requirements and support outbreak investigations for events specified in Annex 2 of the IHR in 94% of countries.

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National laboratory capacity is in place in 91% of countries to meet diagnostic and confirmatory requirements to support outbreak investigations for IHR events. An up-to-date inventory of public and private laboratories with relevant diagnostic capacity is available in 66% of countries and the inventory is accessible in 69%.

National reference laboratories successfully participate in External Quality Assessment schemes for diagnostic laboratories for major public health disciplines in 80% of countries. More than 10 non-AFP hazardous specimens per year were referred to national or international reference laboratories for examination in 66% of countries.

All national reference laboratories are certified or accredited to international standards or to national standards adapted from international standards in 40% of countries.

National regulations are in place which are compatible with international guidelines for packaging and transport of clinical specimens in 91% of countries, and a functional system for collection, packaging, and transport of clinical specimens is available in 94% of countries. Staff at national and other relevant levels have been trained on the safe shipment of infectious substances according to international standards in 97% of countries. 89% of countries reporting have pre-positioned collection and transportation kits at appropriate levels. Clinical specimens from investigation of urgent public health events can be delivered to appropriate laboratories within the appropriate timeframe in 91% of countries with 94% of countries reporting the shipment process consistently meets ICAO/IATA standards. At least 10 hazardous specimens are shipped by 77% of countries internationally per year as part of investigations or exercises.

Laboratory biosafety and biosecurity practices

In 71% of countries, a responsible entity has been designated for laboratory biosafety and biosecurity. An institution or person responsible for inspection of laboratories for compliance with biosafety requirement has been identified in 71% of countries.

Biosafety guidelines are accessible to laboratories in 97% of countries. Regulations, policies, or strategies for laboratory biosafety are available in 86% of countries. Relevant staff have been trained on biosafety guidelines in 94% of countries. A biorisk assessment in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste, has been conducted in 46% of countries.
**Points of Entry**

**General obligations required at Points of Entry**

- A review meeting (or other appropriate method) to designate Points of Entry (PoEs) has been conducted in 94% of countries and 86% have identified designated ports, ground crossings (as relevant), or airports for development of capacities specified in Annex 1. A list of ports authorized to offer ship sanitation certificates has been sent to WHO as applicable in 66% of countries.

- Relevant legislation, regulations, administrative acts, or other government instruments to implement IHR at designated PoEs has been updated as needed in 63% of countries. Updated IHR health documents have been implemented at designated PoEs in 83% of countries.

- 69% of countries report assessing all designated ports.

- Mechanisms for the exchange of information between designated PoEs and medical facilities are in place in 86% of countries. Procedures for coordination and communication between the IHR NFP and PoEs competent authority are in place in 80% of countries and have been tested in 71%. Procedures for communication internationally between PoEs competent authorities and other countries’ PoE competent authorities have been tested 34% of countries and updated as needed in 43%. Bilateral agreements concerning prevention or control of international transmission of disease at designated PoEs have been put in place in 57% of countries.

**Effective surveillance at Points of Entry**

- Priority conditions for surveillance at designated PoEs have been identified in 80% of countries and 83% have shared surveillance information at designated PoEs with the surveillance department/unit. A review of surveillance health threats at designated PoEs have been conducted in the last 12 months 34% of countries and published in 14%.

**Effective response at Points of Entry**

- SOPs for response at PoEs are available in 74% of countries. Results of the effectiveness of response to public health events at PoEs has been evaluated in 43% and published in 9% of countries.
Hazard: Zoonotic Events

*Mechanisms for detecting and responding to zoonoses and potential zoonoses*

- In 97% of countries, there is a coordination mechanism within the responsible government authority/ies for the detection of and response to zoonotic events. A national policy or strategy is in place for the surveillance and response to zoonotic events in 89% of countries. Focal points responsible for animal health for coordination with the MoH and/or IHR NFP have been designated in 94% of countries. 97% of countries have functional mechanisms for intersectoral collaboration which include animal and human health surveillance units and laboratories have been established and documented.

- In 94% of countries, there is a list of priority zoonotic diseases with case definitions available.

- Systematic and timely collection and collation of zoonotic disease data is performed in 83% of countries. A timely and systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks exists in 80% of countries. Zoonotic disease surveillance is implemented with a community component in 83% of countries.

- Laboratory capacity, nationally or internationally to confirm priority zoonotic events, is accessible in 100% of countries.

- A regularly updated roster (list) of experts that can respond to zoonotic events is available in 74% of countries.

- A mechanism for response to outbreaks of zoonotic diseases by human and animal health sectors has been established in 94% of countries. More than 80% of zoonotic events of potential national and international concern are responded to in a timely manner by 94% of countries.

- Country experiences and findings related to zoonotic risks and events of potential national and international concern are shared with the global community by 71% of countries.

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Hazard: Food Safety
Detecting and responding to foodborne disease and food contamination

- National or international food safety standards are available in 97% of countries. 89% have national food laws, regulations, or policies in place to facilitate food safety control. Laws are up to date in 69% of countries and implemented in 74%.

- An operational national multisectoral mechanism for food safety events is in place in 91% of countries. A functioning coordination mechanism has been established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP in 83% of countries and 66% are active members of the INFOSAN network.

- A list of priority food safety risks is available in 66% of countries.

- Guidelines or manuals on the surveillance, assessment, and management of priority food safety risks are available in 77% of countries and have been implemented in 66%. Epidemiological data related to food contamination are collected and systematically analyzed by 77% of countries. Epidemiological data is also shared in a timely and systematic manner with other relevant sectors in 69% of countries.

- Laboratory capacity to confirm priority food safety events of national or international concern, including molecular techniques, is accessible in 86% of countries.

- In 71% of countries, a roster of food safety experts is available for assessing and responding to food safety events.

- Plans for responding to Food Safety Events have been implemented in 43% of countries and 14% of countries, tested in an exercise or actual emergency in 37%, and updated as needed in 29%. Risk based food inspection services are in place in 83% of countries. Mechanisms for tracing, recall, and disposal of contaminated products have been established in 86% of countries.

- Communication mechanisms and materials are in place in 77% of countries to inform, educate, and advise stakeholders across the farm-to-fork continuum.

- Food safety control management systems have been implemented in 94% of countries. In 71% of countries, information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards, and regulations. An analysis of food safety events, foodborne illness trends, and outbreaks, which integrate data across the food chain, has been published in 43% of countries.
Hazard: Chemical Events

Detection, alert, and response to chemical emergencies

- Experts for public health assessment and response to chemical incidents have been identified in 77% of countries.

- In 69%, national policies or plans are in place for chemical event surveillance, alert, and response. In 80% of countries, national authorities responsible for chemical events have designated a focal point for coordination with the MOH and/or the IHR NFP. Coordination mechanisms with relevant sectors are established in 69% of countries with 51% reporting a functional coordination mechanism implemented for surveillance and timely response across sectors. Surveillance is in place for chemical events, intoxication, or poisonings in 66% of countries. A list of priority chemical events/syndromes that may constitute a potential public health event of national and international concern is available in 34% of countries.

- An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies is available in 54% of countries and a national chemical profile has been developed in 54%.

- Manuals and SOPs for rapid assessment, case management, and control of chemical events are available in 46% and have been disseminated in 31% of countries. A timely and systematic information exchange is carried out between appropriate chemical units and surveillance units about urgent chemical events and potential chemical risks in 31% of countries.

- An emergency response plan that defines the roles and responsibilities of relevant agencies for chemical emergencies is available in 49% of countries.

- Laboratory capacity or access to laboratory capacity to confirm priority chemical events is available in 80% of countries.

- Chemical event response plans have been tested through the occurrence of a real event or through a simulation exercise in 37% of countries and updated as needed in 20% of countries.

- 46% of countries report an adequately-resourced Poison Centre(s) is in place.

- Country experience and findings regarding chemical events and risk of national and international concern have been shared with the global community by 37% of countries.

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Hazard: Radiological Events
Detecting and responding to radiological and nuclear emergencies

- Experts have been identified for public health assessment and response to radiological and nuclear events in 74% of countries.

- A national policy or plan for the detection, assessment and response to radiation emergencies is in place in 51%. Plans have been implemented in 37%. A national policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and medical services, is in place in 60% of countries.

- A functional coordination and communication mechanism has been established between relevant national competent authorities responsible for nuclear regulatory control/safety and relevant sectors in 63% of countries. Focal points for radiological and nuclear events for coordination and communication with the MOH and/or the NFP have been established in 63% of countries.

- Monitoring for radiation emergencies is in place in 60% of countries. A systematic information exchange between radiological-competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public health emergency of international concern is in place in 43% of countries.

- Technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation, and management of radiation emergencies have been developed in 49% of countries and have been evaluated and update in 31%. A radiation emergency response plan is in place in 49% of countries. Radiation emergency response drills are carried out regularly at national level, including requesting international assistance (as needed) and international notification, in 37% of countries.

- A mechanism is in place in 46% of countries for access to health facilities (inside or outside of the country) with capacity to manage patients of radiation emergencies.

- Laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards is available in 66% of countries. Regularly updated collaborative mechanisms are in place in 54% of countries for access to specialized laboratories that are able to perform bioassays, biological dosimetry by cytogenetic analysis, and ESR (electron-spin resonance technique). These mechanisms have been evaluated in 37% of countries.

- 49%, of countries have documented and shared experiences with the detection and response to radiological risks and events with the global community.

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NATIONAL CAPACITY MONITORING

With the coming into force of the International Health Regulations (2005) (hereinafter “IHR” or “the Regulations”) on June 15, 2007, all IHR States Parties are required to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response as specified in the IHR and to develop a plan of action to ensure that these capacities will be present and functioning throughout their territories by 2012\(^2\). WHO is mandated to provide appropriate tools, guidance, and support to States Parties to achieve these goals. In accordance with Article 54 of the IHR and related resolution WHA61.2, States Parties and WHO are required to report annually to the World Health Assembly on the implementation of the Regulations. For this purpose, a monitoring framework was developed using technical expert views drawn globally from WHO Member States, technical institutions, and WHO partners, and from within WHO.

In 2013, 100% of countries (i.e. 21/21) in the Eastern Mediterranean Region responded to the IHR Monitoring Questionnaire, which is higher than 2012 (91%) and 2011 (77%). Throughout this Regional Summary sheet, percentage values relate to responding countries only. Information extracted from the inputs provided by National Focal Points is reflected here to provide an overview of the progress achieved in the region as reported by State Parties in 2013. To obtain a full overview of progress of all the indicators please consult the individual Country Profiles 2013.

Analysis of the strengths and weaknesses in this regional profile is based on self-reported data submitted by States Parties with the IHR Monitoring Questionnaire 2013. Specific country contexts and other sources of information, if available, may also need to be considered in identifying priorities and needs and planning for future activities.


For historical data, including maps, please visit the International Health Regulations section of the Global Health Observatory: http://www.who.int/gho/ihr/en/

This summary provides information on (i) eight core capacities, (ii) development of capacities at points of entry, and (iii) capacities for four IHR-relevant hazards: biological (including food safety and zoonoses), chemical, and radionuclear.

Regional Average Attribute Scores
Core Capacity 1: National legislation, policy, and financing

*Legislation, regulations, administrative requirements, policies, or other government instruments, sufficient for implementation of the IHR.*

- Legal requirements and instruments are assessed in 89% of countries and implemented in 74% of countries. National policies have been reviewed to facilitate the implementation of functions of the IHR National Focal point (IHR NFP) and of technical core capacities in 95% of countries. Key elements of national IHR legislation have been published in 37% of countries. Policies to facilitate IHR NFP core and expanded functions and to strengthen technical core capacities have been implemented in 63% of countries.

Core Capacity 2: Coordination and NFP Communications

*Coordination mechanism between relevant sectors implementing the IHR*

- The IHR NFP has been established in 100% of countries. Information on obligations of the NFP under IHR has been disseminated to relevant authorities and stakeholders in 95% of countries. Additional roles and responsibilities for the IHR NFP functions have been implemented in 63% of countries. The functions of the NFP have been evaluated for effectiveness in 74% of countries. The NFP provides WHO with updated contact information and confirmation of the NFP on an annual basis in 100% of countries.

