Action plan to improve public health preparedness and response in the WHO European Region

The draft action plan to improve public health preparedness and response in the WHO European Region, 2018–2023, aims to strengthen national and regional capacities to effectively prevent, prepare for, detect and respond to public health threats and emergencies and to provide support to affected countries, when necessary. It takes into account actions taken and lessons learned in the European Region since the International Health Regulations (IHR) (2005) entered into force in 2007, and as presented in the guiding document EUR/RC67/13, on accelerating implementation of the IHR (2005) and strengthening laboratory capacities for better health in the European Region, at the 67th session of the Regional Committee for Europe (RC67) in September 2017. It builds on the five-year global strategic plan to improve public health preparedness and response, 2018–2023, and is tailored to the needs of the European Region.

The present document outlines the draft action plan to be implemented by States Parties and the WHO Regional Office for Europe in collaboration with key partners and in line with the requirements of the IHR (2005). It is structured around the three strategic pillars described in the global strategic plan: (1) building and maintaining States Parties' core capacities required by the IHR (2005); (2) strengthening event management and compliance with the requirements under the IHR (2005); and (3) measuring progress and promoting accountability. The action plan will be accompanied by a monitoring framework with indicators for each technical area of the strategic pillars.

The regional action plan incorporates feedback received from the Member States during the Standing Committee of the Regional Committee (May 2018) and through previous web-based and face-to-face consultations on the global strategic plan. The revised regional action plan, incorporating the feedback received, is submitted to the 68th session of the Regional Committee for Europe, accompanied by a draft resolution for its adoption.

Contents

Introduction

1.   When the International Health Regulations (IHR) (2005) entered into force on
15 June 2007, States Parties unanimously agreed to "develop, strengthen and maintain … the
capacity to respond promptly and effectively to public health risks and public health
emergencies of international concern" by 2012. Further extensions were granted for the
periods 2012–2014 and 2014–2016 to allow States Parties to undertake the necessary capacity
building to comply with IHR (2005) requirements.

2.   In 2017, in its decision WHA70(11), the World Health Assembly requested the
Director-General "to develop, in full consultation with Member States, including through the
regional committees, a draft five-year global strategic plan to improve public health
preparedness and response … to be submitted for consideration and adoption by the
Seventy-first World Health Assembly" in 2018.

3.   The feedback received from Member States during meetings of the WHO regional
committees and through web-based and face-to-face consultations was incorporated into a
revised draft of the five-year global strategic plan to improve public health preparedness and
response. The global strategic plan was welcomed with appreciation by the World Health
Assembly in May 2018 in decision WHA71(15).

4.   To present the regional priorities for IHR implementation in the WHO European
Region, the WHO Regional Office for Europe, in consultation with Member States and key
partners, submitted document EUR/RC67/13, Accelerating implementation of the IHR (2005)
and strengthening laboratory capacities for better health in the European Region, for
consideration by the 67th Regional Committee (RC67) in September 2017. It was agreed that
the document should serve as the basis for the development of a regional action plan aligned
with the global strategic plan. It would, in addition, allow for the prioritization of all
accelerated actions during 2017–2018.

5.   The action plan to improve public health preparedness and response in the WHO
European Region, 2018–2023 is hereby submitted to RC68, accompanied by a draft resolution
for its adoption.

Current situation, issues and challenges

6.   Member States of the WHO European Region are diverse in terms of geographical and
population sizes, economic performance, epidemiological and risk profiles, health system
maturity[1] and other factors that might influence their health emergency preparedness and
response capacity. The Region is also home to major global air and sea transportation hubs
that enable the movement of passengers and cargo around the world. Several Member States
also have overseas territories, which introduce additional challenges to ensuring health
emergency preparedness across the Region.

