



SHARP

Strengthened International HeAlth
Regulations & Preparedness in the EU

IHR Core Capacity Strengthening and Assessment

Final Report
Work Package 5 - Task 5.1

May 2023

A report on knowledge, practices and added value of strengthening of selected core capacities in the EU and neighbouring countries

Strengthened International HeAlth Regulations & Preparedness in the EU SHARP-Joint Action

Work Package 5: IHR Core Capacity Strengthening and Assessment Task 5.1: Improving IHR Implementation

Final Report submitted by the Public Health Agency of Sweden

May 2023

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Co-funded by the
Health Programme of
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Executive Summary

Work Package 5 Task 5.1 aimed to improve IHR implementation in twelve focus (low GNI) countries by the strengthening of selected core capacities during three annual workshops and corresponding work between workshops.

The task started by conducting a baseline analysis on core capacities according to common international assessment tools. As part of the analysis, information from bilateral interview checkpoints with all twelve countries gathered perspectives on the country information and explored challenges, progress and possibilities for core capacity topics to strengthen over the joint action.

In parallel, WP3 evaluated this task with a pre-test survey and three post-test surveys to determine learning and usefulness of the workshops for IHR strengthening.

Work Package 5 identified IHR core capacities of greatest need for improvement among twelve participating countries. IHR core capacities scores were reassessed to identify changes over the course of the Joint Action by comparing the WHO State Party Annual Reporting (SPAR) tool scores. In addition, examples of IHR core capacity strengthening were identified from checkpoint interviews and workshop evaluation surveys determined the core capacities strengthened over the Joint Action. This report also suggests possible factors that prompted incidences of accelerated IHR strengthening.

The three annual IHR Core Capacity Strengthening workshops took place in Riga, online and in Slovenia. These workshops included both the countries that had undertaken a Joint External Evaluation (JEE) and those that had not taken part in a JEE. The implementation of each workshop was a truly collaborative undertaking. The workshops involved voluntary contributions from all countries by way of presenting examples, moderating sessions, facilitating discussions, and finally sharing perspectives. The workshops focussed on the process of moving forward to strengthen IHR core capacities. In this way, participants provided insight on the levels of individual capacities. Moreover, participants identified barriers, recent progress made and shared plans for improvements in respective countries.

A tool with strategic activity suggestions for IHR strengthening and a progress report template were developed for use in individual country contexts. Due to the COVID-19 pandemic response the IHR strengthening activities within the tool remained unused by focus countries.

Nevertheless, focus countries report that IHR core capacity strengthening did occur in earnest whilst managing the pandemic - particularly in the areas of laboratory capacity, surveillance, and risk communication.

A comparison of self-reported SPAR reports from 2019 and 2022 supports this experience. Increases in core capacities:

- Real Time Surveillance from a 70% to 82%
- National Laboratory System from 73.4% to 74%
- Risk Communication from 56% to 63%
- Chemical events 58% to 67%

In addition, the Work Package 3 evaluation of the workshops concluded that participants' understanding on how to proceed to strengthen preparedness increased.

This report concludes that IHR core capacities did strengthen in the twelve focus countries over the joint action. This is shown by a comparison of the WHO-SPAR scores at baseline in 2019 and 2022 and reflected in the qualitative analysis. As the pandemic occurred during the time of Joint Action, the strengthening of IHR core capacities is inextricably linked to the country response to manage COVID-19.

Background

Work Package 5 (WP5): IHR core capacity strengthening and assessment includes task 5.1 which works to improve IHR implementation among 12 focus countries. This was achieved via three annual workshops which aimed to contribute to the strengthening of IHR-implementation.

The first workshop on IHR Core Capacity Strengthening and Assessment took place from 29 to 30 January 2020 in Riga, Latvia; the second 28 March 2021 took place online and was hosted by colleagues in Poland and the third and final workshop on 18-19 September 2022 in Ljubljana, Slovenia. The following countries were prioritised: Bosnia and Herzegovina, Croatia, Greece, Latvia, Lithuania, Malta, Moldova, Poland, Portugal, Serbia, Slovenia and Spain. Both the countries that have undertaken a Joint External Evaluation (JEE) or not took part in the task together.

In order to plan and implement the IHR Strengthening workshops, a baseline analysis (Annex I) was carried out which involved reviewing IHR SPAR reports, JEE Country reports and the EU Decision 1082/2013 report summary from the twelve focus countries. Thereafter interviews were conducted among the focus countries to gather insights on their current IHR implementation status, recent successes, and identified challenges and barriers. This approach allowed us to benchmark progress in IHR strengthening, and to prioritise topics and format future workshops in terms of promoting dialogue and sharing of practices. The workshops featured topic presentations by the countries to share processes and learnings from IHR strengthening.

Available international measurement tools that have been used to benchmark IHR strengthening have evolved since the baseline analysis. For example, the SPAR tool was updated to version 2 which introduced new areas and set a higher threshold of criteria to achieve the higher levels.

This process continued during the Joint Action which also coincided with the COVID-19 pandemic. Noting that the partners involved in SHARP were also highly active in managing the pandemic in their respective countries, experience and advances made to IHR-strengthening were also taken into consideration in planning, implementing and evaluating activities. For this task IHR strengthening has been inextricably linked to efforts and investments undertaken to manage the pandemic.

The first workshop (Annex II- workshop report) prioritised four IHR Core Capacity areas: Risk Communication, Chemicals, Biosafety and Biosecurity and AMR-One Health. It was planned that these topics would continue over the three years, yet due to the COVID-19 pandemic, adjustments were necessary.

For the second workshop (Annex III-workshop report), it was deemed important to take less time (than 2-days planned, but rather a half day) to gather and discuss aspects of risk communication - including building trust among the population online.

Preparation for the third and final workshop (Annex IV-workshop report) involved taking inventory among the focus countries on which IHR core capacities had strengthened over the joint action and concurrently during the pandemic. Notably, these topics were surveillance, biosafety and biosecurity and risk communication.

Progress in countries were showcased during the final workshop, as well as identifying possible “root” factors which catalysed these changes. In addition, changing international legislative structures for both the EU Decision 1082/2013; the IHR and pandemic-related instruments were discussed.