- Use of the IHR Event Information Site as an integral information resource was reported by 89% of countries. An active IHR website or web page has been established in 32% of countries.

- 100% of countries report having a multisectoral, multidisciplinary committee, body or task force to address IHR requirements on surveillance and response for a PHEIC. Coordination between relevant ministries on events that may constitute a public health event of national or international concern (PHEIC) was reported by 100% of countries as being in place. Standard Operating Procedures
(SOPs) are available for coordination between IHR NFP and stakeholders of relevant sectors in 74% of countries. Coordination mechanisms have been tested in 68% of countries through an actual event occurrence or through exercises and 74% report these mechanisms have been updated as needed. Action plans have been developed to incorporate lessons learnt from multisectoral and multidisciplinary coordination and communication mechanisms in 53% of countries.

- National stakeholders involved in the implementation of IHR have been identified by 100% of countries and 74% disseminate annual updates on the status of IHR implementation to stakeholders across all sectors. Roles and responsibilities of various stakeholders under the IHR have been defined in 79% of countries and disseminated in 79%. Plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR have been implemented in 63% of countries.

Core Capacity 3: Surveillance

*Early warning function for detection of public health events in indicator-based (Routine) surveillance (IBS)*

- Lists of priority diseases or conditions for surveillance as well as case definitions for priority diseases are available in 100% of countries. Also, 100% of countries have designated specific units for surveillance of public health risks and 89% of countries indicate timely reporting from at least 80% of all reporting units.

- Surveillance data on epidemic prone and priority diseases is analyzed at least weekly at national and sub-national levels in 89% of countries. 89% of countries have defined baseline estimates, trends, and thresholds for alert and action for the local public health response level for priority diseases/events. In 89% of countries, reports or other documentation show that deviations or values exceeding thresholds are detected and used for action at the primary public health response level. Regular feedback of surveillance results is disseminated to all levels and relevant stakeholders in 95% of countries.
• Evaluations of the early warning function of the indicator-based surveillance have been carried out and country experiences, findings, and lessons learnt have been shared with the global community in 84% of countries. 84% have shared global experiences, findings, and lessons learnt on IBS with the global community.

**Event-Based Surveillance**

• SOPs and guidelines for event-based surveillance are available in 79% of countries. Designated unit(s) for event-based surveillance that may be part of an existing routine surveillance system were reported in 95% of countries. SOPs and guidelines for event capture, reporting, confirmation, verification, assessment, and notification have been developed and disseminated in 68% of countries.

• Information sources for public health events and risks have been identified in 89% of countries. A system at national and/or sub-national levels for capturing and registering public health events from a variety of sources, including media (print, broadcast, community, electronic, internet etc.), is in place in 89% of countries. 74% have actively engaged and sensitized community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events. In 79% of countries, arrangements have been established with neighboring countries to share data on surveillance and the control of public health events that may be of international concern. In 63% of countries, implementation of local community reporting has been evaluated and updated as needed.

• Country experiences and findings on implementation of event-based surveillance and the integration with indicator-based surveillance has been documented in 58% of countries and shared with the global community in 58% of countries.

• The decision instrument in Annex 2 of the IHR (2005) is used to notify WHO in 100% of countries and in 79% its use has been reviewed, with procedures for decision making updated on the basis of lessons learnt in 74%. Country experiences and findings in notification and use of Annex 2 of the IHR have been documented in 84% of countries. And shared with the global community in 68%. Events that meet the criteria for notification under Annex 2 of IHR have been notified by the IHR NFP to WHO within 24 hours of conducting risk assessments over the last 12 months in 84% of countries. All events identified as urgent within the past 12 months were assessed within 48 hours of reporting in 89% of countries reporting. The IHR NFP has responded to all verification requests from WHO within 24 hours in 95% of countries.
Core Capacity 4: Response

Public Health Emergency Response mechanisms

- 79% of countries report implementing response procedures for a real or simulated public health response in the past 12 months.
- Case management guidelines are in place for priority conditions in 100% of countries.
- In 95% of countries, management procedures have been established for command, communications, and control during public health emergency response operations. A functional, dedicated command and control operations centre at the national or other relevant level exists in 89% of countries. Emergency response management procedures have been evaluated after a real or simulated public health response in 63% of countries and updated in 74%. Assistance from 52% of countries has been offered to other States Parties for developing their response capacities or implementing control measures.
- Resources for rapid response during outbreaks of national or international concern are accessible in 100% of countries. Rapid Response Teams (RRT) are available in 100% of countries, and 74% have SOPs available for the deployment of RRT members. In 95% of countries, multidisciplinary RRT can be deployed within 48 hours from the time when the decision to respond is taken. Evaluations of response including the timeliness and quality of response are systematically carried out in 63% of countries. Staff (including RRT members) have been trained in specimen collection and transport was reported by 100% of countries.

Infection Prevention and Control (IPC) at national and hospital levels

- In 79% of countries, responsibilities are assigned for surveillance of health-care-associated infections and in 68% of countries for anti-microbial resistance. In 74% of countries, national infection prevention and control policies/guidelines, and an operational plan for infection control are available and have been implemented nationwide in 68% of countries.
- SOPs, guidelines, and protocols for IPC are available to all hospitals in 95% of countries, and defined norms or guidelines for protecting health-care workers have been developed in 79% of countries. Infection control measures and their effectiveness are regularly evaluated and published in 58% of countries. 79% report that tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions according to national or international guidelines. In 79% of countries, qualified IPC professionals are in place. 63% of countries carry out surveillance within high risk groups to promptly detect and investigate clusters of infectious disease patients, as well as unexplained illnesses in health workers. A national programme for protecting health-care workers has been implemented in 68% of countries.
- A monitoring system for antimicrobial resistance (AMR) has been established in 53% of countries. In 47% of countries have implemented an AMR monitoring system, and 47% have available data on the magnitude and trends in AMR.

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Core Capacity 5: Preparedness
Multi-hazard National Public Health emergency Preparedness & Response Plan

- An assessment of the capacity of existing national structures and resources to meet IHR core capacities for the implementation of IHR have been conducted in 84% of countries.

- A national plan to meet the IHR core capacity requirements has been developed (Annex 1A Article 2) in 95% of countries and a national public health emergency response plan for IHR related hazards and Points of Entry (PoE) has been developed (Annex 1A, Article 6g) in 84% of countries. National public health emergency response plan(s) have been implemented or tested in 74% of countries in an actual emergency or simulation and updated as needed in 74%.

- In 68% of countries, a procedure or strategy is in place to reallocate or mobilize resources from national and sub-national levels to support action at community/primary response levels and the strategy has been implemented in 74% and reviewed and updated in 63%. Surge capacity is available in 84% of countries. Surge capacity has been tested either through response to a public health event or during an exercise in 63% of countries.

- Experiences and findings on emergency response and in mobilizing surge capacity have been documented in 63% of countries and shared with the global community in 32%.

Public health risk and resource mapping

- A national risk assessment to identify the most likely sources of “urgent public health event” has been conducted in 58% of countries. National resources have been mapped in 53% of countries to address priority risks with national profiles on risks and resources developed in 47%. The national risk profile is assessed regularly in 37% of countries. Regular assessment of the national resources for priority risks are performed by 47% of countries.

- A directory of experts in health and other sectors to support a response to IHR-related hazards is available in 89% of countries.

- A plan for management and distribution (if applicable) of national stockpiles is available in 79% of countries and 58% have stockpiles (critical stock levels) available and accessible for responding to the country’s priority biological, chemical, and radiological events and other emergencies. Contributions to international stockpiles are made by 32% of countries.
Core Capacity 6: Risk Communication
Mechanisms for effective risk communication during a public health emergency

- Risk communication partners and stakeholders have been identified in 95% of countries and a risk communication plan has been developed in 58%. Plans have been validated by 53% of countries through an actual emergency or simulation exercise in the past 12 months.

- Policies, SOPs, or guidelines on the clearance and release of information during a public health event have been developed in 68% of countries. In 84% of countries, regularly updated information sources are accessible to media and the public for information dissemination. Accessible and relevant IEC (Information, Education and Communications) materials are tailored to the needs of the population in 95% of countries.

- Evaluation of public health communication after emergencies, including for timeliness, transparency, and appropriateness of communications, and updating SOPs as needed following evaluation of the public health communication has taken place in 47% of countries. The results of evaluations have been used to update the risk communications plan in 53% of countries and 37% have shared the results of these evaluations with the global community.

- 84% of countries report informing populations and partners of a real or potential risk within 24 hours of confirmation in the last three national or international public health emergencies.

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Core 7: Human Resource Capacity

**Human resources available to implement IHR Core Capacity Requirements**

- In 89% of countries, a unit has been identified to assess human resource capacities to meet the country’s IHR requirements. A needs assessment has been conducted to identify gaps in human resources and training (numbers and competencies) to meet IHR requirements in 68% of countries. A workforce development or training plan has been developed that includes human resource requirements for IHR in 89% of countries. Specific programs with allocated budgets to train workforces in IHR relevant hazards exist in 58% of countries. Progress for meeting workforce numbers and skills is consistent with training program milestones in 58% of countries.

- A strategy has been developed for the country to access field epidemiology training (one year or more) in-country, regionally, or internationally in 79% of countries and implemented in 63%.

### Human Resources

![Human Resources Map](image)

**Implementation status (%)**

- Light green: 0–24
- Yellow: 25–49
- Green: 50–74
- Dark green: 75–100
- Grey: Not part of WHO Eastern Mediterranean Region
- Light grey: Not applicable

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Core Capacity 8: Laboratory

**Laboratory services to test for priority health threats**

- 89% of countries have policies in place to ensure the quality of laboratory diagnostic capacities. National laboratory quality standards/guidelines are available in 84% of countries.

- A network of national and international laboratories is in place to meet diagnostic and confirmatory requirements and support outbreak investigations for events specified in Annex 2 of the IHR in 89% of countries.
- National laboratory capacity is in place in 100% of countries to meet diagnostic and confirmatory requirements to support outbreak investigations for IHR events. An up-to-date inventory of public and private laboratories with relevant diagnostic capacity is available in 74% of countries and the inventory is accessible in 79%.

- National reference laboratories successfully participate in External Quality Assessment schemes for diagnostic laboratories for major public health disciplines in 95% of countries. More than 10 non-AFP hazardous specimens per year were referred to national or international reference laboratories for examination in 89% of countries.

- All national reference laboratories are certified or accredited to international standards or to national standards adapted from international standards in 68% of countries.

- National regulations are in place which are compatible with international guidelines for packaging and transport of clinical specimens in 89% of countries, and a functional system for collection, packaging, and transport of clinical specimens is available in 100% of countries. Staff at national and other relevant levels have been trained on the safe shipment of infectious substances according to international standards in 89% of countries. 89% of countries reporting have pre-positioned collection and transportation kits at appropriate levels. Clinical specimens from investigation of urgent public health events can be delivered to appropriate laboratories within the appropriate timeframe in 100% of countries with 89% of countries reporting the shipment process consistently meets ICAO/IATA standards. At least 10 hazardous specimens are shipped by 79% of countries internationally per year as part of investigations or exercises.

Laboratory biosafety and biosecurity practices

- In 89% of countries, a responsible entity has been designated for laboratory biosafety and biosecurity. An institution or person responsible for inspection of laboratories for compliance with biosafety requirement has been identified in 63% of countries.

- Biosafety guidelines are accessible to laboratories in 89% of countries. Regulations, policies, or strategies for laboratory biosafety are available in 79% of countries. Relevant staff have been trained on biosafety guidelines in 100% of countries. A biorisk assessment in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste, has been conducted in 53% of countries.
**Points of Entry**

*General obligations required at Points of Entry*

- A review meeting (or other appropriate method) to designate Points of Entry (PoEs) has been conducted in 84% of countries and 89% have identified designated ports, ground crossings (as relevant), or airports for development of capacities specified in Annex 1. A list of ports authorized to offer ship sanitation certificates has been sent to WHO as applicable in 58% of countries.