7.   Since the entry into force of the IHR (2005) in 2007, WHO has been actively assisting
States Parties in further developing IHR (2005) core capacities and, where necessary, has

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[1] WHO Thirteenth General Programme of Work, 2019–2023:
http://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/

coordinated and assisted in the provision of essential services to States Parties and vulnerable populations affected by emergencies. In the WHO European Region, most States Parties have made good progress in implementing the IHR (2005), but multiple challenges remain.

8.   The information-sharing network under the IHR (2005) is one of the key elements of success in the Region's overall health security. National IHR Focal Points (NFPs) notify WHO of any potential public health events of international concern. On average, 55% of events detected by WHO in 2017 were reported by NFPs, an increase from just 24% in 2007. The timeliness of information sharing has also improved and the use of the Event Information System, through which event-related information is disseminated to NFPs, has increased continuously over the past 10 years.

9.   States Parties have made efforts to encourage sectors other than health to contribute to assessments, planning and interventions aimed at strengthening preparedness and response capacities under the IHR (2005). Nevertheless, effective multisectoral collaboration remains a challenge in many countries. In some States Parties, IHR implementation is perceived as being the sole responsibility of the national health sector. Insufficient legislation or authority to fully operationalize IHR (2005) requirements and to convene the necessary sectors often hinders the effective operation of the NFPs. Legislation outlining roles and responsibilities during emergency situations often lacks the necessary provisions for coordinating an effective and timely response.

10.   Surveillance systems are frequently under-resourced and do not allow for reliable and timely detection, assessment and notification of potential public health events of international concern. Furthermore, formal mechanisms for sharing data between sectors, such as agriculture, veterinary, environment and trade, are often insufficient. Workforce capacity remains limited, particularly in the areas of diagnosis, clinical management, investigation and response.

11.   Laboratory capacity and collaboration through networks has improved in Member States of the WHO European Region, particularly for disease-specific programmes, such as poliomyelitis, measles and rubella, tuberculosis, HIV/AIDS and influenza. However, national public health laboratories and national networks in some Member States of the Region have not yet reached adequate capacity.

12.   An emphasis on strengthening public health capacities at points of entry has improved arrangements for the management of infectious disease, and many States Parties have developed multisectoral public health emergency response plans at designated points of entry. Nevertheless, coordination between national health surveillance mechanisms, the NFPs and the various sectors and authorities operating at the points of entry is often insufficient.

13.   The importance of establishing public health emergency operation centres to coordinate health interventions during emergencies has been recognized and acted on in many, but not all, States Parties. Similarly, risk communication capacity in compliance with IHR (2005) requirements has been scaled up. Yet, the coordination among agencies during the response, to ensure sustained human and financial resources and engagement with communities, needs to be improved.

14.   A lack of accurate information on the status of IHR (2005) capacities and implementation at the country level is a challenge, which impedes the further needs-based

capacity development that is required. In 2016, in the European Region, only 35 of 55 States Parties fulfilled their annual IHR (2005) reporting obligations. In 2016 and 2017 States Parties and WHO have taken steps to build a more accurate picture of capacities using other forms of assessment to complement the obligatory annual reporting.

Vision

15.   The vision reflects a joint commitment by Member States, key partners,[2] and the Regional Office to the following common purpose:

"A WHO European Region where the impact of health emergencies is prevented or minimized".

Goal

16.   The goal is to strengthen and maintain adequate capacities in the European Region to effectively prevent, prepare for, detect and respond to public health threats and to provide assistance to affected countries, when necessary, through three strategic pillars:

- • Strategic pillar 1. Build, strengthen and maintain States Parties' core capacities required under the IHR (2005);

- • Strategic pillar 2. Strengthen event management and compliance with the requirements under the IHR (2005);

- • Strategic pillar 3. Measure progress and promote accountability.