Planning and Implementation

Being that the annual workshops took place in Latvia, Poland and Slovenia, the WP5 leaders at the Public Health Agency of Sweden commissioned a sub-group for Task 5.1 to include representatives from these countries. This group serves in an advisory and planning role prior to communicating and disseminating material to all WP5 partners.

There are 20 partner-countries involved in the WP5 of which 12 are focus countries*:

Bosnia and Herzegovina (BA)*

Croatia (HR)*

Greece (GR)*

Finland (FI)

France (FR)

Latvia (LV)*

Lithuania (LI)*

Germany (DE)

Malta (MT)*

Moldova (MD)*

Netherlands (NL)

Norway (NO)

Poland (PL)*

Portugal (PT)*

Serbia (RS)*

Slovenia (SI)*

Spain (ES)*

Sweden (SE)

Italy (I)

United Kingdom (UK)

In addition, the European Centre for Disease Prevention and Control (ECDC) and the WHO Regional Office EURO were represented in all three workshops. Representatives from the Ukraine and Ukraine's WHO country office joined Workshop 1 as self-financed, external participants as well as the European Commission (DG SANTE).

The workshops were structured to engage countries in discussion and information sharing regarding select IHR Core Capacities. The main presentations were by the focus countries who described examples of advances in core capacities as well as challenges.

The workshop topics featured information such as JEEs, preparedness legislation from ECDC, WHO and the EC. Each workshop ended with a "Way Forward" session

to discuss aims to be achieved to the next workshop as well as sustainability after the joint action.

The first workshop focused on four IHR capacities in need of strengthening and on sharing experiences on Joint External Evaluations. The second on risk communication and the final workshop on surveillance and risk communication. Advancing core capacities is context-specific and requires assessing where countries stand today, identifying and addressing barriers and determining facilitators.

After the country presentations round-table moderated discussions took place. Moderators for the discussion were partners in the task and were prepared with questions that could be adapted based on the country dialogue. Table 1.0 provides an overview among the countries involved in WP5 categorised by JEE, participation in the check-point interviews, including those few that responded in writing, and representation at the three workshops.

Table 1.0: Overview among the focus countries involved in Work Package 5 with information on JEE, focus country and representation at the three workshops.

Country	JEE	Check-point 1	Workshop 1	Check-point 2	Workshop 2	Check-point 3	Workshop 3
Bosnia and Herzegovina		x	x	x	x		x
Croatia		x	x	x	x	x	x
Greece		x	x	x	x	x	x
Latvia	x	x	x	x	x	x	x
Lithuania	x	x		x		x	
Malta		x		x	x	x	
Moldova		x					
Poland		x	x	x	x	x	x
Portugal	x*	x		x	x	x	x
Serbia	x	x	x	x	x	x	x
Slovenia	x	x	x	x	x	x	x
Spain		x	x	x	x	x	

*Portugal was involved in testing the JEE tool prior to its formal adoption.

Assessing Core Capacities

Methodology

A baseline analysis was conducted at the start of the Joint Action in 2019 to gain insight on IHR implementation challenges and strengths by way of:

- A review of data presented in the Decision1082/2013 report summary, the 2019 SPAR reports or latest IHR reports and JEE/JEET reports.
- Partner meetings to review IHR core capacity areas and start determining the appropriateness to work in these areas.
- A content Analysis of country telephone interviews to determine areas in IHR implementation that are working well, have recently improved or require improvement.

Common areas to strengthen over the JA were based preparedness levels reported by focus countries using common preparedness measuring tools. Representatives from each country were also interviewed to discuss their SPAR report or if available JEE report and provide insight on preparedness in the country context and present challenges.

Representatives from the twelve focus countries were invited to participate in the first set of voluntary telephone interviews with a representative from the Public Health Agency of Sweden (FOHM). The aim of the telephone interviews was to gain better insight on the country's context and the IHR implementation of the present day. Open-ended questions under four themes were posed. These themes are (1) what is working well or not so well, (2) recent improvements, (3) country context and (4) specific areas lifted in the analysis to work on in the Work Package over the JA.

With the baseline analysis complete Task 5.1 started with the planning and implementation of three annual workshops with two additional check-point interviews and the formal evaluation from work package 3. Eleven countries participated in the second set of check-point interviews and ten countries (two submitting answers in writing) in the third set. In 2023 a follow-up analysis of the focus country SPAR reports was conducted to determine differences in the baseline core capacity levels.

Results

The baseline report (Annex I) determined the core capacities to work toward strengthening with during the JA by identifying barriers as well as challenges to implementing core capacities in respective country contexts.

All twelve countries¹ participated in the first round of check-point interviews from August to September 2019. The interviews were documented by note-taking dialogue and were reviewed by the Public Health Agency of Sweden. Countries were invited to provide additional information on to their country's IHR implementation - including national policies, plans and strategies to provide a better picture of the country context after the interview.

The results of the first set of interviews concluded that, in general, the areas of the IHR implementation working well in countries are IHR coordination and communication vertically from national to local levels, within the health sector). Legislation, immunization, food safety and surveillance worked well yet enhancements to, for example, AMR surveillance could be made.

¹ Information from one country was not included in the content analysis because the conversation focused on the Joint Action itself and not on the country's IHR implementation.

The areas that require continued work include multi-sector collaboration (veterinary sectors, chemical), risk communication, AMR, constructing action plans, biosafety and biosecurity, points of entry and human resources.

It was recognised that countries are continuously working yet emphasised the need to continuously improve IHR implementation. Important factors identified to strengthen IHR implementation include consideration of the specific country context that the IHR functions in multi-sector work not only in communicating but in working together and maintaining efforts to raise the importance of the IHR in the country.

Several barriers were described to possibly explain reasons why IHR areas may not be moving forward. Barriers that emerged were categorised as:

- from paper to practice
- bridging across sector structures to raise importance of IHR
- drawing clear responsibility lines in the IHR areas as in, for example, risk communication.

An excel matrix tool to document progress made in the original four IHR areas was produced and presented for the partners during the first workshop in January 2020.