- Relevant legislation, regulations, administrative acts, or other government instruments to implement IHR at designated PoEs has been updated as needed in 63% of countries. Updated IHR health documents have been implemented at designated PoEs in 74% of countries.

- 79% of countries report assessing all designated ports.

- Mechanisms for the exchange of information between designated PoEs and medical facilities are in place in 89% of countries. Procedures for coordination and communication between the IHR NFP and PoEs competent authority are in place in 79% of countries and have been tested in 63%. Procedures for communication internationally between PoEs competent authorities and other countries’ PoE competent authorities have been tested 53% of countries and updated as needed in 42%. Bilateral agreements concerning prevention or control of international transmission of disease at designated PoEs have been put in place in 58% of countries.

*Effective surveillance at Points of Entry*

- Priority conditions for surveillance at designated PoEs have been identified in 79% of countries and 95% have shared surveillance information at designated PoEs with the surveillance department/unit. A review of surveillance health threats at designated PoEs have been conducted in the last 12 months 53% of countries and published in 32%.

*Effective response at Points of Entry*

- SOPs for response at PoEs are available in 53% of countries. Results of the effectiveness of response to public health events at PoEs has been evaluated in 32% and published in 11% of countries.
Hazard: Zoonotic Events

Mechanisms for detecting and responding to zoonoses and potential zoonoses

- In 100% of countries, there is a coordination mechanism within the responsible government authority/ies for the detection of and response to zoonotic events. A national policy or strategy is in place for the surveillance and response to zoonotic events in 95% of countries. Focal points responsible for animal health for coordination with the MoH and/or IHR NFP have been designated in 100% of countries. 89% of countries have functional mechanisms for intersectoral collaboration which include animal and human health surveillance units and laboratories have been established and documented.

- In 100% of countries, there is a list of priority zoonotic diseases with case definitions available.

- Systematic and timely collection and collation of zoonotic disease data is performed in 89% of countries. A timely and systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks exists in 84% of countries. Zoonotic disease surveillance is implemented with a community component in 63% of countries.

- Laboratory capacity, nationally or internationally to confirm priority zoonotic events, is accessible in 100% of countries.

- A regularly updated roster (list) of experts that can respond to zoonotic events is available in 79% of countries.

- A mechanism for response to outbreaks of zoonotic diseases by human and animal health sectors has been established in 100% of countries. More than 80% of zoonotic events of potential national and international concern are responded to in a timely manner by 89% of countries.

- Country experiences and findings related to zoonotic risks and events of potential national and international concern are shared with the global community by 63% of countries.
Hazard: Food Safety
Detecting and responding to foodborne disease and food contamination

- National or international food safety standards are available in 95% of countries. 89% have national food laws, regulations, or policies in place to facilitate food safety control. Laws are up to date in 74% of countries and implemented in 79%.

- An operational national multisectoral mechanism for food safety events is in place in 89% of countries. A functioning coordination mechanism has been established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP in 74% of countries and 74% are active members of the INFOSAN network.

- A list of priority food safety risks is available in 74% of countries.

- Guidelines or manuals on the surveillance, assessment, and management of priority food safety risks are available in 74% of countries and have been implemented in 74%. Epidemiological data related to food contamination are collected and systematically analyzed by 79% of countries. Epidemiological data is also shared in a timely and systematic manner with other relevant sectors in 79% of countries.

- Laboratory capacity to confirm priority food safety events of national or international concern, including molecular techniques, is accessible in 95% of countries.

- In 68% of countries, a roster of food safety experts is available for assessing and responding to food safety events.

- Plans for responding to Food Safety Events have been implemented in 79% of countries and 14% of countries, tested in an exercise or actual emergency in 68%, and updated as needed in 74%. Risk based food inspection services are in place in 95% of countries. Mechanisms for tracing, recall, and disposal of contaminated products have been established in 84% of countries.

- Communication mechanisms and materials are in place in 68% of countries to inform, educate, and advise stakeholders across the farm-to-fork continuum.

- Food safety control management systems have been implemented in 95% of countries. In 89% of countries, information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards, and regulations. An analysis of food safety events, foodborne illness trends, and outbreaks, which integrate data across the food chain, has been published in 26% of countries.
**Hazard: Chemical Events**

*Detection, alert, and response to chemical emergencies*

- Experts for public health assessment and response to chemical incidents have been identified in 63% of countries.

- In 58%, national policies or plans are in place for chemical event surveillance, alert, and response. In 89% of countries, national authorities responsible for chemical events have designated a focal point for coordination with the MOH and/or the IHR NFP. Coordination mechanisms with relevant sectors are established in 79% of countries with 58% reporting a functional coordination mechanism implemented for surveillance and timely response across sectors. Surveillance is in place for chemical events, intoxication, or poisonings in 58% of countries. A list of priority chemical events/syndromes that may constitute a potential public health event of national and international concern is available in 53% of countries.

- An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies is available in 68% of countries and a national chemical profile has been developed in 37%.

- Manuals and SOPs for rapid assessment, case management, and control of chemical events are available in 53% and have been disseminated in 32% of countries. A timely and systematic information exchange is carried out between appropriate chemical units and surveillance units about urgent chemical events and potential chemical risks in 63% of countries.

- An emergency response plan that defines the roles and responsibilities of relevant agencies for chemical emergencies is available in 53% of countries.

- Laboratory capacity or access to laboratory capacity to confirm priority chemical events is available in 89% of countries.

- Chemical event response plans have been tested through the occurrence of a real event or through a simulation exercise in 37% of countries and updated as needed in 42% of countries.

- 58% of countries report an adequately-resourced Poison Centre(s) is in place.

- Country experience and findings regarding chemical events and risk of national and international concern have been shared with the global community by 42% of countries.
Hazard: Radiological Events

Detecting and responding to radiological and nuclear emergencies

- Experts have been identified for public health assessment and response to radiological and nuclear events in 89% of countries.

- A national policy or plan for the detection, assessment and response to radiation emergencies is in place in 79%. Plans have been implemented in 74%. A national policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and medical services, is in place in 79% of countries.

- A functional coordination and communication mechanism has been established between relevant national competent authorities responsible for nuclear regulatory control/safety and relevant sectors in 84% of countries. Focal points for radiological and nuclear events for coordination and communication with the MOH and/or the NFP have been established in 79% of countries.

- Monitoring for radiation emergencies is in place in 74% of countries. A systematic information exchange between radiological-competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public health emergency of international concern is in place in 53% of countries.

- Technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation, and management of radiation emergencies have been developed in 63% of countries and have been evaluated and update in 42%. A radiation emergency response plan is in place in 74% of countries. Radiation emergency response drills are carried out regularly at national level, including requesting international assistance (as needed) and international notification, in 47% of countries.

- A mechanism is in place in 47% of countries for access to health facilities (inside or outside of the country) with capacity to manage patients of radiation emergencies.

- Laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards is available in 68% of countries. Regularly updated collaborative mechanisms are in place in 47% of countries for access to specialized laboratories that are able to perform bioassays, biological dosimetry by cytogenetic analysis, and ESR (electron-spin resonance technique). These mechanisms have been evaluated in 47% of countries.

- 42%, of countries have documented and shared experiences with the detection and response to radiological risks and events with the global community.

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NATIONAL CAPACITY MONITORING

With the coming into force of the International Health Regulations (2005) (hereinafter “IHR” or “the Regulations”) on June 15, 2007, all IHR States Parties are required to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response as specified in the IHR and to develop a plan of action to ensure that these capacities will be present and functioning throughout their territories by 2012. WHO is mandated to provide appropriate tools, guidance, and support to States Parties to achieve these goals. In accordance with Article 54 of the IHR and related resolution WHA61.2, States Parties and WHO are required to report annually to the World Health Assembly on the implementation of the Regulations. For this purpose, a monitoring framework was developed using technical expert views drawn globally from WHO Member States, technical institutions, and WHO partners, and from within WHO.

In 2013, 58% of countries (i.e. 31/53) in the European Region responded to the IHR Monitoring Questionnaire, which is lower than 2012 (60%) and 2011 (83%). Throughout this Regional Summary sheet, percentage values relate to responding countries only. Information extracted from the inputs provided by National Focal Points is reflected here to provide an overview of the progress achieved in the region as reported by State Parties in 2013. To obtain a full overview of progress of all the indicators please consult the individual Country Profiles 2013.

Analysis of the strengths and weaknesses in this regional profile is based on self-reported data submitted by States Parties with the IHR Monitoring Questionnaire 2013. Specific country contexts and other sources of information, if available, may also need to be considered in identifying priorities and needs and planning for future activities.


For historical data, including maps, please visit the International Health Regulations section of the Global Health Observatory: http://www.who.int/gho/ihr/en/

This summary provides information on (i) eight core capacities, (ii) development of capacities at points of entry, and (iii) capacities for four IHR-relevant hazards: biological (including food safety and zoonoses), chemical, and radionuclear.

Regional Average Attribute Scores

[Graph showing regional average attribute scores for various capacities]
Core Capacity 1: National legislation, policy, and financing

*Legislation, regulations, administrative requirements, policies, or other government instruments, sufficient for implementation of the IHR.*

- Legal requirements and instruments are assessed in 100% of countries and implemented in 79% of countries. National policies have been reviewed to facilitate the implementation of functions of the IHR National Focal point (IHR NFP) and of technical core capacities in 97% of countries. Key elements of national IHR legislation have been published in 93% of countries. Policies to facilitate IHR NFP core and expanded functions and to strengthen technical core capacities have been implemented in 76% of countries.

Core Capacity 2: Coordination and NFP Communications

*Coordination mechanism between relevant sectors implementing the IHR*

- The IHR NFP has been established in 100% of countries. Information on obligations of the NFP under IHR has been disseminated to relevant authorities and stakeholders in 93% of countries. Additional roles and responsibilities for the IHR NFP functions have been implemented in 69% of countries. The functions of the NFP have been evaluated for effectiveness in 34% of countries. The NFP provides WHO with updated contact information and confirmation of the NFP on an annual basis in 100% of countries.

- Use of the IHR Event Information Site as an integral information resource was reported by 90% of countries. An active IHR website or web page has been established in 34% of countries.

- 86% of countries report having a multisectoral, multidisciplinary committee, body or task force to address IHR requirements on surveillance and response for a PHEIC. Coordination between relevant ministries on events that may constitute a public health event of national or international concern (PHEIC) was reported by 97% of countries as being in place. Standard Operating Procedures (SOPs) are available for coordination between IHR NFP and stakeholders of relevant sectors in 79% of countries. Coordination mechanisms have been tested in 66% of countries through an actual event occurrence or through exercises and 83% report these
mechanisms have been updated as needed. Action plans have been developed to incorporate lessons learnt from multisectoral and multidisciplinary coordination and communication mechanisms in 52% of countries.

- National stakeholders involved in the implementation of IHR have been identified by 93% of countries and 59% disseminate annual updates on the status of IHR implementation to stakeholders across all sectors. Roles and responsibilities of various stakeholders under the IHR have been defined in 72% of countries and disseminated in 69%. Plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR have been implemented in 62% of countries.

Core Capacity 3: Surveillance

*Early warning function for detection of public health events in indicator-based (Routine) surveillance (IBS)*

- Lists of priority diseases or conditions for surveillance as well as case definitions for priority diseases are available in 97% of countries. Also, 97% of countries have designated specific units for surveillance of public health risks and 93% of countries indicate timely reporting from at least 80% of all reporting units.

- Surveillance data on epidemic prone and priority diseases is analyzed at least weekly at national and sub-national levels in 97% of countries. 90% of countries have defined baseline estimates, trends, and thresholds for alert and action for the local public health response level for priority diseases/events. In 86% of countries, reports or other documentation show that deviations or values exceeding thresholds are detected and used for action at the primary public health response level. Regular feedback of surveillance results is disseminated to all levels and relevant stakeholders in 100% of countries.
• Evaluations of the early warning function of the indicator-based surveillance have been carried out and country experiences, findings, and lessons learnt have been shared with the global community in 52% of countries. 45% have shared global experiences, findings, and lessons learnt on IBS with the global community.