Guiding principles of the draft action plan

17.   Building on the global strategic plan to improve public health preparedness and response, 2018–2023, the European action plan recognizes the interdependence of health emergency preparedness, health systems strengthening and the essential public health functions. The action plan adheres to the framework and principles of the IHR (2005). It strives to contribute to the achievement of the commitment in the Sustainable Development Goals to leave no one behind, through the promotion of universal health coverage, and complies with existing international health policy frameworks.[3] The action plan also recognizes the fundamental importance of country ownership that focuses on a needs-based approach to capacity development and draws, where possible, on domestic sources of funding in order to ensure sustainability. All preparedness and response strategies and actions undertaken by States Parties should be based on national risks, hazards and vulnerabilities and should involve all relevant national and, where applicable, international stakeholders.

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[2] Working in partnership with a variety of actors has been a crucial element of the work of the Regional Office and collaboration with many key partners has been established over the years. Document EUR/RC67/17, Rev.1 Partnerships for health in the WHO European Region (available at
http://www.euro.who.int/__data/assets/pdf_file/0010/346969/67wd17e_Rev.1_Partnerships_170712.pdf?ua=1), presents the vision for partnerships for health in the WHO European Region, taking into account recently adopted WHO reform elements, including the Framework of Engagement with non-State Actors.
[3] The implementation of the action plan will be guided the WHO European health policy framework, Health 2020, the Sendai Framework and the relevant Sustainable Development Goals.

18. The action plan emphasizes the leadership role of WHO in guiding stakeholders to support countries in capacity development and coordinate the provision of assistance during an emergency in line with the IHR (2005); acknowledges existing subregional frameworks;[4] prioritizes WHO support to priority countries[5] in the WHO European Region; and is based on the importance of an all-hazard,[6] as well as One Health approach, focusing on all phases of the emergency management cycle.[7]

Strategic pillar 1. Build, strengthen and maintain States Parties' core capacities required under the IHR (2005)

19. Establishing the capacities required in order to respond effectively and in a timely manner to potential public health emergencies of international concern is an obligation for States Parties under the IHR (2005). Developing these capacities should include efforts to strengthen health systems and to coordinate the mobilization of domestic and international funding through multisectoral action plans.

National policies, plans and legislation

20. National legislation encompasses a broad range of legal, administrative and other governmental instruments that may facilitate the implementation of the IHR (2005) by States Parties. It serves to institutionalize and strengthen the role of the IHR (2005) within a State Party and facilitates the necessary processes, including coordination and communication, among the relevant entities.

21. States Parties will:

(a) ensure political and financial commitments to develop and maintain IHR (2005) implementation at both the regional, national, and subnational levels. This will include the development of national policies and action plans for health emergency preparedness that clearly define the relevant roles, responsibilities, deliverables and timelines; and

(b) improve governance for multisectoral IHR implementation through whole-of-government and whole-of-society approaches. This may include, where necessary, support for the revision of relevant legal and regulatory frameworks and the establishment of mechanisms to ensure coordination between sectors.

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[4] For example, Decision 1082/2013/EU of the European Parliament and of the Council on serious cross-border threats to health.

[5] Based on countries' hazards mapping, vulnerability and health system maturity the following priority countries were selected: Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Ukraine and Uzbekistan.

[6] In adopting the IHR (2005), States Parties agreed to broaden the scope of the Regulations from specific infectious diseases to a risk-based approach that includes biological, chemical, foodborne, radiological, nuclear and other hazards that might affect human health.

[7] The emergency management cycle illustrates the continuous process by which all organizations should plan for and reduce the impact of disasters, react during and immediately following a disaster and take steps to recover after a disaster has occurred.

22. The Regional Office, in collaboration with key partners, will:

(a) advocate for and support integrated multisectoral IHR implementation to ensure that non-health sectors are engaged, as relevant, and have clear roles and responsibilities;

(b) support States Parties, upon request, in the development and revision of relevant national legislative and regulatory frameworks, and of standard operating procedures;

(c) collate examples of good practices of development of relevant national legal and regulatory frameworks for countries undergoing restructuring;

(d) support States Parties in the development and implementation of national policies and costed action plans for health emergency preparedness and engage technical and financial partners, as relevant.