This tool was informed by the WHO Benchmarking Tool² and by the interviews. The tool listed activities to strategically work to level up for upcoming SPAR reports. The subsequent second check-point interviews among the partners determined that the excel tool was not used. This was due to time required in managing the Covid-19 pandemic. The priority of putting efforts on the four areas identified during the baseline analysis was questioned as circumstances changed due to the pandemic.

After the first set of interviews, the first annual workshop took place in January 2020. Between the workshop and the second set of interviews, representatives from countries were greatly occupied with responding to the COVID-19 pandemic. With this in mind the second set of interviews focused on country changes to core capacity preparedness and areas participations deemed useful to profile during a possible, second annual workshop.

The second set of interviews also determined that the area of risk communication was strengthened since the first assessment. As challenges to address communicating about COVID-19 were immediately apparent in societies, this core capacity improved through:

- increased human resources
- increased understanding on how to reach out to different target groups
- increased use of different communication channels

² WHO Benchmarks for International Health Regulations (IHR) Capacities. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

The participants identified a need to proceed as planned with the SHARP Joint Action annual workshop 2 to discuss IHR-strengthening and upcoming challenges on communicating information such as COVID-19 vaccine. This second workshop was best to take place online given the global situation and time required to continue working with the response. In addition, WP8 created and hosted trainings in risk communication.

The third set of interviews questions were posed to identify what core capacities have strengthened over the joint action, because of managing the pandemic. As well, notions behind prompts behind core capacity strengthening. The common capacities that were strengthened and identified were surveillance, lab capacity and risk communication. The original areas (AMR and Chemicals) were not given as areas that had strengthened over the joint action. Importantly, some participants highlighted that recommendations from JEEs were ultimately implemented in earnest to address the COVID-19 pandemic.

The final analysis was based on the SPAR 2022 results among the focus countries. The SPAR and JEE tools changed over the course of the Joint Action and WP 5 was involved in a WHO consultation to improve the tools based on initial (first wave period) lessons learned from COVID-19. Changes included additional measurement areas as well as more stringent criteria to attain higher levels. As Member State reporting for EU Decision 1082/2013 did not occur and Joint External Evaluations not implemented by the countries in WP5, only the SPAR reports were analysed in the follow-up report.

The average score levels among the focus countries in the areas selected for WP5 were higher in 2022 compared to the baseline in 2019 (Table 2.0). SPAR (version 2) scores from 2022 (data collected in 2021) were reviewed and compared to the SPAR (version 1) 2019 scores (data collected 2018). For surveillance, the focus country group average increased from a 70% to 82%, for laboratory from 73.4% to 74%, for risk communication from 56% to 63% and for chemicals 58% to 67%. The comparison shows improvements in SPAR report scores for the core capacities selected in this WP5 task over time according to the self-reported SPAR reports among the focus group countries. Table 2.0 presents the 10 countries³ from SPAR v1 2019 and 12 countries' SPAR v2 2022 scores are higher at follow-up in the areas selected during this JA task.

When comparing the average scores, it should be noted that the SPAR tool changed over the Joint Action to include more indicators and core capacities and in version 2 there are more requirements for countries to achieve a higher level. With this noted, the average score of the group of focus countries in WP5 improved over the two time points although these differences have not undergone a test for significance.

³ During the time of the Task 5.1 baseline analysis, Poland and Greece did not have a SPAR 2019 report available for analysis. Therefore a 10-country average is reported.

Table 2.0: Improvements in SPAR score per select core capacity over the time of JA SHARP among the twelve focus countries ⁴

SURVEILLANCE	Average	Range
SPAR v2 - 2022 (2021 data collection)		
C5. Surveillance	82%	40%-100%
C5.1. Early warning surveillance function	83%	40%-100%
C5.2. Event management	80%	40%-100%
SPAR v1 - 2019 (2018 data collection)		
C6: Surveillance	70%	20%-80%
C.6.1 Early warning function: indicator- and event-based surveillance	70%	
C.6.2 Mechanism for event management (verification, risk assessment analysis, investigation)	70%	
LABORATORY		
SPAR v2 - 2022 (2021 data collection)		
C4. Laboratory	74%	44%-92%
C4.1. Specimen referral and transport system	73%	40%-100%
C4.2. Implementation of a laboratory biosafety and biosecurity regime	67%	20%-100%
C4.3. Laboratory quality system	77%	20%-100%
C4.4. Laboratory testing capacity modalities	82%	60%-100%
C4.5. Effective national diagnostic network	72%	20%-100%
SPAR v1 - 2019 (2018 data collection)		
C5: Laboratory	73.8%	33%-100%
C.5.1 Specimen referral and transport system	84%	
C.5.2 Implementation of a laboratory biosafety & biosecurity regime	60%	
C.5.3 Access to laboratory testing capacity for priority diseases	78%	
RISK COMMUNICATION		
SPAR v2 - 2022 (2021 data collection)		
C10. Risk communication and community engagement (RCCE)	63%	20%-87%
C10.1. RCCE system for emergencies	60%	20%-100%
C10.2. Risk communication	68%	40%-100%
C10.3. Community engagement	61%	20%-100%
SPAR v1 - 2019 (2018 data collection)		
C10: Risk Communication	56%	20%-80%
C.10.1 Capacity for emergency risk communications	56%	
CHEMICALS		
SPAR v2 - 2022 (2021 data collection)		
C14. Chemical events	67%	20%-100%
C14.1. Resources for detection and alert	67%	20%-100%
SPAR v1 - 2019 (2018 data collection)		
C.12 Chemical events	58%	(20%-80%)
C.12.1 Resources for detection and alert	58%	

⁴AMR data is not possible to collect and compare given that AMR scores are derived from JEE results and no country within SHARP has undergone a JEE during the duration of the Joint Action due to managing the Covid-19 pandemic

Given the qualitative data from the country check-point interviews, the results of workshop dialog and improvements in SPAR scores it can be concluded that IHR-strengthening among select core capacities strengthened over the time of the JA. Importantly, country pandemic response occurred during the JA and hence improvements in core capacities is associated to the efforts made by countries to manage the pandemic.