**Event-Based Surveillance**

• SOPs and guidelines for event-based surveillance are available in 83% of countries. Designated unit(s) for event-based surveillance that may be part of an existing routine surveillance system were reported in 97% of countries. SOPs and guidelines for event capture, reporting, confirmation, verification, assessment, and notification have been developed and disseminated in 79% of countries.

• Information sources for public health events and risks have been identified in 97% of countries. A system at national and/or sub-national levels for capturing and registering public health events from a variety of sources, including media (print, broadcast, community, electronic, internet etc.), is in place in 97% of countries. 76% have actively engaged and sensitized community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events. In 83% of countries, arrangements have been established with neighboring countries to share data on surveillance and the control of public health events that may be of international concern. In 69% of countries, implementation of local community reporting has been evaluated and updated as needed.

• Country experiences and findings on implementation of event-based surveillance and the integration with indicator-based surveillance has been documented in 55% of countries and shared with the global community in 59% of countries.

• The decision instrument in Annex 2 of the IHR (2005) is used to notify WHO in 100% of countries and in 55% its use has been reviewed, with procedures for decision making updated on the basis of lessons learnt in 52%. Country experiences and findings in notification and use of Annex 2 of the IHR have been documented in 31% of countries. And shared with the global community in 17%. Events that meet the criteria for notification under Annex 2 of IHR have been notified by the IHR NFP to WHO within 24 hours of conducting risk assessments over the last 12 months in 79% of countries. All events identified as urgent within the past 12 months were assessed within 48 hours of reporting in 79% of countries reporting. The IHR NFP has responded to all verification requests from WHO within 24 hours in 76% of countries.

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Core Capacity 4: Response

Public Health Emergency Response mechanisms

- 79% of countries report implementing response procedures for a real or simulated public health response in the past 12 months.
- Case management guidelines are in place for priority conditions in 83% of countries.
- In 93% of countries, management procedures have been established for command, communications, and control during public health emergency response operations. A functional, dedicated command and control operations centre at the national or other relevant level exists in 93% of countries. Emergency response management procedures have been evaluated after a real or simulated public health response in 69% of countries and updated in 66%. Assistance from 52% of countries has been offered to other States Parties for developing their response capacities or implementing control measures.
- Resources for rapid response during outbreaks of national or international concern are accessible in 97% of countries. Rapid Response Teams (RRT) are available in 90% of countries, and 86% have SOPs available for the deployment of RRT members. In 93% of countries, multidisciplinary RRT can be deployed within 48 hours from the time when the decision to respond is taken. Evaluations of response including the timeliness and quality of response are systematically carried out in 62% of countries. Staff (including RRT members) have been trained in specimen collection and transport was reported by 90% of countries.

Infection Prevention and Control (IPC) at national and hospital levels

- In 100% of countries, responsibilities are assigned for surveillance of health-care-associated infections and in 93% of countries for anti-microbial resistance. In 90% of countries, national infection prevention and control policies/guidelines, and an operational plan for infection control are available and have been implemented nationwide in 97% of countries.
- SOPs, guidelines, and protocols for IPC are available to all hospitals in 93% of countries, and defined norms or guidelines for protecting health-care workers have been developed in 100% of countries. Infection control measures and their effectiveness are regularly evaluated and published in 79% of countries. 93% report that tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions according to national or international guidelines. In 97% of countries, qualified IPC professionals are in place. 100% of countries carry out surveillance within high risk groups to promptly detect and investigate clusters of infectious disease patients, as well as unexplained illnesses in health workers. A national programme for protecting health-care workers has been implemented in 90% of countries.
- A monitoring system for antimicrobial resistance (AMR) has been established in 79% of countries. In 72% of countries have implemented an AMR monitoring system, and 62% have available data on the magnitude and trends in AMR.
Core Capacity 5: Preparedness

Multi-hazard National Public Health emergency Preparedness & Response Plan

- An assessment of the capacity of existing national structures and resources to meet IHR core capacities for the implementation of IHR have been conducted in 93% of countries.

- A national plan to meet the IHR core capacity requirements has been developed (Annex 1A Article 2) in 69% of countries and a national public health emergency response plan for IHR related hazards and Points of Entry (PoE) has been developed (Annex 1A, Article 6g) in 72% of countries. National public health emergency response plan(s) have been implemented or tested in 69% of countries in an actual emergency or simulation and updated as needed in 72%.

- In 79% of countries, a procedure or strategy is in place to reallocate or mobilize resources from national and sub-national levels to support action at community/primary response levels and the strategy has been implemented in 45% and reviewed and updated in 41%. Surge capacity is available in 86% of countries. Surge capacity has been tested either through response to a public health event or during an exercise in 59% of countries.

- Experiences and findings on emergency response and in mobilizing surge capacity have been documented in 31% of countries and shared with the global community in 24%.

Public health risk and resource mapping

- A national risk assessment to identify the most likely sources of “urgent public health event” has been conducted in 90% of countries. National resources have been mapped in 66% of countries to address priority risks with national profiles on risks and resources developed in 66%. The national risk profile is assessed regularly in 83% of countries. Regular assessment of the national resources for priority risks are performed by 62% of countries.

- A directory of experts in health and other sectors to support a response to IHR-related hazards is available in 86% of countries.

- A plan for management and distribution (if applicable) of national stockpiles is available in 90% of countries and 93% have stockpiles (critical stock levels) available and accessible for responding to the country's priority biological, chemical, and radiological events and other emergencies. Contributions to international stockpiles are made by 28% of countries.
Core Capacity 6: Risk Communication
Mechanisms for effective risk communication during a public health emergency

- Risk communication partners and stakeholders have been identified in 97% of countries and a risk communication plan has been developed in 76%. Plans have been validated by 62% of countries through an actual emergency or simulation exercise in the past 12 months.

- Policies, SOPs, or guidelines on the clearance and release of information during a public health event have been developed in 76% of countries. In 93% of countries, regularly updated information sources are accessible to media and the public for information dissemination. Accessible and relevant IEC (Information, Education and Communications) materials are tailored to the needs of the population in 86% of countries.

- Evaluation of public health communication after emergencies, including for timeliness, transparency, and appropriateness of communications, and updating SOPs as needed following evaluation of the public health communication has taken place in 62% of countries. The results of evaluations have been used to update the risk communications plan in 45% of countries and 41% have shared the results of these evaluations with the global community.

- 100% of countries report informing populations and partners of a real or potential risk within 24 hours of confirmation in the last three national or international public health emergencies.

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Core 7: Human Resource Capacity

Human resources available to implement IHR Core Capacity Requirements

- In 76% of countries, a unit has been identified to assess human resource capacities to meet the country’s IHR requirements. A needs assessment has been conducted to identify gaps in human resources and training (numbers and competencies) to meet IHR requirements in 72% of countries. A workforce development or training plan has been developed that includes human resource requirements for IHR in 41% of countries. Specific programs with allocated budgets to train workforces in IHR relevant hazards exist in 45% of countries. Progress for meeting workforce numbers and skills is consistent with training program milestones in 34% of countries.

- A strategy has been developed for the country to access field epidemiology training (one year or more) in-country, regionally, or internationally in 59% of countries and implemented in 59%.

Core Capacity 8: Laboratory

Laboratory services to test for priority health threats

- 97% of countries have policies in place to ensure the quality of laboratory diagnostic capacities. National laboratory quality standards/guidelines are available in 86% of countries.

- A network of national and international laboratories is in place to meet diagnostic and confirmatory requirements and support outbreak investigations for events specified in Annex 2 of the IHR in 79% of countries.

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- National laboratory capacity is in place in 97% of countries to meet diagnostic and confirmatory requirements to support outbreak investigations for IHR events. An up-to-date inventory of public and private laboratories with relevant diagnostic capacity is available in 66% of countries and the inventory is accessible in 66%.

- National reference laboratories successfully participate in External Quality Assessment schemes for diagnostic laboratories for major public health disciplines in 79% of countries. More than 10 non-AFP hazardous specimens per year were referred to national or international reference laboratories for examination in 52% of countries.

- All national reference laboratories are certified or accredited to international standards or to national standards adapted from international standards in 76% of countries.

- National regulations are in place which are compatible with international guidelines for packaging and transport of clinical specimens in 90% of countries, and a functional system for collection, packaging, and transport of clinical specimens is available in 100% of countries. Staff at national and other relevant levels have been trained on the safe shipment of infectious substances according to international standards in 83% of countries. 76% of countries reporting have pre-positioned collection and transportation kits at appropriate levels. Clinical specimens from investigation of urgent public health events can be delivered to appropriate laboratories within the appropriate timeframe in 97% of countries with 79% of countries reporting the shipment process consistently meets ICAO/IATA standards. At least 10 hazardous specimens are shipped by 62% of countries internationally per year as part of investigations or exercises.

**Laboratory biosafety and biosecurity practices**

- In 76% of countries, a responsible entity has been designated for laboratory biosafety and biosecurity. An institution or person responsible for inspection of laboratories for compliance with biosafety requirement has been identified in 76% of countries.

- Biosafety guidelines are accessible to laboratories in 97% of countries. Regulations, policies, or strategies for laboratory biosafety are available in 97% of countries. Relevant staff have been trained on biosafety guidelines in 83% of countries. A biorisk assessment in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste, has been conducted in 76% of countries.
Points of Entry

General obligations required at Points of Entry

- A review meeting (or other appropriate method) to designate Points of Entry (PoEs) has been conducted in 83% of countries and 83% have identified designated ports, ground crossings (as relevant), or airports for development of capacities specified in Annex 1. A list of ports authorized to offer ship sanitation certificates has been sent to WHO as applicable in 66% of countries.

- Relevant legislation, regulations, administrative acts, or other government instruments to implement IHR at designated PoEs has been updated as needed in 76% of countries. Updated IHR health documents have been implemented at designated PoEs in 79% of countries.

- 55% of countries report assessing all designated ports.

- Mechanisms for the exchange of information between designated PoEs and medical facilities are in place in 83% of countries. Procedures for coordination and communication between the IHR NFP and PoEs competent authority are in place in 66% of countries and have been tested in 62%. Procedures for communication internationally between PoEs competent authorities and other countries’ PoE competent authorities have been tested in 21% of countries and updated as needed in 41%. Bilateral agreements concerning prevention or control of international transmission of disease at designated PoEs have been put in place in 38% of countries.

Effective surveillance at Points of Entry

- Priority conditions for surveillance at designated PoEs have been identified in 90% of countries and 83% have shared surveillance information at designated PoEs with the surveillance department/unit. A review of surveillance health threats at designated PoEs have been conducted in the last 12 months 21% of countries and published in 10%.

Effective response at Points of Entry

SOPs for response at PoEs are available in 69% of countries. Results of the effectiveness of response to public health events at PoEs has been evaluated in 31% and published in 10% of countries.
Hazard: Zoonotic Events
Mechanisms for detecting and responding to zoonoses and potential zoonoses

- In 93% of countries, there is a coordination mechanism within the responsible government authority/ies for the detection of and response to zoonotic events. A national policy or strategy is in place for the surveillance and response to zoonotic events in 93% of countries. Focal points responsible for animal health for coordination with the MoH and/or IHR NFP have been designated in 62% of countries. 86% of countries have functional mechanisms for intersectoral collaboration which include animal and human health surveillance units and laboratories have been established and documented.

- In 86% of countries, there is a list of priority zoonotic diseases with case definitions available.

- Systematic and timely collection and collation of zoonotic disease data is performed in 93% of countries. A timely and systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks exists in 90% of countries. Zoonotic disease surveillance is implemented with a community component in 76% of countries.

- Laboratory capacity, nationally or internationally to confirm priority zoonotic events, is accessible in 90% of countries.

- A regularly updated roster (list) of experts that can respond to zoonotic events is available in 76% of countries.

- A mechanism for response to outbreaks of zoonotic diseases by human and animal health sectors has been established in 93% of countries. More than 80% of zoonotic events of potential national and international concern are responded to in a timely manner by 86% of countries.

- Country experiences and findings related to zoonotic risks and events of potential national and international concern are shared with the global community by 62% of countries.