IHR (2005) coordination, communication and advocacy

23. Effective IHR implementation requires strong collaboration among and within relevant sectors, and responsible governmental bodies at the national, regional and local levels, with the NFP engaged in the process. Fundamental to this multisectoral collaboration is the recognition that risks to human health can emerge from various sources including infections transmitted via goods, food, water or animals, as well as chemical, radionuclear and environmental events. Coordination and communication capacities are essential for the prevention and detection of, and response to, public health risks and should exist at all necessary levels within all relevant sectors.

24. States Parties will:

(a) establish, maintain and strengthen national multisectoral mechanisms for coordinated decision-making for IHR implementation; and

(b) strengthen the functional capacity of the NFP, or relevant national authority, through the use of operational coordination and communication mechanisms between sectors.

25. The Regional Office, in collaboration with key partners, will:

(a) assist States Parties in the development of guidance, tools, training and advocacy materials in order to improve multisectoral implementation of the IHR (2005) and the role and functioning of the NFP;

(b) support States Parties, as needed, to establish, maintain or improve national multisectoral platforms for coordinated decision-making for IHR implementation;

(c) provide regional platforms to strengthen NFP networking and the exchange of best practices, including through annual regional and subregional meetings; and

(d) collate examples of good practices of development and strengthening of multisectoral platforms for coordinated decision-making for IHR implementation.

National laboratory systems

26. A well-managed, quality-assured laboratory system plays a crucial role in health emergency preparedness and the timely detection of public health threats. It is vital to maintain systems that ensure reliable, safe and timely collection of specimens, as well as their transport, characterization and shipment to reference laboratories, and the sharing of results.

27.   States Parties will:

(a)   implement national laboratory strategies focusing on quality assurance of public health laboratories including human, environmental and veterinary laboratories;

(b)   establish, maintain or strengthen national and international referral systems for biological and environmental specimens, based on a One Health approach;

(c)   implement the biosafety regime in the European Region; and

(d)   link networks of laboratories to effective reporting mechanisms and surveillance systems in accordance with international strategies.

28.   The Regional Office will provide leadership, together with key partners, to:

(a)   support States Parties, upon request, in establishing and maintaining national quality-assured laboratory networks;

(b)   establish, maintain and strengthen quality-assured regional laboratory networks for emergency preparedness and response, building on existing WHO and other international laboratory networks, and promote international information exchange between laboratories;

(c)   support States Parties, upon request, in establishing and improving national and international referral systems for clinical and environmental samples through the development of national sample referral guidelines and export permits, the WHO Infectious Substances Shipping Training, and training in bio-risk management;

(d)   ensure dissemination of, or develop where needed, examples of national good practices of public health laboratory systems that can serve as models for countries undergoing laboratory restructuring and laboratory quality training; and

(e)   support the development of laboratory human resources capacity.

National surveillance systems

29.   The IHR (2005) require national surveillance systems to be capable of timely detection, assessment and analyses of epidemiological data, including laboratory results, for informed decision-making and reporting of outbreaks and other public health risks. These systems should also include early warning systems and community-based surveillance.

30.   States Parties will:

(a)   ensure that an integrated early warning function for priority hazards is in place, for timely detection of potential outbreaks and other public health risks;

(b)   establish, maintain or strengthen formalized data-sharing procedures and tools across sectors and between the regional and national levels; and

(c)   establish, maintain or strengthen interoperable electronic tools for public health surveillance.

31. The Regional Office, in collaboration with key partners, will:

(a) support countries, upon request, with analysis and strategic utilization of information collected through national surveillance systems to inform evidence-based policy-making;

(b) support implementation and evaluation of early warning systems for priority health hazards and improve the regular and timely analysis and dissemination of epidemiological data, including laboratory results;

(c) facilitate training and capacity-building on all-hazard risk assessment including biological, chemical, radiological, nuclear and natural hazards; and

(d) support the implementation of data-secure mechanisms on relevant platforms (for example, the WHO Event Information Site) for the exchange of personal data for the purpose of coordinated contact tracing between NFPs.