As a high level of preparedness is important for all countries, it is also essential to examine how the twelve countries compare within other countries in Europe. Table 3.0 provides the overall average scores for all indicators in spar among the twelve focus countries compared to the EURO average. This comparison shows that the twelve countries have a higher, relatively equal or lower average in the different core capacity indicators.

Table 3.0: Average State Party Annual Reports version 2 scores (C1-C7) among 12 Focus countries compared to WHO-EURO average

IHR Area SPAR Tool (Version 2) 2022 (C1 – C7)	Average	Range	EURO Ave
	71%	38%-82%	74%
C1. Policy, legal and normative instruments to implement IHR	65%	38%-85%	61%
C1.1. Policy, legal and normative instruments	38%	20%-100%	71%
C1.2. Gender equality in health emergencies	59%	20%-100%	52%
C2. IHR coordination and National IHR Focal Point	76%	47%-93%	75%
C2.1. National IHR Focal Point functions	77%	40%-100%	74%
C2.2. Multisectoral coordination mechanisms	82%	40%-100%	79%
C2.3. Advocacy for IHR implementation	72%	40%-100%	72%
C3. Financing	77%	60%-100%	74%
C3.1. Financing for IHR implementation	73%	40%-100%	68%
C3.2. Financing for public health emergency response	80%	60%-100%	80%
C4. Laboratory	74%	44%-92%	80%
C4.1. Specimen referral and transport system	73%	40%-100%	80%
C4.2. Implementation of a laboratory biosafety and biosecurity regime	67%	20%-100%	75%
C4.3. Laboratory quality system	77%	20%-100%	80%
C4.4. Laboratory testing capacity modalities	82%	60%-100%	84%
C4.5. Effective national diagnostic network	72%	20%-100%	80%
C5. Surveillance	82%	40%-100%	85%
C5.1. Early warning surveillance function	83%	40%-100%	86%
C5.2. Event management	80%	40%-100%	84%
C6. Human resources	58%	20%-90%	67%
C6.1. Human resources for implementation of IHR	63%	20%-80%	71%
C6.2. Workforce surge during a public health event	53%	20%-100%	63%
C7. Health emergency management	78%	53%-100%	77%
C7.1. Planning for health emergencies	75%	20%-100%	74%
C7.2. Management of health emergency response	80%	20%-100%	80%
C7.3. Emergency logistic and supply chain management	80%	60%-100%	79%

Table 3.0: Average State Party Annual Reports version 2 scores (C8-C15) among 12 Focus countries compared to WHO-EURO average

IHR Area SPAR Tool (Version 2) 2022 (C8 – C15)	Average	Range	EURO Ave
C8. Health services provision	77%	27%-93%	80%
C8.1 Case management	70%	0%-100%	80%
C8.2 Utilization of health services	87%	0%-100%	82%
C8.3 Continuity of essential health services (EHS)	75%	40%-80%	77%
C9. Infection prevention and control (IPC)	71%	27%-100%	72%
C9.1. Infection prevention and control programmes	63%	20%-100%	69%
C9.2 Health care-associated infections (HCAI) surveillance	73%	40%-100%	70%
C9.3 Safe environment in health facilities	75%	20%-100%	77%
C10. Risk communication and community engagement (RCCE)	63%	20%-87%	69%
C10.1. RCCE system for emergencies	60%	20%-100%	70%
C10.2. Risk communication	68%	40%-100%	72%
C10.3. Community engagement	61%	20%-100%	64%
C11. Points of entry (PoE) and border health Section	60%	0%-100%	65%
C11.1. Core capacity requirements at all times for PoE (airports, ports and ground crossings)	58%	0%-100%	64%
C11.2. Public health response at PoE	57%	0%-100%	63%
C11.3. Risk-based approach to international travel-related measures	63%	0%-100%	71%
C12. Zoonotic diseases	77%	20%-100%	76%
C12.1. One Health collaborative efforts across sectors on activities to address zoonoses	77%	20%-100%	76%
C13. Food safety	80%	40%-100%	78%
C13.1. Multisectoral collaboration mechanism for food safety events	80%	40%-100%	78%
C14. Chemical events	67%	20%-100%	70%
C14.1. Resources for detection and alert	67%	20%-100%	70%
C15. Radiation emergencies	58%	0%-100%	74%
C15.1 Capacity and resources	58%	0%-100%	74%

In addition, the summary reports from the workshops and the results of the checkpoint interviews identified areas where strengthening in IHR implementation occurred and factors behind IHR-strengthening.

Suggested reasons and prompts behind the IHR-strengthening are political support to strengthen core capacities, financial resources including additional trained human resources and acute challenges to be solved when responding to COVID-19.

Evaluation

Prior to the first workshop a survey, developed by WP3, was sent to participants to determine baseline knowledge in IHR core capacities and Joint External Evaluation. The results concluded that all responders had basic or good understanding of preparing for a Joint External Evaluation and the majority were neutral on whether their country would initiate a JEE in the coming year.

On a 4-point scale, the majority had basic or good knowledge on what was required for strengthening the IHR Core Capacities of AMR, Biosafety and Biosecurity, Chemicals and Risk Communication. Responding countries were either neutral or confident that their country would improve IHR core capacities in the coming years.

The post workshop survey noted that the workshop increased understanding of how to increase preparedness in the identified areas of AMR, Chemicals and Risk communication; with slightly more than 50% had increased understanding in biosafety and biosecurity.

Dialogue with focus countries noted that the participants in SHARP were actively involved in responding to the pandemic. As a result, the IHR core capacities selected during the second and third annual workshops were adjusted. The survey questions focused on evaluating actual progress made in core capacity strengthening from the previous workshop. After both the second and third workshops most of the participants agreed or strongly agreed that they had opportunities to share experiences on IHR Core Capacity Strengthening in their countries. The majority agreed or strongly agreed that the workshops provided an opportunity to discuss recent progress and current challenges.