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**Hazard: Food Safety**

*Detecting and responding to foodborne disease and food contamination*

- National or international food safety standards are available in 90% of countries. 93% have national food laws, regulations, or policies in place to facilitate food safety control. Laws are up to date in 83% of countries and implemented in 86%.

- An operational national multisectoral mechanism for food safety events is in place in 93% of countries. A functioning coordination mechanism has been established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP in 86% of countries and 79% are active members of the INFOSAN network.

- A list of priority food safety risks is available in 79% of countries.

- Guidelines or manuals on the surveillance, assessment, and management of priority food safety risks are available in 83% of countries and have been implemented in 83%. Epidemiological data related to food contamination are collected and systematically analyzed by 93% of countries. Epidemiological data is also shared in a timely and systematic manner with other relevant sectors in 93% of countries.

- Laboratory capacity to confirm priority food safety events of national or international concern, including molecular techniques, is accessible in 93% of countries.

- In 86% of countries, a roster of food safety experts is available for assessing and responding to food safety events.

- Plans for responding to Food Safety Events have been implemented in 83% of countries and 14% of countries, tested in an exercise or actual emergency in 62%, and updated as needed in 66%. Risk based food inspection services are in place in 93% of countries. Mechanisms for tracing, recall, and disposal of contaminated products have been established in 90% of countries.

- Communication mechanisms and materials are in place in 93% of countries to inform, educate, and advise stakeholders across the farm-to-fork continuum.

- Food safety control management systems have been implemented in 93% of countries. In 86% of countries, information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards, and regulations. An analysis of food safety events, foodborne illness trends, and outbreaks, which integrate data across the food chain, has been published in 62% of countries.
Hazard: Chemical Events

Detection, alert, and response to chemical emergencies

- Experts for public health assessment and response to chemical incidents have been identified in 86% of countries.

- In 93%, national policies or plans are in place for chemical event surveillance, alert, and response. In 72% of countries, national authorities responsible for chemical events have designated a focal point for coordination with the MOH and/or the IHR NFP. Coordination mechanisms with relevant sectors are established in 90% of countries with 83% reporting a functional coordination mechanism implemented for surveillance and timely response across sectors. Surveillance is in place for chemical events, intoxication, or poisonings in 79% of countries. A list of priority chemical events/syndromes that may constitute a potential public health event of national and international concern is available in 55% of countries.

- An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies is available in 86% of countries and a national chemical profile has been developed in 45%.

- Manuals and SOPs for rapid assessment, case management, and control of chemical events are available in 55% and have been disseminated in 52% of countries. A timely and systematic information exchange is carried out between appropriate chemical units and surveillance units about urgent chemical events and potential chemical risks in 83% of countries.

- An emergency response plan that defines the roles and responsibilities of relevant agencies for chemical emergencies is available in 93% of countries.

- Laboratory capacity or access to laboratory capacity to confirm priority chemical events is available in 72% of countries.

- Chemical event response plans have been tested through the occurrence of a real event or through a simulation exercise in 66% of countries and updated as needed in 72% of countries.

- 72% of countries report an adequately-resourced Poison Centre(s) is in place.

- Country experience and findings regarding chemical events and risk of national and international concern have been shared with the global community by 48% of countries.
Hazard: Radiological Events
Detecting and responding to radiological and nuclear emergencies

- Experts have been identified for public health assessment and response to radiological and nuclear events in 86% of countries.
- A national policy or plan for the detection, assessment and response to radiation emergencies is in place in 93%. Plans have been implemented in 90%. A national policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and medical services, is in place in 83% of countries.
- A functional coordination and communication mechanism has been established between relevant national competent authorities responsible for nuclear regulatory control/safety and relevant sectors in 90% of countries. Focal points for radiological and nuclear events for coordination and communication with the MOH and/or the NFP have been established in 86% of countries.
- Monitoring for radiation emergencies is in place in 90% of countries. A systematic information exchange between radiological-competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public health emergency of international concern is in place in 79% of countries.
- Technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation, and management of radiation emergencies have been developed in 69% of countries and have been evaluated and update in 55%. A radiation emergency response plan is in place in 90% of countries. Radiation emergency response drills are carried out regularly at national level, including requesting international assistance (as needed) and international notification, in 79% of countries.
- A mechanism is in place in 79% of countries for access to health facilities (inside or outside of the country) with capacity to manage patients of radiation emergencies.
- Laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards is available in 86% of countries. Regularly updated collaborative mechanisms are in place in 62% of countries for access to specialized laboratories that are able to perform bioassays, biological dosimetry by cytogenetic analysis, and ESR (electron-spin resonance technique). These mechanisms have been evaluated in 52% of countries.
- 62% of countries have documented and shared experiences with the detection and response to radiological risks and events with the global community.

*Map disclaimer:* The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
NATIONAL CAPACITY MONITORING

With the coming into force of the International Health Regulations (2005) (hereinafter “IHR” or “the Regulations”) on June 15, 2007, all IHR States Parties are required to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response as specified in the IHR and to develop a plan of action to ensure that these capacities will be present and functioning throughout their territories by 2012. WHO is mandated to provide appropriate tools, guidance, and support to States Parties to achieve these goals. In accordance with Article 54 of the IHR and related resolution WHA61.2, States Parties and WHO are required to report annually to the World Health Assembly on the implementation of the Regulations. For this purpose, a monitoring framework was developed using technical expert views drawn globally from WHO Member States, technical institutions, and WHO partners, and from within WHO.

In 2013, 100% of countries (i.e. 11/11) in the South-East Asia Region responded to the IHR Monitoring Questionnaire, which is higher than 2012 (91%) and 2011 (41%). Throughout this Regional Summary sheet, percentage values relate to responding countries only. Information extracted from the inputs provided by National Focal Points is reflected here to provide an overview of the progress achieved in the region as reported by State Parties in 2013. To obtain a full overview of progress of all the indicators please consult the individual Country Profiles 2013.

Analysis of the strengths and weaknesses in this regional profile is based on self-reported data submitted by States Parties with the IHR Monitoring Questionnaire 2013. Specific country contexts and other sources of information, if available, may also need to be considered in identifying priorities and needs and planning for future activities.

For further reference and information on individual elements (core capacities, indicators, attributes), please consult: http://www.who.int/ihr/IHR.Monitoring_Framework.Checklist.and.Indicators.pdf.

For historical data, including maps, please visit the International Health Regulations section of the Global Health Observatory: http://www.who.int/gho/ihr/en/

This summary provides information on (i) eight core capacities, (ii) development of capacities at points of entry, and (iii) capacities for four IHR-relevant hazards: biological (including food safety and zoonoses), chemical, and radionuclear.

Regional Average Attribute Scores
Core Capacity 1: National legislation, policy, and financing

Legislation, regulations, administrative requirements, policies, or other government instruments, sufficient for implementation of the IHR.

- Legal requirements and instruments are assessed in 100% of countries and implemented in 73% of countries. National policies have been reviewed to facilitate the implementation of functions of the IHR National Focal point (IHR NFP) and of technical core capacities in 91% of countries. Key elements of national IHR legislation have been published in 45% of countries. Policies to facilitate IHR NFP core and expanded functions and to strengthen technical core capacities have been implemented in 73% of countries.

Core Capacity 2: Coordination and NFP Communications

Coordination mechanism between relevant sectors implementing the IHR

- The IHR NFP has been established in 100% of countries. Information on obligations of the NFP under IHR has been disseminated to relevant authorities and stakeholders in 91% of countries. Additional roles and responsibilities for the IHR NFP functions have been implemented in 73% of countries. The functions of the NFP have been evaluated for effectiveness in 45% of countries. The NFP provides WHO with updated contact information and confirmation of the NFP on an annual basis in 100% of countries.

- Use of the IHR Event Information Site as an integral information resource was reported by 82% of countries. An active IHR website or web page has been established in 55% of countries.

- 100% of countries report having a multisectoral, multidisciplinary committee, body or task force to address IHR requirements on surveillance and response for a PHEIC. Coordination between relevant ministries on events that may constitute a public health event
of national or international concern (PHEIC) was reported by 100% of countries as being in place. Standard Operating Procedures (SOPs) are available for coordination between IHR NFP and stakeholders of relevant sectors in 64% of countries. Coordination mechanisms have been tested in 82% of countries through an actual event occurrence or through exercises and 73% report these mechanisms have been updated as needed. Action plans have been developed to incorporate lessons learnt from multisectoral and multidisciplinary coordination and communication mechanisms in 55% of countries.

- National stakeholders involved in the implementation of IHR have been identified by 100% of countries and 64% disseminate annual updates on the status of IHR implementation to stakeholders across all sectors. Roles and responsibilities of various stakeholders under the IHR have been defined in 73% of countries and disseminated in 55%. Plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR have been implemented in 55% of countries.

Core Capacity 3: Surveillance

*Early warning function for detection of public health events in indicator-based (Routine) surveillance (IBS)*

- Lists of priority diseases or conditions for surveillance as well as case definitions for priority diseases are available in 100% of countries. Also, 100% of countries have designated specific units for surveillance of public health risks and 55% of countries indicate timely reporting from at least 80% of all reporting units.

- Surveillance data on epidemic prone and priority diseases is analyzed at least weekly at national and sub-national levels in 91% of countries. 82% of countries have defined baseline estimates, trends, and thresholds for alert and action for the local public health response level for priority diseases/events. In 82% of countries, reports or other documentation show that deviations or values...
Exceeding thresholds are detected and used for action at the primary public health response level. Regular feedback of surveillance results is disseminated to all levels and relevant stakeholders in 91% of countries.

- Evaluations of the early warning function of the indicator-based surveillance have been carried out and country experiences, findings, and lessons learnt have been shared with the global community in 73% of countries. 64% have shared global experiences, findings, and lessons learnt on IBS with the global community.

**Event-Based Surveillance**

- SOPs and guidelines for event-based surveillance are available in 91% of countries. Designated unit(s) for event-based surveillance that may be part of an existing routine surveillance system were reported in 100% of countries. SOPs and guidelines for event capture, reporting, confirmation, verification, assessment, and notification have been developed and disseminated in 64% of countries.

- Information sources for public health events and risks have been identified in 82% of countries. A system at national and/or sub-national levels for capturing and registering public health events from a variety of sources, including media (print, broadcast, community, electronic, internet etc.), is in place in 82% of countries. 73% have actively engaged and sensitized community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events. In 55% of countries, arrangements have been established with neighboring countries to share data on surveillance and the control of public health events that may be of international concern. In 64% of countries, implementation of local community reporting has been evaluated and updated as needed.

- Country experiences and findings on implementation of event-based surveillance and the integration with indicator-based surveillance has been documented in 45% of countries and shared with the global community in 36% of countries.

- The decision instrument in Annex 2 of the IHR (2005) is used to notify WHO in 91% of countries and in 82% its use has been reviewed, with procedures for decision making updated on the basis of lessons learnt in 64%. Country experiences and findings in notification and use of Annex 2 of the IHR have been documented in 27% of countries. And shared with the global community in 18%. Events that meet the criteria for notification under Annex 2 of IHR have been notified by the IHR NFP to WHO within 24 hours of conducting risk assessments over the last 12 months in 73% of countries. All events identified as urgent within the past 12 months were assessed within 48 hours of reporting in 73% of countries reporting. The IHR NFP has responded to all verification requests from WHO within 24 hours in 82% of countries.
Core Capacity 4: Response

Public Health Emergency Response mechanisms

- 91% of countries report implementing response procedures for a real or simulated public health response in the past 12 months.
- Case management guidelines are in place for priority conditions in 100% of countries.
- In 100% of countries, management procedures have been established for command, communications, and control during public health emergency response operations. A functional, dedicated command and control operations centre at the national or other relevant level exists in 82% of countries. Emergency response management procedures have been evaluated after a real or simulated public health response in 82% of countries and updated in 73%. Assistance from 52% of countries has been offered to other States Parties for developing their response capacities or implementing control measures.
- Resources for rapid response during outbreaks of national or international concern are accessible in 91% of countries. Rapid Response Teams (RRT) are available in 91% of countries, and 73% have SOPs available for the deployment of RRT members. In 91% of countries, multidisciplinary RRT can be deployed within 48 hours from the time when the decision to respond is taken. Evaluations of response including the timeliness and quality of response are systematically carried out in 64% of countries. Staff (including RRT members) have been trained in specimen collection and transport was reported by 100% of countries.