Human resources

32. The availability of human resources with the appropriate mix of competencies, knowledge and skills is an essential requirement for fulfilling the IHR (2005) obligations and the management of health emergencies. It requires a sustainable approach to the continuous development of the knowledge and skills of health workers and other relevant personnel.

33. States Parties will:

(a) develop and implement a needs-based workforce strategy, aimed at building, maintaining and retaining appropriate skills in health and other sectors, as relevant;

(b) ensure adequate distribution of the emergency preparedness and response workforce across the health system;

(c) establish, strengthen and maintain the capacity of a multisectoral workforce through training and testing of their capabilities for the early detection and prevention of, preparedness for and response to potential events of international concern at all levels.

34. The Regional Office, in collaboration with key partners, will support States Parties to further develop health workforce capacities through face-to-face and online training, curriculum development, simulation exercises and meetings and workshops. These training activities will be continuously evaluated to ensure their targeted impact on the improvement of the health workforce.

Risk communication

35. The adverse effects of an emergency can be reduced through effective real-time exchanges of information, advice and opinion between public health experts, officials and the public, which enables informed decisions and actions to be taken to mitigate the harmful effects of the threat.

36. States Parties will:

(a) establish, maintain and strengthen an intersectoral risk communication system at all levels to communicate public health threats transparently, and in a timely and coordinated manner; and

(b) ensure that an all-hazard emergency risk communication function is in place and integrated into new or existing national action plans for emergency preparedness and response under the IHR (2005).

37. The Regional Office, in collaboration with key partners, will provide States Parties with the necessary guidance, training, tools and on-site and remote support as part of the emergency risk communication five-step capacity-building package, and support integration of the package into national action plans for health emergency preparedness. These training activities will be continuously evaluated to ensure the package's targeted impact on improvement of the emergency risk communication function.

Points of entry

38. Effective public health measures and response capacity at points of entry such as airports, ports and ground crossings are an integral part of health emergency preparedness and response systems. The IHR (2005) require States Parties to develop and maintain routine and emergency capacities at designated points of entry, including the development of public health emergency response plans and operating procedures.

39. States Parties will:

(a) develop and maintain routine and emergency capacities at designated points of entry and ensure regular evaluation;

(b) establish, maintain and strengthen competent authorities to ensure routine and emergency capacities at points of entry; and

(c) ensure compliance with maritime provisions in the IHR (2005).

40. The Regional Office, in collaboration with key partners, will:

(a) support States Parties in strengthening and maintaining routine and emergency capacities at points of entry;

(b) coordinate activities aimed at strengthening health provisions at points of entry through formal and informal platforms and networks, such as the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation and the WHO Ports, Airports and Ground Crossings Network;

(c) maintain and regularly update the list of international ports authorized to issue Ship Sanitation Certificates; and

(d) maintain and regularly update a list of IHR (2005) designated points of entry in the WHO European Region.

Synergies between emergency preparedness and response, health system strengthening and essential public health functions

41.   In order to prepare for and respond to public health emergencies, synergies at the intersections between IHR implementation and the strengthening of health system and public health functions require identification and strengthening. Full implementation of the IHR (2005) will serve to further strengthen health systems and essential public health functions. Integration of work in these areas will serve as a basis for making progress towards universal health coverage across the region.

42.   States Parties will:

(a)   review ongoing activities for strengthening health systems and essential public health functions and in relation to IHR implementation, in order to identify and use synergies at their intersection; and

(b)   address identified lack of synergy and weaknesses in health systems and essential public functions for emergency preparedness and response in the national action plan for health emergency preparedness.