Conclusion - Strengthening Core Capacities

Strengthening of IHR core capacities during the SHARP Joint Action is inextricably linked to efforts made in IHR core capacities when responding to the COVID-19 pandemic. It is difficult to conclude that the task 5.1 itself prompted IHR strengthening over time; but rather to consider catalysts (i.e., investments and increased human resources) behind advancements of IHR core capacities. In particular, capacities such as surveillance; human resources for IHR; biosafety and biosecurity improved over time.

The Joint Action has prompted participating countries to continuously re-visit and re-assess preparedness challenges during the WP5 task 5.1 activities; namely the bilateral interviews, participating in the workshops and assessing the workshops in the evaluation surveys.

The opportunities to learn from other countries has provided ideas and examples on how to progress further; and expanded the participants' network of public health preparedness professionals which may facilitate further collaborations.

Finally participants emphasise the importance that countries now continue to maintain this more advanced level of preparedness for the future and continued strengthening of IHR core capacities.

ANNEX I – BACKGROUND ANALYSIS FOR TASK 5.1

A Report on Selecting the IHR Core Capacities to Pursue-

Presented during WP5 Partner Meeting 14 October 2019

Implementing IHR and complying with Decision 1082/2013/EC relies on essential public health services capacities and functions (1). Health security in Europe hinges on compliance with Decision 1082 and in fully implementing the International Health Regulations (IHR 2005) in every country (source). There is a wide range in preparedness capacities across the European Region (source SPAR).

Work Package 5 (WP5) aims to address gaps that exist in the IHR core capacities of SHARP JA focus countries⁵ (2). Core capacities are public health functions that each country needs to have in place in order to effectively prevent, detect and control to manage threats to public health (IHR 2005). Task 5.1 of WP5 is to improve IHR implementation primarily by facilitating and strengthening of selected core capacities.

WP5 started with an analysis to first identify and select the areas that required the greatest improvement among the twelve focus countries involved in the WP during the Joint Action. These core capacities would in turn be addressed through sharing of best practice and through focused work in the respective countries and by sharing of experiences among all countries in WP5.

Twelve focus countries are involved in the JA-SHARP WP5:

1. Bosnia and Herzegovina (BA)
2. Croatia (HR)
3. Greece (GR)
4. Latvia (LV)
5. Lithuania (LI)
6. Malta (MT)
7. Moldova (MD)
8. Poland (PL)
9. Portugal (PT)
10. Serbia (RS)
11. Slovenia (SI)
12. Spain (ES)

Additional Countries are involved:

13. Netherlands (NL)
14. Finland (FI)
15. France (FR)
16. Sweden (SE)
17. Norway (NO)
18. Italy (I)
19. Germany (DE)
20. United Kingdom (UK)

⁵ GNI 2016, threshold is 90% EU average

In this report we describe the identification of key challenges by identifying common gaps in IHR implementation among 12 focus countries by investigating existing data and in discussion with partners represented in the work package.

Methodology

With the intention of gaining better insight to the present day IHR implementation challenges and strengths, the following took place:

- 1.0 A review of data presented in the Decision1082/2013 report summary, the 2018 SPAR reports or latest IHR reports and JEE/JEET reports.
- 2.0 Partner meetings to review IHR core capacity areas and start determining the appropriateness to work in these areas.
- 3.0 Content Analysis of country telephone conversations to determine areas in IHR implementation that are working well, have recently improved or require improvement.

1.0 Review

1.1 Results of Decision 1082 Reports from 2017 to the EC.

European Union and EEA

Every third year, under Article 4(2) of Decision 1082/2013/EU,⁶ EU and EEA Member States report, by way of a template under Implementing Decision 2014/504/EU,⁷ the most recent status of national level preparedness and response planning.

The first reporting cycle was 2014 followed by 2017. During this latest cycle, Twenty-five EU Member States and three EEA countries submitted information. The report investigated IHR capacities, Interoperability, Business Continuity and Revision of National Preparedness Planning.⁸ The 2017 results were presented during the Health Security Committee Plenary Session in 2018 to provide a comprehensive picture of preparedness in the EU by identifying areas of strength and areas that need for improvement.

In addition to completing the template, countries submitted the most current IHR (2005) report⁹. The overall capacity level was above 80% among the 27 EU/EEA countries in 2017. The capacities for 'Response' and 'Zoonotic events', 'Food safety', and 'Radiation emergencies' scored above 90%. Human Resource and Points of Entry capacity required improvements, as well as actions to maintain and develop all IHR core capacities.¹⁰

⁶ DECISION No 1082/2013/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on serious cross-border threats to health and repealing Decision No 2119/98/EC

https://ec.europa.eu/health/sites/health/files/preparedness_response/docs/decision_serious_crossborder_threats_22102013_en.pdf

⁷ COMMISSION IMPLEMENTING DECISION of 25 July 2014 implementing Decision No 1082/2013/EU of the European Parliament and of the Council with regard to the template for providing the information on preparedness and response planning in relation to serious cross-border threats to health <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014D0504&from=EN>

⁸ The full report is available exclusively to the members of the Health Security Committee. Results presented in this paper are from the summary.

⁹ IHR (2005) reports from 2017.

¹⁰ European Commission. Summary of the Report on Preparedness and Response Planning for the Health Security Committee (Article 4 of Decision 1082/2013/EU on serious cross-border threats to health)

Twenty-eight of the 30 countries involved other sectors in the preparedness and response planning for the health sector; whereby all 28 reported that sectors dealing with threats of foodborne, zoonotic and waterborne origin were involved in preparedness and response planning.⁶ Twenty-four countries indicated that they have national business continuity plans in place.⁶

1.2 Results of IHR and SPAR reports

Article 54 of the International Health Regulations (2005) requires Parties and World Health Organization (WHO) to annually report on the implementation of the IHR to the World Health Assembly.¹¹ Information on IHR implementation is collected by way of the State Parties Self-Assessment Annual Reporting (SPAR) Tool.¹² Results from 2018 country reports are publically available on the WHO-SPAR Extranet.¹³

The SPAR reports for the WHO European Area with 53 countries reports an overall capacity of 73%. As a Region, the strongest areas are C5 Laboratory (80%), C1 Legislation and financing (77%), C2 IHR Coordinating (77%). The areas that pose the greatest challenges are C11 Points of entry (57%), C12 Chemical events (65%), C10 Risk Communication (66%).