Infection Prevention and Control (IPC) at national and hospital levels

- In 91% of countries, responsibilities are assigned for surveillance of health-care-associated infections and in 82% of countries for anti-microbial resistance. In 91% of countries, national infection prevention and control policies/guidelines, and an operational plan for infection control are available and have been implemented nationwide in 55% of countries.
- SOPs, guidelines, and protocols for IPC are available to all hospitals in 82% of countries, and defined norms or guidelines for protecting health-care workers have been developed in 82% of countries. Infection control measures and their effectiveness are regularly evaluated and published in 45% of countries. 73% report that tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions according to national or international guidelines. In 55% of countries, qualified IPC professionals are in place. 55% of countries carry out surveillance within high risk groups to promptly detect and investigate clusters of infectious disease patients, as well as unexplained illnesses in health workers. A national programme for protecting health-care workers has been implemented in 64% of countries.
- A monitoring system for antimicrobial resistance (AMR) has been established in 55% of countries. In 36% of countries have implemented an AMR monitoring system, and 45% have available data on the magnitude and trends in AMR.
Core Capacity 5: Preparedness

Multi-hazard National Public Health emergency Preparedness & Response Plan

- An assessment of the capacity of existing national structures and resources to meet IHR core capacities for the implementation of IHR have been conducted in 91% of countries.

- A national plan to meet the IHR core capacity requirements has been developed (Annex 1A Article 2) in 100% of countries and a national public health emergency response plan for IHR related hazards and Points of Entry (PoE) has been developed (Annex 1A, Article 6g) in 73% of countries. National public health emergency response plan(s) have been implemented or tested in 64% of countries in an actual emergency or simulation and updated as needed in 64%.

- In 73% of countries, a procedure or strategy is in place to reallocate or mobilize resources from national and sub-national levels to support action at community/primary response levels and the strategy has been implemented in 73% and reviewed and updated in 55%. Surge capacity is available in 82% of countries. Surge capacity has been tested either through response to a public health event or during an exercise in 55% of countries.

- Experiences and findings on emergency response and in mobilizing surge capacity have been documented in 64% of countries and shared with the global community in 45%.

Public health risk and resource mapping

- A national risk assessment to identify the most likely sources of “urgent public health event” has been conducted in 73% of countries. National resources have been mapped in 64% of countries to address priority risks with national profiles on risks and resources developed in 64%. The national risk profile is assessed regularly in 55% of countries. Regular assessment of the national resources for priority risks are performed by 64% of countries.

- A directory of experts in health and other sectors to support a response to IHR-related hazards is available in 100% of countries.

- A plan for management and distribution (if applicable) of national stockpiles is available in 100% of countries and 45% have stockpiles (critical stock levels) available and accessible for responding to the country’s priority biological, chemical, and radiological events and other emergencies. Contributions to international stockpiles are made by 18% of countries.
Core Capacity 6: Risk Communication

Mechanisms for effective risk communication during a public health emergency

- Risk communication partners and stakeholders have been identified in 100% of countries and a risk communication plan has been developed in 82%. Plans have been validated by 55% of countries through an actual emergency or simulation exercise in the past 12 months.

- Policies, SOPs, or guidelines on the clearance and release of information during a public health event have been developed in 82% of countries. In 91% of countries, regularly updated information sources are accessible to media and the public for information dissemination. Accessible and relevant IEC (Information, Education and Communications) materials are tailored to the needs of the population in 91% of countries.

- Evaluation of public health communication after emergencies, including for timeliness, transparency, and appropriateness of communications, and updating SOPs as needed following evaluation of the public health communication has taken place in 55% of countries. The results of evaluations have been used to update the risk communications plan in 55% of countries and 9% have shared the results of these evaluations with the global community.

- 91% of countries report informing populations and partners of a real or potential risk within 24 hours of confirmation in the last three national or international public health emergencies.
Core 7: Human Resource Capacity

Human resources available to implement IHR Core Capacity Requirements

- In 82% of countries, a unit has been identified to assess human resource capacities to meet the country’s IHR requirements. A needs assessment has been conducted to identify gaps in human resources and training (numbers and competencies) to meet IHR requirements in 36% of countries. A workforce development or training plan has been developed that includes human resource requirements for IHR in 73% of countries. Specific programs with allocated budgets to train workforces in IHR relevant hazards exist in 64% of countries. Progress for meeting workforce numbers and skills is consistent with training program milestones in 73% of countries.

- A strategy has been developed for the country to access field epidemiology training (one year or more) in-country, regionally, or internationally in 91% of countries and implemented in 73%.

Core Capacity 8: Laboratory

Laboratory services to test for priority health threats

- 91% of countries have policies in place to ensure the quality of laboratory diagnostic capacities. National laboratory quality standards/guidelines are available in 82% of countries.

- A network of national and international laboratories is in place to meet diagnostic and confirmatory requirements and support outbreak investigations for events specified in Annex 2 of the IHR in 91% of countries.
- National laboratory capacity is in place in 82% of countries to meet diagnostic and confirmatory requirements to support outbreak investigations for IHR events. An up-to-date inventory of public and private laboratories with relevant diagnostic capacity is available in 82% of countries and the inventory is accessible in 82%.

- National reference laboratories successfully participate in External Quality Assessment schemes for diagnostic laboratories for major public health disciplines in 100% of countries. More than 10 non-AFP hazardous specimens per year were referred to national or international reference laboratories for examination in 73% of countries.

- All national reference laboratories are certified or accredited to international standards or to national standards adapted from international standards in 73% of countries.

- National regulations are in place which are compatible with international guidelines for packaging and transport of clinical specimens in 91% of countries, and a functional system for collection, packaging, and transport of clinical specimens is available in 100% of countries. Staff at national and other relevant levels have been trained on the safe shipment of infectious substances according to international standards in 100% of countries. 82% of countries reporting have pre-positioned collection and transportation kits at appropriate levels. Clinical specimens from investigation of urgent public health events can be delivered to appropriate laboratories within the appropriate timeframe in 82% of countries with 91% of countries reporting the shipment process consistently meets ICAO/IATA standards. At least 10 hazardous specimens are shipped by 64% of countries internationally per year as part of investigations or exercises.

**Laboratory biosafety and biosecurity practices**

- In 73% of countries, a responsible entity has been designated for laboratory biosafety and biosecurity. An institution or person responsible for inspection of laboratories for compliance with biosafety requirement has been identified in 73% of countries.

- Biosafety guidelines are accessible to laboratories in 82% of countries. Regulations, policies, or strategies for laboratory biosafety are available in 82% of countries. Relevant staff have been trained on biosafety guidelines in 82% of countries. A biorisk assessment in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste, has been conducted in 55% of countries.
Points of Entry

General obligations required at Points of Entry

- A review meeting (or other appropriate method) to designate Points of Entry (PoEs) has been conducted in 82% of countries and 91% have identified designated ports, ground crossings (as relevant), or airports for development of capacities specified in Annex 1. A list of ports authorized to offer ship sanitation certificates has been sent to WHO as applicable in 55% of countries.

- Relevant legislation, regulations, administrative acts, or other government instruments to implement IHR at designated PoEs has been updated as needed in 82% of countries. Updated IHR health documents have been implemented at designated PoEs in 73% of countries.

- 73% of countries report assessing all designated ports.

- Mechanisms for the exchange of information between designated PoEs and medical facilities are in place in 91% of countries. Procedures for coordination and communication between the IHR NFP and PoEs competent authority are in place in 82% of countries and have been tested in 55%. Procedures for communication internationally between PoEs competent authorities and other countries’ PoE competent authorities have been tested 64% of countries and updated as needed in 9%. Bilateral agreements concerning prevention or control of international transmission of disease at designated PoEs have been put in place in 27% of countries.

Effective surveillance at Points of Entry

- Priority conditions for surveillance at designated PoEs have been identified in 82% of countries and 73% have shared surveillance information at designated PoEs with the surveillance department/unit. A review of surveillance health threats at designated PoEs have been conducted in the last 12 months 64% of countries and published in 18%.

Effective response at Points of Entry

- SOPs for response at PoEs are available in 64% of countries. Results of the effectiveness of response to public health events at PoEs has been evaluated in 27% and published in 9% of countries.
Hazard: Zoonotic Events

Mechanisms for detecting and responding to zoonoses and potential zoonoses

- In 100% of countries, there is a coordination mechanism within the responsible government authority/ies for the detection of and response to zoonotic events. A national policy or strategy is in place for the surveillance and response to zoonotic events in 100% of countries. Focal points responsible for animal health for coordination with the MoH and/or IHR NFP have been designated in 91% of countries. 100% of countries have functional mechanisms for intersectoral collaboration which include animal and human health surveillance units and laboratories have been established and documented.

- In 100% of countries, there is a list of priority zoonotic diseases with case definitions available.

- Systematic and timely collection and collation of zoonotic disease data is performed in 91% of countries. A timely and systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks exists in 91% of countries. Zoonotic disease surveillance is implemented with a community component in 82% of countries.

- Laboratory capacity, nationally or internationally to confirm priority zoonotic events, is accessible in 91% of countries.

- A regularly updated roster (list) of experts that can respond to zoonotic events is available in 82% of countries.

- A mechanism for response to outbreaks of zoonotic diseases by human and animal health sectors has been established in 100% of countries. More than 80% of zoonotic events of potential national and international concern are responded to in a timely manner by 82% of countries.

- Country experiences and findings related to zoonotic risks and events of potential national and international concern are shared with the global community by 73% of countries.
Hazard: Food Safety

Detecting and responding to foodborne disease and food contamination

- National or international food safety standards are available in 100% of countries. 91% have national food laws, regulations, or policies in place to facilitate food safety control. Laws are up to date in 100% of countries and implemented in 100%.

- An operational national multisectoral mechanism for food safety events is in place in 82% of countries. A functioning coordination mechanism has been established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP in 82% of countries and 91% are active members of the INFOSAN network.

- A list of priority food safety risks is available in 100% of countries.

- Guidelines or manuals on the surveillance, assessment, and management of priority food safety risks are available in 82% of countries and have been implemented in 73%. Epidemiological data related to food contamination are collected and systematically analyzed by 64% of countries. Epidemiological data is also shared in a timely and systematic manner with other relevant sectors in 91% of countries.

- Laboratory capacity to confirm priority food safety events of national or international concern, including molecular techniques, is accessible in 91% of countries.

- In 91% of countries, a roster of food safety experts is available for assessing and responding to food safety events.

- Plans for responding to Food Safety Events have been implemented in 64% of countries and 14% of countries, tested in an exercise or actual emergency in 64%, and updated as needed in 64%. Risk based food inspection services are in place in 91% of countries. Mechanisms for tracing, recall, and disposal of contaminated products have been established in 73% of countries.

- Communication mechanisms and materials are in place in 82% of countries to inform, educate, and advise stakeholders across the farm-to-fork continuum.

- Food safety control management systems have been implemented in 91% of countries. In 91% of countries, information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards, and regulations. An analysis of food safety events, foodborne illness trends, and outbreaks, which integrate data across the food chain, has been published in 36% of countries.

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Hazard: Chemical Events
Detection, alert, and response to chemical emergencies

- Experts for public health assessment and response to chemical incidents have been identified in 36% of countries.

- In 64%, national policies or plans are in place for chemical event surveillance, alert, and response. In 82% of countries, national authorities responsible for chemical events have designated a focal point for coordination with the MOH and/or the IHR NFP. Coordination mechanisms with relevant sectors are established in 64% of countries with 36% reporting a functional coordination mechanism implemented for surveillance and timely response across sectors. Surveillance is in place for chemical events, intoxication, or poisonings in 64% of countries. A list of priority chemical events/syndromes that may constitute a potential public health event of national and international concern is available in 64% of countries.