43.   The Regional Office, in collaboration with key partners, will:

(a)   guide States Parties in identifying synergies at the intersection between health system capacities and health emergency preparedness and the IHR (2005);

(b)   support States Parties, upon request, in developing national action plans for emergency preparedness that integrate activities relating to health system strengthening for emergency preparedness and response;

(c)   support States Parties in implementing national action plans for health emergency preparedness; and

(d)   conduct assessments, upon request, of the ability of State Parties to perform the essential public health functions relevant to the IHR (2005) and emergency response, including the Health System Capacity for Crisis Management and Hospital Safety Index.

One Health

44.   The One Health approach, based on the premise that the health of humans, animals and ecosystems are interconnected, involves applying a coordinated, collaborative, multidisciplinary and cross-sectoral approach to address potential or existing risks that originate at the human–animal–ecosystem interface. Close cooperation between the human and animal (domestic and wild) health and environment sectors is necessary for the effective prevention and control of emerging and re-emerging infectious diseases, in order to move towards optimal health outcomes for both humans and animals. The areas of work in which the One Health approach is particularly relevant include food safety, the control of zoonoses and combating antibiotic resistance.

45.   States Parties will:

(a)   establish national mechanisms for cross-sectoral coordination, integrated preparedness and response, surveillance and event information sharing, joint risk assessment, risk communication and risk reduction strategies, and workforce development in the human and animal health sectors;

46.   The Regional Office, in collaboration with key partners, will:

(a)   provide technical guidance, tools and best practices for implementing a One Health approach, including those contained in the revised tripartite zoonosis guide and toolkit;

(b)   upon request, support States Parties with IHR (2005)/performance of veterinary services bridging workshops to enhance the linkages between human and animal health sectors;

(c)   support States Parties in strengthening their capacity to address zoonoses under the IHR (2005); and

(d)   work closely with the Food and Agriculture Organization, the World Organisation for Animal Health and other relevant global and regional organizations, to promote multisectoral responses to food safety hazards, risks from zoonoses and other public health threats at the human–animal–ecosystem interface.

Sustainable financing of IHR implementation

47.   Provision of an adequate and consistent level of domestic financing for the full implementation of the IHR (2005) will ensure long-term sustainability for the health emergency preparedness and response capacities of a State Party. All actions for health emergency preparedness, including national action plans if available, should be integrated into national budgets and planning cycles.

48.   States Parties will:

(a)   ensure that activities for health emergency preparedness are included in national budgets and health system financing plans; and

(b)   mobilize additional resources, if necessary, to enable implementation of national action plans for public health emergency preparedness.

49.   The Regional Office, in collaboration with key partners, will work with donors to mobilize additional resources when States Parties need external technical and financial support in costing and financing national action plans.

Strategic pillar 2. Strengthen event management and compliance with the requirements under the IHR (2005)

50.   The Secretariat and States Parties should continue to fulfil their obligations under the IHR (2005) in relation to the detection, assessment and notification of, and response to, public health risks. The sustainable and effective functioning of NFPs is essential to fulfilling this obligation. In addition, regionally coordinated processes, partnerships and mechanisms to provide assistance where necessary, led by the Regional Office in partnership with key stakeholders, are critical.

Notification and information sharing

51.   The timely and accurate notification of public health events to WHO, assessed in accordance with Annex 2 of the IHR (2005), is a critical function for all States Parties and requires the NFP to be sufficiently trained and resourced. Furthermore, the effective functioning of the NFP requires coordinated and multisectoral information exchange with clear procedures and mechanisms for communication.

52.   States Parties will:

(a)   establish, maintain or strengthen a national system, including processes for multisectoral coordination, to ensure timely detection, investigation, risk assessment and information sharing among relevant national stakeholders; and

(b)   ensure that the NFP has sufficient capacity to comply with obligations for notification, consultation, verification and information exchange with WHO.