Ten of the 12 focus countries involved in WP5 submitted SPAR reports for its first cycle in 2018. Table 1.0 presents the mean percentage for the ten countries and the range compared to the EURO Region mean. The overall level for the ten countries completing the SPAR 2018 report was 69.5%; which is below the EURO average of 73%. The highest scores were in the areas of C1 Legislation and financing (84.1%), C4 Food Safety (82%) and C2 IHR Coordination & NFP Functions (79%).

The average score for the group point to common areas that pose the common greatest challenges among the 10 countries:

C10 Risk Communication (56%)

- C.10.1 Capacity for emergency risk communications (56%)

C11 Points of entry (57%)

- C.11.1 Core capacity requirements at all times for designated airports, ports and ground crossings (58%)
- C.11.2 Effective public health response at points of entry (56%)

C12 Chemical events (58%)

- C.12.1 Resources for detection and alert (58%)

C.5.2 Implementation of a laboratory biosafety and biosecurity regime (60%)

25 May 2018

¹¹ World Health Organization. International Health Regulations (2005). Available at: <https://www.who.int/ihr/publications/9789241580496/en/>

¹² World Health Organization. State Party self-assessment annual reporting tool. International Health Regulations (2005) <https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.16/en/>

¹³ World Health Organization. Electronic State Parties Self-Assessment Annual Reporting Tool. Available at: <https://extranet.who.int/e-spar#capacity-score>

C8 National health emergency framework (64.7%)

- C.8.1 – Planning for emergency preparedness and response Mechanism (64%)
- C.8.2 – Management of health emergency response operation (68%)
- C.8.3 – Emergency resource mobilization (60%)

C13 Radiation (66%)

- C.13.1 – Capacity and resources (66%)

C3 Zoonotic events and the human-animal interface (66%)

- C.3.1 Collaborative effort on activities to address zoonoses (66%)

Although these areas represent the group mean, the wide range among the individual countries must also be taken into consideration. This range indicates that while in some IHR areas great improvement needed in one country the same challenges may not be relevant in another.

In 2018 the WHO updated the IHR reporting to introduce the State Parties Annual Reporting tool. The two WP5 countries that submitted their latest report in the IHR reporting tool reported the strongest IHR areas to be Coordination (91.4%), Response (91.4%) and Preparedness (87%) and laboratory (87%). The areas of greatest improvement are Legislation (25%) and Human Resources (41.5%). It should be noted that the use of different tools presents more challenges when comparing the data between countries.

Table 1.0 Average scores among ten focus countries from reported SPAR 2019 scores.

IHR Area	Mean	Range	Euro Average
C1: Legislation and financing	84.1%	(60% - 100%)	77%
C.1.1 Legislation, laws, regulations, policy, administrative requirements or other government instruments to implement the IHR (2005)	94		
C.1.2 Financing for the implementation of IHR capacities	78		
C.1.3 Financing mechanism and funds for the timely response to public health emergencies	80		
C2: IHR Coordination & NFP Functions	79%	(30% - 100%)	78%
C.2.1 NFP functions under IHR	78%		
C.2.2 Multi-sectoral IHR coordination mechanisms	80%		
C3: Zoonotic events and the human-animal interface	66%	(20% - 80%)	77%
C.3.1 Collaborative effort on activities to address zoonoses	66%		
C4: Food Safety	82%	(80% - 100%)	74%
C.4.1 Multisectoral collaboration mechanism for food safety events	82%		
C5: Laboratory	73.8%	(33%-100%)	80%
C.5.1 Specimen referral and transport system	84%		
C.5.2 Implementation of a laboratory biosafety & biosecurity regime	60%		
C.5.3 Access to laboratory testing capacity for priority diseases	78%		
C6: Surveillance	70%	(20%-80%)	76%
C.6.1 Early warning function : indicator- and event-based surveillance	70%		
C.6.2 Mechanism for event management (verification, risk assessment analysis, investigation)	70%		
C7: Human Resources	70%	(20%-100%)	70%
C.7.1 Human resources to implement IHR (2005) capacities	70%		
C8: National health emergency framework	64.7%	(20%-93)	72%
C.8.1 Planning for emergency preparedness and response mechanism	64%		
C.8.2 Management of health emergency response operation	68%		
C.8.3 Emergency resource mobilization	60%		
C9 Health service provision	75.3%	(33%-100%)	77%
C.9.1 Case management capacity for IHR relevant hazards	66%		
C.9.2 Capacity for infection prevention and control (IPC) and chemical and radiation decontamination	76%		
C.9.3 Access to essential health services	84%		
C10: Risk Communication	56%	(20%-80%)	66%
C.10.1 Capacity for emergency risk communications	56%		
C11: Points of entry	57%	(0-80%)	57%
C.11.1 Core capacity requirements at all times for designated airports, ports and ground crossings	58%		
C.11.2 Effective public health response at points of entry	56%		
C.12 Chemical events	58%	(20%-80%)	65%
C.12.1 Resources for detection and alert	58%		
C13: Radiation emergencies	66%	(40%-100%)	74%
C13.1 Capacity and resources	66%		

1.3 A Closer look at the five post JEE Countries

Joint External Evaluation (JEE) is a voluntary, collaborative, multi-sectoral process to provide a comprehensive evaluation of a national capacity to prevent, detect, assess, notify, and rapidly respond to various public health risks and acute events.¹⁴ Conclusions from a global analysis from Joint External Evaluations suggest that it is likely that JEEs are accurately measuring the strength of IHR-specific, public health capabilities.¹⁵

Finland¹⁶, Lithuania, Latvia, Republic of Moldova, Serbia and Slovenia make up the WP5 Partners that have undertaken Joint External Evaluation (JEE) to date. At present Bosnia and Herzegovina has expressed interest in conducting a JEE and Portugal tested the JEE tool in 2014 during a “JEET”. Table 2.0 presents focus countries in WP5 that have undergone a JEE.

Table 2.0: WP5 Partner from focus countries that have undertaken a JEE.