- An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies is available in 27% of countries and a national chemical profile has been developed in 45%.

- Manuals and SOPs for rapid assessment, case management, and control of chemical events are available in 55% and have been disseminated in 36% of countries. A timely and systematic information exchange is carried out between appropriate chemical units and surveillance units about urgent chemical events and potential chemical risks in 36% of countries.

- An emergency response plan that defines the roles and responsibilities of relevant agencies for chemical emergencies is available in 55% of countries.

- Laboratory capacity or access to laboratory capacity to confirm priority chemical events is available in 82% of countries.

- Chemical event response plans have been tested through the occurrence of a real event or through a simulation exercise in 36% of countries and updated as needed in 18% of countries.

- 45% of countries report an adequately-resourced Poison Centre(s) is in place.

- Country experience and findings regarding chemical events and risk of national and international concern have been shared with the global community by 36% of countries.
Hazard: Radiological Events
Detecting and responding to radiological and nuclear emergencies

- Experts have been identified for public health assessment and response to radiological and nuclear events in 55% of countries.

- A national policy or plan for the detection, assessment and response to radiation emergencies is in place in 36%. Plans have been implemented in 27%. A national policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and medical services, is in place in 45% of countries.

- A functional coordination and communication mechanism has been established between relevant national competent authorities responsible for nuclear regulatory control/safety and relevant sectors in 45% of countries. Focal points for radiological and nuclear events for coordination and communication with the MOH and/or the NFP have been established in 36% of countries.

- Monitoring for radiation emergencies is in place in 64% of countries. A systematic information exchange between radiological-competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public health emergency of international concern is in place in 27% of countries.

- Technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation, and management of radiation emergencies have been developed in 36% of countries and have been evaluated and update in 27%. A radiation emergency response plan is in place in 27% of countries. Radiation emergency response drills are carried out regularly at national level, including requesting international assistance (as needed) and international notification, in 27% of countries.

- A mechanism is in place in 45% of countries for access to health facilities (inside or outside of the country) with capacity to manage patients of radiation emergencies.

- Laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards is available in 45% of countries. Regularly updated collaborative mechanisms are in place in 27% of countries for access to specialized laboratories that are able to perform bioassays, biological dosimetry by cytogenetic analysis, and ESR (electron-spin resonance technique). These mechanisms have been evaluated in 27% of countries.

- 36%, of countries have documented and shared experiences with the detection and response to radiological risks and events with the global community.
NATIONAL CAPACITY MONITORING
With the coming into force of the International Health Regulations (2005) (hereinafter “IHR” or “the Regulations”) on June 15, 2007, all IHR States Parties are required to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response as specified in the IHR and to develop a plan of action to ensure that these capacities will be present and functioning throughout their territories by 2012\(^1\). WHO is mandated to provide appropriate tools, guidance, and support to States Parties to achieve these goals. In accordance with Article 54 of the IHR and related resolution WHA61.2, States Parties and WHO are required to report annually to the World Health Assembly on the implementation of the Regulations. For this purpose, a monitoring framework was developed using technical expert views drawn globally from WHO Member States, technical institutions, and WHO partners, and from within WHO.

In 2013, 96% of countries (i.e. 26/27) in the Western Pacific Region responded to the IHR Monitoring Questionnaire, which is the same as 2012 (96%) and higher than 2011 (70%).

Throughout this Regional Summary sheet, percentage values relate to responding countries only. Information extracted from the inputs provided by National Focal Points is reflected here to provide an overview of the progress achieved in the region as reported by State Parties in 2013. To obtain a full overview of progress of all the indicators please consult the individual Country Profiles 2013.

Analysis of the strengths and weaknesses in this regional profile is based on self-reported data submitted by States Parties with the IHR Monitoring Questionnaire 2013. Specific country contexts and other sources of information, if available, may also need to be considered in identifying priorities and needs and planning for future activities.

For further reference and information on individual elements (core capacities, indicators, attributes), please consult: http://www.who.int/ihr/IHR.Monitoring_Framework.Checklist.and.Indicators.pdf.

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This summary provides information on (i) eight core capacities, (ii) development of capacities at points of entry, and (iii) capacities for four IHR-relevant hazards: biological (including food safety and zoonoses), chemical, and radionuclear.

Regional Average Attribute Scores
Core Capacity 1: National legislation, policy, and financing

Legislation, regulations, administrative requirements, policies, or other government instruments, sufficient for implementation of the IHR.

- Legal requirements and instruments are assessed in 92% of countries and implemented in 73% of countries. National policies have been reviewed to facilitate the implementation of functions of the IHR National Focal point (IHR NFP) and of technical core capacities in 81% of countries. Key elements of national IHR legislation have been published in 62% of countries. Policies to facilitate IHR NFP core and expanded functions and to strengthen technical core capacities have been implemented in 73% of countries.

Core Capacity 2: Coordination and NFP Communications

Coordination mechanism between relevant sectors implementing the IHR

- The IHR NFP has been established in 100% of countries. Information on obligations of the NFP under IHR has been disseminated to relevant authorities and stakeholders in 88% of countries. Additional roles and responsibilities for the IHR NFP functions have been implemented in 69% of countries. The functions of the NFP have been evaluated for effectiveness in 46% of countries. The NFP provides WHO with updated contact information and confirmation of the NFP on an annual basis in 96% of countries.

- Use of the IHR Event Information Site as an integral information resource was reported by 85% of countries. An active IHR website or web page has been established in 35% of countries.

- 85% of countries report having a multisectoral, multidisciplinary committee, body or task force to address IHR requirements on surveillance and response for a PHEIC. Coordination between relevant ministries on events that may constitute a public health event
of national or international concern (PHEIC) was reported by 100% of countries as being in place. Standard Operating Procedures (SOPs) are available for coordination between IHR NFP and stakeholders of relevant sectors in 85% of countries. Coordination mechanisms have been tested in 88% of countries through an actual event occurrence or through exercises and 77% report these mechanisms have been updated as needed. Action plans have been developed to incorporate lessons learnt from multisectoral and multidisciplinary coordination and communication mechanisms in 73% of countries.

- National stakeholders involved in the implementation of IHR have been identified by 96% of countries and 81% disseminate annual updates on the status of IHR implementation to stakeholders across all sectors. Roles and responsibilities of various stakeholders under the IHR have been defined in 88% of countries and disseminated in 81%. Plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR have been implemented in 73% of countries.

Core Capacity 3: Surveillance

*Early warning function for detection of public health events in indicator-based (Routine) surveillance (IBS)*

- Lists of priority diseases or conditions for surveillance as well as case definitions for priority diseases are available in 100% of countries. Also, 96% of countries have designated specific units for surveillance of public health risks and 85% of countries indicate timely reporting from at least 80% of all reporting units.

- Surveillance data on epidemic prone and priority diseases is analyzed at least weekly at national and sub-national levels in 100% of countries. 96% of countries have defined baseline estimates, trends, and thresholds for alert and action for the local public health response level for priority diseases/events. In 92% of countries, reports or other documentation show that deviations or values exceeding thresholds are detected and used for
action at the primary public health response level. Regular feedback of surveillance results is disseminated to all levels and relevant stakeholders in 88% of countries.

- Evaluations of the early warning function of the indicator-based surveillance have been carried out and country experiences, findings, and lessons learnt have been shared with the global community in 85% of countries. 73% have shared global experiences, findings, and lessons learnt on IBS with the global community.

**Event-Based Surveillance**

- SOPs and guidelines for event-based surveillance are available in 81% of countries. Designated unit(s) for event-based surveillance that may be part of an existing routine surveillance system were reported in 92% of countries. SOPs and guidelines for event capture, reporting, confirmation, verification, assessment, and notification have been developed and disseminated in 69% of countries.

- Information sources for public health events and risks have been identified in 92% of countries. A system at national and/or sub-national levels for capturing and registering public health events from a variety of sources, including media (print, broadcast, community, electronic, internet etc.), is in place in 81% of countries. 77% have actively engaged and sensitized community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events. In 100% of countries, arrangements have been established with neighboring countries to share data on surveillance and the control of public health events that may be of international concern. In 69% of countries, implementation of local community reporting has been evaluated and updated as needed.

- Country experiences and findings on implementation of event-based surveillance and the integration with indicator-based surveillance has been documented in 73% of countries and shared with the global community in 65% of countries.

- The decision instrument in Annex 2 of the IHR (2005) is used to notify WHO in 96% of countries and in 58% its use has been reviewed, with procedures for decision making updated on the basis of lessons learnt in 69%. Country experiences and findings in notification and use of Annex 2 of the IHR have been documented in 62% of countries. And shared with the global community in 54%. Events that meet the criteria for notification under Annex 2 of IHR have been notified by the IHR NFP to WHO within 24 hours of conducting risk assessments over the last 12 months in 81% of countries. All events identified as urgent within the past 12 months were assessed within 48 hours of reporting in 81% of countries reporting. The IHR NFP has responded to all verification requests from WHO within 24 hours in 81% of countries.
Core Capacity 4: Response

Public Health Emergency Response mechanisms

- 88% of countries report implementing response procedures for a real or simulated public health response in the past 12 months.

- Case management guidelines are in place for priority conditions in 96% of countries.

- In 92% of countries, management procedures have been established for command, communications, and control during public health emergency response operations. A functional, dedicated command and control operations centre at the national or other relevant level exists in 85% of countries. Emergency response management procedures have been evaluated after a real or simulated public health response in 85% of countries and updated in 81%. Assistance from 52% of countries has been offered to other States Parties for developing their response capacities or implementing control measures.

- Resources for rapid response during outbreaks of national or international concern are accessible in 92% of countries. Rapid Response Teams (RRT) are available in 96% of countries, and 81% have SOPs available for the deployment of RRT members. In 85% of countries, multidisciplinary RRT can be deployed within 48 hours from the time when the decision to respond is taken. Evaluations of response including the timeliness and quality of response are systematically carried out in 81% of countries. Staff (including RRT members) have been trained in specimen collection and transport was reported by 92% of countries.

Infection Prevention and Control (IPC) at national and hospital levels

- In 96% of countries, responsibilities are assigned for surveillance of health-care-associated infections and in 92% of countries for anti-microbial resistance. In 96% of countries, national infection prevention and control policies/guidelines, and an operational plan for infection control are available and have been implemented nationwide in 85% of countries.

- SOPs, guidelines, and protocols for IPC are available to all hospitals in 96% of countries, and defined norms or guidelines for protecting health-care workers have been developed in 96% of countries. Infection control measures and their effectiveness are regularly evaluated and published in 65% of countries. 92% report that tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions according to national or international guidelines. In 81% of countries, qualified IPC professionals are in place. 85% of countries carry out surveillance within high risk groups to promptly detect and investigate clusters of infectious disease patients, as well as unexplained illnesses in health workers. A national programme for protecting health-care workers has been implemented in 77% of countries.

- A monitoring system for antimicrobial resistance (AMR) has been established in 69% of countries. In 73% of countries have implemented an AMR monitoring system, and 65% have available data on the magnitude and trends in AMR.
Core Capacity 5: Preparedness

Multi-hazard National Public Health emergency Preparedness & Response Plan

- An assessment of the capacity of existing national structures and resources to meet IHR core capacities for the implementation of IHR have been conducted in 77% of countries.

- A national plan to meet the IHR core capacity requirements has been developed (Annex 1A Article 2) in 96% of countries and a national public health emergency response plan for IHR related hazards and Points of Entry (PoE) has been developed (Annex 1A, Article 6g) in 88% of countries. National public health emergency response plan(s) have been implemented or tested in 85% of countries in an actual emergency or simulation and updated as needed in 69%.

- In 88% of countries, a procedure or strategy is in place to reallocate or mobilize resources from national and sub-national levels to support action at community/primary response levels and the strategy has been implemented in 85% and reviewed and updated in 77%. Surge capacity is available in 92% of countries. Surge capacity has been tested either through response to a public health event or during an exercise in 81% of countries.

- Experiences and findings on emergency response and in mobilizing surge capacity have been documented in 62% of countries and shared with the global community in 46%.