53.   The Regional Office, in collaboration with key partners, will:

(a)   support States Parties in building their capacities for effective notification, consultation, verification and information exchange through NFP training and the provision of technical support at the country level; and

(b)   support NFPs in conducting risk assessments for cross-border hazards.

Emergency preparedness and response operations

54.   National emergency frameworks and systems that include risk-based emergency preparedness and response plans, robust emergency management structures, including emergency operation centres, a trained workforce and mobilization of resources during an emergency, are critical for timely response. In cases where international assistance is required, supportive national systems and legislation are necessary for a coordinated health response.

55.   States Parties will:

(a)   conduct and regularly update all-hazard risk mapping that will serve as the basis of national preparedness planning;

(b)   develop and regularly update national multisectoral, all-hazard emergency preparedness and response activities and supporting policies and procedures with dedicated financial and human resources;

(c)   establish, maintain or strengthen emergency response coordination mechanisms, including incident management systems and health emergency operations centres; and

(d)   implement appropriate policies and standard operating procedures to ensure the continuous delivery of essential health services packages.

56.   The Regional Office will provide leadership, together with key partners, to:

(a)   support the strengthening of States Parties capacity to conduct and regularly update national risk mapping and national preparedness, response and contingency plans;

(b)   coordinate the collective response by operational health partners and agencies of the United Nations, as relevant, to ensure equitable access to essential health services during emergencies; and

(c)   support countries' communication activities during emergencies, by providing tools and guidance, including for the coordination of communication efforts.

Medical countermeasures and personnel deployment

57.   The ability to enable a rapid and appropriate medical response during an emergency requires countries to have the necessary legal and regulatory processes and logistic plans in place that enable the national or cross-border deployment of public health and medical personnel. Furthermore, the development and dissemination of case management guidance for priority health hazards is critical to providing an effective and appropriate response.

58.   States Parties will:

(a)   develop a system for activating and coordinating medical countermeasures during a public health emergency, including mechanisms for sending and receiving medical countermeasures and deployed health personnel;

(b)   establish, maintain or strengthen the guaranteed availability of essential supplies and pharmaceuticals on the basis of national risk profiles; and

(c)   establish, maintain or strengthen a procurement and supply chain management system.

59.   The Regional Office, in collaboration with key partners, will:

(a)   ensure the provision of essential life-saving health services and public health interventions during health emergencies, including supplies and expertise, as needed, to the affected populations;

(b)   provide specific protocols for the clinical management of identified high-threat pathogens and other hazards;

(c)   support States Parties in engaging with regional and global intergovernmental organizations that provide assistance during health emergencies, including emergency medical teams, the Global Outbreak Alert and Response Network, and standby partners;

(d)   provide support for the coordination of the health sector and activation of the health cluster, according to WHO standard operating procedures and guidelines;

(e)   provide assistance to national institutions and networks in the European Region in joining the Global Outbreak Alert and Response Network; and

(f)   support States Parties, upon request, in strengthening national capacities and mechanisms to coordinate the timely and effective response of emergency medical teams.

Strategic pillar 3. Measure progress and promote accountability

60.   To ensure that Member States establish and maintain adequate capacity for effective preparedness and response, progress must be continuously monitored and periodically evaluated. This includes annual reporting to the World Health Assembly, an obligation under the IHR (2005), as well as voluntary forms of qualitative and quantitative assessments, which can assist in the development of comprehensive national action plans to address identified weaknesses.

61.   The fulfilment of this obligation by States Parties of the European Region contributes to mutual accountability and the shared building of health security in the Region.

Mandatory annual reporting by States Parties

62.   According to the IHR (2005), "States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly". Such reports shall describe the status of core capacities, as defined in Annex 1 of the Regulations, on an annual basis. Since 2010, the Secretariat has proposed a self-assessment tool, focusing on core capacities, for use by States Parties in fulfilling the annual reporting obligation to the World Health Assembly.