Date	Country	Tool
April 2015	Portugal	JEET Pilot
May 2017	Latvia	JEE Tool first edition
June 2017	Slovenia	JEE Tool first edition
October 2018	Moldova	JEE Tool second edition
October 2018	Serbia	JEE Tool second edition
November 2018	Lithuania	JEE tool second edition

The results of the JEE shows the following areas as needing the most improvement and falling into the scope of the Joint Action:

- Antimicrobial stewardship activities (P.3.4)
- Biosafety and biosecurity (P.6.1 and P.6.2)
- Risk Communication (R.5.1 and R. 5.4)
- Chemicals (CE.1 and CE.2)

Table 3.0 notes the JEE area with an average score among the five countries as 3 or less as well as the range of this score. Although there are several areas that motivate efforts for improvement, these are not proposed for further work in WP5 task 5.1 as they are out of the scope of this JA or because current efforts in another Work Package or Joint Action are taking place.

¹⁴ JEE, WHO

¹⁵ Gupta et al. Analysis of results from the Joint External Evaluation: examining its strength and assessing for trends among participating countries. Journal of Global Health. December 2018. Vol 8(2).

¹⁶ Finland is considered a high GNI country and has been excluded from the JEE analysis.

Table 3.0 JEE Average scores and range among five focus countries involved in WP5 with scores of 3 or less. The division (///) notes discrepancy with different versions of the JEE tools.

Category	JEE Area	Average	Range
National Legislation, policy and financing	P.1.3 A financing mechanism and funds are available for timely response to public health emergencies (<i>new tool only</i>)	3	2 to 3
Antimicrobial resistance	P.3.4 Antimicrobial stewardship activities /// P.3.4 Optimize use of antimicrobial medicines in human and animal health and agriculture	2.6	1 to 4
Biosafety and biosecurity	P.6.1 Whole-of-Government biosafety and biosecurity system is in place for human, animal, and agriculture facilities /// P.6.1 Whole-of-government biosafety and biosecurity system in place for all sectors (including human, animal and agriculture facilities)	2.4	2 to 3
	P.6.2 Biosafety and biosecurity training and practices /// P.6.2 Biosafety and biosecurity training and practices in all relevant sectors (including human, animal and agriculture)	2.8	2 to 4
Real-time Surveillance / Surveillance	D.2.2 Inter-operable, interconnected, electronic real-time reporting system /// D.2.2 Use of electronic tools	2.4	2 to 3
Workforce Development / Human Resources (animal and human health sectors)	D.4.1 Human resources are available to implement IHR core capacity requirements /// D.4.1 An up-to-date multi-sectoral workforce strategy in place	2.8	2 to 4
	D.4.3 Workforce strategy /// D.4.3 In-service trainings are available	2.4	2 to 3
	D.4.4 FETP or other applied epidemiology training programme in place (<i>new tool only</i>)	2.6	2 to 3
Emergency Preparedness	R.1.2 Priority public health risks and resources are mapped and utilized. /// R.1.2 National multi-sectoral multi-hazard emergency preparedness measures, including emergency response plans, are developed, implemented and tested	3	1 to 4
Medical Counter-measures and personnel deployment	R.4.2 System is in place for sending and receiving health personnel during a public health emergency /// R.4.2 System in place for activating and coordinating health personnel during a public health emergency	2.6	2 to 5
	R.4.3 Case management procedures implemented for IHR relevant hazards (<i>new tool only</i>)	2.3	2 to 3
Risk Communication	R.5.1 Risk Communication Systems (plans, mechanisms, etc.) /// R.5.1 Risk communication systems for unusual/unexpected events and emergencies	2.8	2 to 3
	R.5.2 Internal and Partner Communication and Coordination /// R.5.2 Internal and partner coordination for emergency risk communication	3	3
	R.5.4 Communication Engagement with Affected Communities (<i>same in both tools</i>)	2.6	2 to 3
Points of Entry	PoE.1 Routine capacities are established at PoE. (<i>same in both tools</i>)	3	2 to 4
Chemicals	CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies. (<i>same in both tools</i>)	3	2 to 4
	CE.2 Enabling environment is in place for management of chemical Events (<i>same in both tools</i>)	3	2 to 4
Radiation Emergencies	RE.1 Mechanisms are established and functioning for detecting and responding to radiological and nuclear emergencies. (<i>same in both tools</i>)	3	2 to 4

2.0 Partner meeting

Based on a review of IHR SPAR scores and the JEE reports, four areas, Biosafety and Biosecurity, Chemicals, AMR-One Health and Risk Communication were presented to the Partners during a WP5 start-up meeting on 4 July. The discussion determined that all of these areas were important however a more in-depth analysis was required.

In addition, Medical Counter-measures and personnel deployment and multi-hazards plan were deemed important from the JEE scores yet could be addressed in Task 5.2 and WP6 respectively.

3.0 Content Analysis

The qualitative content analysis serves as a complement to triangulate data from the existing reports.

Representatives from the twelve focus countries were invited to participate in voluntary telephone conversations with a representative from the Public Health Agency of Sweden (FOHM). The aim of the telephone conversations was to gain better insight on the country's context and the IHR implementation of the present day. Open-ended questions under four themes were posed. These themes are (1) what is working well or not so well, (2) recent improvements, (3) country context and (4) specific areas lifted in the analysis to work on in the Work Package over the JA.

All twelve countries¹⁷ participated in a telephone conversation from 22 August to 27 September. One to two representatives per country took part. Note-taking from the telephone conversations documented the dialogue and were reviewed by FOHM to conclude the results. Countries were invited to provide additional information in English on to their country's IHR implementation after the telephone conversation. Additional information included national policies, plans and strategies to provide a better picture from the country context.

The results are presented as aggregate:

- In general, the areas of the IHR implementation working well in countries are IHR coordination/communication (mainly vertically, national to local, within health sector), legislation, immunization, food safety and surveillance (yet enhancements to surveillance could take place specifically AMR).
- The areas that require strengthening and continued work include multi-sector collaboration or cross-sector collaboration, risk communication, AMR with vet sectors, collaboration with chemical sectors, constructing action plans (specific to an area or overarching), biosafety and biosecurity, points of entry and human resources.
- It was emphasised that countries are continuously working yet can always improve IHR implementation. For example structures such as SOPs, networks and legislation are in place yet require continuous improvements.