Public health risk and resource mapping

- A national risk assessment to identify the most likely sources of “urgent public health event” has been conducted in 73% of countries. National resources have been mapped in 65% of countries to address priority risks with national profiles on risks and resources developed in 65%. The national risk profile is assessed regularly in 58% of countries. Regular assessment of the national resources for priority risks are performed by 58% of countries.

- A directory of experts in health and other sectors to support a response to IHR-related hazards is available in 88% of countries.

- A plan for management and distribution (if applicable) of national stockpiles is available in 88% of countries and 69% have stockpiles (critical stock levels) available and accessible for responding to the country’s priority biological, chemical, and radiological events and other emergencies. Contributions to international stockpiles are made by 27% of countries.
Core Capacity 6: Risk Communication

Mechanisms for effective risk communication during a public health emergency

- Risk communication partners and stakeholders have been identified in 100% of countries and a risk communication plan has been developed in 92%. Plans have been validated by 81% of countries through an actual emergency or simulation exercise in the past 12 months.

- Policies, SOPs, or guidelines on the clearance and release of information during a public health event have been developed in 77% of countries. In 96% of countries, regularly updated information sources are accessible to media and the public for information dissemination. Accessible and relevant IEC (Information, Education and Communications) materials are tailored to the needs of the population in 100% of countries.

- Evaluation of public health communication after emergencies, including for timeliness, transparency, and appropriateness of communications, and updating SOPs as needed following evaluation of the public health communication has taken place in 77% of countries. The results of evaluations have been used to update the risk communications plan in 62% of countries and 38% have shared the results of these evaluations with the global community.

- 88% of countries report informing populations and partners of a real or potential risk within 24 hours of confirmation in the last three national or international public health emergencies.

Map disclaimer: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
Core 7: Human Resource Capacity

*Human resources available to implement IHR Core Capacity Requirements*

- In 88% of countries, a unit has been identified to assess human resource capacities to meet the country's IHR requirements. A needs assessment has been conducted to identify gaps in human resources and training (numbers and competencies) to meet IHR requirements in 77% of countries. A workforce development or training plan has been developed that includes human resource requirements for IHR in 77% of countries. Specific programs with allocated budgets to train workforces in IHR relevant hazards exist in 73% of countries. Progress for meeting workforce numbers and skills is consistent with training program milestones in 62% of countries.

- A strategy has been developed for the country to access field epidemiology training (one year or more) in-country, regionally, or internationally in 73% of countries and implemented in 69%.

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Core Capacity 8: Laboratory

*Laboratory services to test for priority health threats*

- 92% of countries have policies in place to ensure the quality of laboratory diagnostic capacities. National laboratory quality standards/guidelines are available in 85% of countries.

- A network of national and international laboratories is in place to meet diagnostic and confirmatory requirements and support outbreak investigations for events specified in Annex 2 of the IHR in 100% of countries.
- National laboratory capacity is in place in 88% of countries to meet diagnostic and confirmatory requirements to support outbreak investigations for IHR events. An up-to-date inventory of public and private laboratories with relevant diagnostic capacity is available in 88% of countries and the inventory is accessible in 73%.

- National reference laboratories successfully participate in External Quality Assessment schemes for diagnostic laboratories for major public health disciplines in 96% of countries. More than 10 non-AFP hazardous specimens per year were referred to national or international reference laboratories for examination in 65% of countries.

- All national reference laboratories are certified or accredited to international standards or to national standards adapted from international standards in 77% of countries.

- National regulations are in place which are compatible with international guidelines for packaging and transport of clinical specimens in 92% of countries, and a functional system for collection, packaging, and transport of clinical specimens is available in 88% of countries. Staff at national and other relevant levels have been trained on the safe shipment of infectious substances according to international standards in 92% of countries. 85% of countries reporting have pre-positioned collection and transportation kits at appropriate levels. Clinical specimens from investigation of urgent public health events can be delivered to appropriate laboratories within the appropriate timeframe in 88% of countries with 100% of countries reporting the shipment process consistently meets ICAO/IATA standards. At least 10 hazardous specimens are shipped by 92% of countries internationally per year as part of investigations or exercises.

**Laboratory biosafety and biosecurity practices**

- In 81% of countries, a responsible entity has been designated for laboratory biosafety and biosecurity. An institution or person responsible for inspection of laboratories for compliance with biosafety requirement has been identified in 65% of countries.

- Biosafety guidelines are accessible to laboratories in 85% of countries. Regulations, policies, or strategies for laboratory biosafety are available in 81% of countries. Relevant staff have been trained on biosafety guidelines in 81% of countries. A biorisk assessment in laboratories to guide and update biosafety regulations, procedures and practice, including for decontamination and management of infectious waste, has been conducted in 65% of countries.
Points of Entry
General obligations required at Points of Entry

- A review meeting (or other appropriate method) to designate Points of Entry (PoEs) has been conducted in 88% of countries and 88% have identified designated ports, ground crossings (as relevant), or airports for development of capacities specified in Annex 1. A list of ports authorized to offer ship sanitation certificates has been sent to WHO as applicable in 62% of countries.

- Relevant legislation, regulations, administrative acts, or other government instruments to implement IHR at designated PoEs has been updated as needed in 77% of countries. Updated IHR health documents have been implemented at designated PoEs in 77% of countries.

- 65% of countries report assessing all designated ports.

- Mechanisms for the exchange of information between designated PoEs and medical facilities are in place in 88% of countries. Procedures for coordination and communication between the IHR NFP and PoEs competent authority are in place in 88% of countries and have been tested in 85%. Procedures for communication internationally between PoEs competent authorities and other countries’ PoE competent authorities have been tested 73% of countries and updated as needed in 65%. Bilateral agreements concerning prevention or control of international transmission of disease at designated PoEs have been put in place in 77% of countries.

Effective surveillance at Points of Entry

- Priority conditions for surveillance at designated PoEs have been identified in 88% of countries and 88% have shared surveillance information at designated PoEs with the surveillance department/unit. A review of surveillance health threats at designated PoEs have been conducted in the last 12 months 73% of countries and published in 38%.

Effective response at Points of Entry

- SOPs for response at PoEs are available in 77% of countries. Results of the effectiveness of response to public health events at PoEs has been evaluated in 54% and published in 42% of countries.
Hazard: Zoonotic Events
Mechanisms for detecting and responding to zoonoses and potential zoonoses

- In 96% of countries, there is a coordination mechanism within the responsible government authority/ies for the detection of and response to zoonotic events. A national policy or strategy is in place for the surveillance and response to zoonotic events in 85% of countries. Focal points responsible for animal health for coordination with the MoH and/or IHR NFP have been designated in 88% of countries. 85% of countries have functional mechanisms for intersectoral collaboration which include animal and human health surveillance units and laboratories have been established and documented.

- In 85% of countries, there is a list of priority zoonotic diseases with case definitions available.

- Systematic and timely collection and collation of zoonotic disease data is performed in 62% of countries. A timely and systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks exists in 81% of countries. Zoonotic disease surveillance is implemented with a community component in 69% of countries.

- Laboratory capacity, nationally or internationally to confirm priority zoonotic events, is accessible in 88% of countries.

- A regularly updated roster (list) of experts that can respond to zoonotic events is available in 69% of countries.

- A mechanism for response to outbreaks of zoonotic diseases by human and animal health sectors has been established in 81% of countries. More than 80% of zoonotic events of potential national and international concern are responded to in a timely manner by 65% of countries.

- Country experiences and findings related to zoonotic risks and events of potential national and international concern are shared with the global community by 50% of countries.
Hazard: Food Safety
Detecting and responding to foodborne disease and food contamination

- National or international food safety standards are available in 85% of countries 92% have national food laws, regulations, or policies in place to facilitate food safety control. Laws are up to date in 85% of countries and implemented in 85%.

- An operational national multisectoral mechanism for food safety events is in place in 85% of countries. A functioning coordination mechanism has been established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP in 92% of countries and 92% are active members of the INFOSAN network.

- A list of priority food safety risks is available in 73% of countries.

- Guidelines or manuals on the surveillance, assessment, and management of priority food safety risks are available in 65% of countries and have been implemented in 69%. Epidemiological data related to food contamination are collected and systematically analyzed by 62% of countries. Epidemiological data is also shared in a timely and systematic manner with other relevant sectors in 85% of countries.

- Laboratory capacity to confirm priority food safety events of national or international concern, including molecular techniques, is accessible in 73% of countries.

- In 73% of countries, a roster of food safety experts is available for assessing and responding to food safety events.

- Plans for responding to Food Safety Events have been implemented 69% of countries and 14% of countries, tested in an exercise or actual emergency in 65%, and updated as needed in 54%. Risk based food inspection services are in place in 92% of countries. Mechanisms for tracing, recall, and disposal of contaminated products have been established in 92% of countries.

- Communication mechanisms and materials are in place in 88% of countries to inform, educate, and advise stakeholders across the farm-to-fork continuum.

- Food safety control management systems have been implemented in 92% of countries. In 85% of countries, information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards, and regulations. An analysis of food safety events, foodborne illness trends, and outbreaks, which integrate data across the food chain, has been published in 42% of countries.
Hazard: Chemical Events

Detection, alert, and response to chemical emergencies

- Experts for public health assessment and response to chemical incidents have been identified in 65% of countries.

- In 50%, national policies or plans are in place for chemical event surveillance, alert, and response. In 65% of countries, national authorities responsible for chemical events have designated a focal point for coordination with the MOH and/or the IHR NFP. Coordination mechanisms with relevant sectors are established in 69% of countries with 62% reporting a functional coordination mechanism implemented for surveillance and timely response across sectors. Surveillance is in place for chemical events, intoxication, or poisonings in 58% of countries. A list of priority chemical events/syndromes that may constitute a potential public health event of national and international concern is available in 50% of countries.

- An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies is available in 62% of countries and a national chemical profile has been developed in 46%.

- Manuals and SOPs for rapid assessment, case management, and control of chemical events are available in 46% and have been disseminated in 38% of countries. A timely and systematic information exchange is carried out between appropriate chemical units and surveillance units about urgent chemical events and potential chemical risks in 62% of countries.

- An emergency response plan that defines the roles and responsibilities of relevant agencies for chemical emergencies is available in 58% of countries.

- Laboratory capacity or access to laboratory capacity to confirm priority chemical events is available in 65% of countries.

- Chemical event response plans have been tested through the occurrence of a real event or through a simulation exercise in 50% of countries and updated as needed in 50% of countries.

- 62% of countries report an adequately-resourced Poison Centre(s) is in place.

- Country experience and findings regarding chemical events and risk of national and international concern have been shared with the global community by 58% of countries.
Hazard: Radiological Events

Detecting and responding to radiological and nuclear emergencies

- Experts have been identified for public health assessment and response to radiological and nuclear events in 69% of countries.

- A national policy or plan for the detection, assessment and response to radiation emergencies is in place in 46%. Plans have been implemented in 42%. A national policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and medical services, is in place in 54% of countries.

- A functional coordination and communication mechanism has been established between relevant national competent authorities responsible for nuclear regulatory control/safety and relevant sectors in 54% of countries. Focal points for radiological and nuclear events for coordination and communication with the MOH and/or the NFP have been established in 62% of countries.

- Monitoring for radiation emergencies is in place in 42% of countries. A systematic information exchange between radiological-competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public health emergency of international concern is in place in 42% of countries.

- Technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation, and management of radiation emergencies have been developed in 38% of countries and have been evaluated and update in 31%. A radiation emergency response plan is in place in 38% of countries. Radiation emergency response drills are carried out regularly at national level, including requesting international assistance (as needed) and international notification, in 31% of countries.

- A mechanism is in place in 62% of countries for access to health facilities (inside or outside of the country) with capacity to manage patients of radiation emergencies.

- Laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards is available in 69% of countries. Regularly updated collaborative mechanisms are in place in 62% of countries for access to specialized laboratories that are able to perform bioassays, biological dosimetry by cytogenetic analysis, and ESR (electron-spin resonance technique). These mechanisms have been evaluated in 35% of countries.

- 38%, of countries have documented and shared experiences with the detection and response to radiological risks and events with the global community.