63.   States Parties will:

(a)   report annually to the World Health Assembly on the status of implementation of the IHR (2005); and

(b)   ensure that gaps identified through the obligatory annual reporting are addressed in the national action plans for health emergency preparedness.

64.   The Regional Office will assist States Parties in building capacity for translating assessment results into action and facilitate cross-country sharing of experiences and good practices.

Assessment of capacities through use of voluntary tools

65.   In compliance with resolution WHA68.5 (2015) on the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, including the recommendation that the Secretariat should develop options "to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts", the action plan proposes voluntary instruments that could be applied by the States Parties in addition to the obligatory self-assessment tool. These include joint external evaluations, simulation exercises and after action reviews. The Secretariat has developed technical tools and will revise and adapt them in the light of experience gained from the use of the voluntary instruments. The provision of support to States Parties is not conditional on these voluntary assessments being conducted. In addition, as recommended by the Review Committee, States Parties should urgently strengthen their current self-assessment system and implement in-depth reviews of significant disease outbreaks and public health events.

66.   States Parties may consider the use of voluntary tools to complement the assessment and monitoring of core capacities under the IHR (2005).

67.   The Regional Office, in collaboration with key partners, will provide technical support to States Parties upon request to use the voluntary instruments for monitoring and evaluation of IHR implementation.

Annex. Summary of the draft action plan to improve public health preparedness and response in the WHO European Region, 2018–2023

ACTION PLAN TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE IN THE WHO EUROPEAN REGION, 2018–2023	
VISION	A WHO European Region where the impact of health emergencies is prevented or minimized
GOAL	To strengthen and maintain adequate capacities in the European Region to effectively prevent, prepare for, detect and respond to public health threats and to provide assistance to affected countries

THREE STRATEGIC PILLARS OF INTERVENTION

1. Build, strengthen and maintain States Parties' core capacities required under the International Health Regulations (IHR) (2005)

Establishing the capacities required to respond effectively and in a timely manner to potential public health emergencies of international concern is required by States Parties under the IHR (2005). These capacities should include efforts to strengthen health systems and to coordinate mobilization of domestic and international funding through multisectoral action plans.

2. Strengthen event management and compliance with the requirements under the IHR (2005)

The Secretariat and States Parties should continue to fulfil their obligations under the IHR (2005) in relation to the detection, assessment and notification of, and response to, public health risks. Sustainable and effective functioning of the National IHR Focal Point (NFP) is essential to fulfilling this obligation. In addition, regionally coordinated processes, partnerships and mechanisms led by the Regional Office, in partnership with key stakeholders, to provide assistance where necessary are critical.

3. Measure progress and promote accountability

To ensure that Member States establish and maintain adequate capacity for effective preparedness and response, progress must be continuously monitored and periodically evaluated to identify weaknesses and address them. States Parties are obligated to report annually to the World Health Assembly under the IHR (2005). Other forms of qualitative and quantitative assessments can be undertaken voluntarily.

The fulfilment of this obligation by States Parties of the European Region contributes to mutual accountability and shared efforts to building health security in the Region.

TARGETS (to be achieved by 2023)	**Strategic pillar 1:** • all countries maintain and/or strengthen their core capacities for health emergency preparedness and disaster risk management under the IHR (2005) in order to reach sufficient levels, as assessed through annual reporting scores.

	Strategic pillar 2: • all health events are detected and, if necessary, any risks are assessed and communicated in a timely manner for appropriate action by countries in the European Region; • Secretariat support is provided to the NFPs for the implementation of the IHR (2005), when requested; • populations affected by health emergencies have access to essential life-saving health services and public health interventions.
	Strategic pillar 3: • all States Parties report annually to the World Health Assembly on implementation of the IHR (2005) using the self-assessment annual reporting tool; • The Secretariat provides technical support to States Parties, upon request, for the use of instruments for monitoring and evaluation of IHR implementation.

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