¹⁷ Information from one country was not included in the content analysis because the conversation focused on the Joint Action itself and not on the country's IHR implementation.

- Important factors to strengthen IHR implementation include taking into consideration the specific country context that the IHR functions in, multi-sector work not only in communicating but in working together and maintaining efforts to raise the importance of the IHR in the country.

After the open-ended questions were posed, a direct question was raised to gather insight on the importance of the four IHR topic areas that were discussed during the partner meeting on 4 July and gain opinions on working in these areas in the future.

- The majority of the respondents said that all four areas were relevant.
- Two countries ranked or prioritised the areas noting the AMR was the most important or a good opportunity to work with at this time.
- One country prioritised risk communication over all others.
- Two countries noted that biosafety biosecurity were the biggest challenges.
- Three countries acknowledged that chemicals was a difficult area to work with.

Through the open-ended questions, a number of barriers were described to possibly explain reasons why IHR areas may not be moving forward. Barriers that emerged were categorised as the following, from paper to practice, bridging across sector structures to raise importance of IHR and drawing clear responsibility lines in the IHR areas as in for example risk communication.

ANNEX II – Workshop 1 of 3 Report – Riga, Latvia

IHR Core Capacity Strengthening and Assessment

Workshop Report

Work Package 5 - Task 5.1

Riga, Latvia, 29-30 January 2020

A report on knowledge and practices and added value of external evaluation processes and facilitating strengthening of selected core capacities in the EU and neighbouring countries

Publication date: March 2020

EXECUTIVE SUMMARY

Workshop one of three within Work Package 5 on IHR Core Capacity Strengthening and Assessment took place from 29 to 30 January 2020 in Riga, Latvia. Forty-five professionals representing 15 countries participated to share insight on their own country's IHR implementation, current challenges and future work. The areas of focus were AMR-Stewardship, Risk Communication, Chemicals and Biosafety and Biosecurity. In addition, there was a panel dedicated to sharing experiences related to Joint External Evaluations.

The workshop involved voluntary contributions from all countries by way of presenting examples, moderating sessions, facilitating discussions and finally sharing perspectives. The focus of the workshop was on the process of moving forward to strengthen IHR-core capacities. In this way, participants provided insight regarding levels of individual capacities. Moreover, participants discussed identified barriers, recent progress made and shared plans for improvements in respective countries.

From the table discussions, one general point of agreement was the importance of functioning cross-sectoral collaboration, which is in place in varying degrees in countries. Additional discussion points are summarised in the workshop report. For countries that have undergone a JEE, although in practice the process itself was challenging, it proved valuable in driving progress by raising the importance in specific IHR areas. Lastly, countries have already made improvements in recent years within the workshop's four IHR themes.

The final day ended with a way forward for countries to learn more about activities and resources in the four areas during the coming year of the Joint Action. Availability of support systems such as the other work packages, particularly WP8 on training, Partner countries participating in WP5 as well as inter-governmental agencies (ECDC, EC and WHO) was emphasised.

BACKGROUND

The first workshop on IHR Core Capacity Strengthening and Assessment took place from 29 to 30 January 2020 in Riga, Latvia. As per in the SHARP Grant Agreement, Task 5.1 in WP5 prioritises the following countries: Bosnia and Herzegovina, Croatia, Greece, Latvia, Lithuania, Malta, Moldova, Poland, Portugal, Serbia, Slovenia and Spain.

From July to September 2019, WP5 conducted an analysis (Annex I), which involved reviewing IHR SPAR reports, JEE Country reports and the EU Decision 1082 report summary from the 12 focus countries. In addition, bilateral telephone interviews took place with each country to gain insight on the present day IHR implementation status, recent successes and identified barriers. Since SHARP's launch, two WP5 Partner Meetings took place on 4 July 2019 and 14 October 2019.

These steps led to a prioritising the following four IHR Core Capacity areas: Risk Communication, Chemicals, Biosafety and Biosecurity and AMR-One Health within WP5 over the duration of the JA. In addition, WP5 Partners expressed a preference to plan the annual workshops to include together, countries that have undertaken Joint External Evaluation (JEE) and those that have not. These decisions led WP5 Partners to implement this first of three annual workshops.

Workshop objectives:

- To increase and share knowledge of the JEE and the specific IHR indicators (AMR, Chemicals, Risk Communication and Biosafety and Biosecurity) and apply these to country context.
- To discuss recent progress and current challenges for IHR areas of (AMR, Chemicals, Risk Communication and Biosafety and Biosecurity) in the context of countries and related to the IHR and JEE standards.
- To support countries in undertaking work in these areas for the coming year.

Workshop outcomes:

- A "solid start" to a "Country WP5 Plan" to implement manageable/feasible activities in the four IHR areas over the course of the JA to strengthen IHR capacity.
- Progress on assessing (internal and external) capacity in the four areas.
- Acquiring contacts with WP5 Partner countries as well as the ECDC, EC and WHO.

WORKSHOP IMPLEMENTATION

Being that the annual workshops are to take place in Latvia, Poland and Slovenia, Work Package leaders at the Public Health Agency of Sweden commissioned a sub-group for Task 5.1 to include representatives from these countries. This group serves in an advisory and planning role prior to communicating and disseminating material to all WP5 partners.

Although 20 partner-countries are involved in the WP5, 14 of these countries participated in the workshop. One additional country had made a formal request to CHAFEA to participate as a self-financed external guest bringing the total to 15 countries. Reasons for non-attendance included last minute cancellations during the COVID-19 outbreak and administrative issues.

The countries that participated in the workshop:

1. Bosnia and Herzegovina (BA)
2. Croatia (HR)
3. Greece (GR) (via link)
4. Latvia (LV)
5. Poland (PL)
6. Serbia (RS)
7. Slovenia (SI)
8. Spain (ES)
9. Netherlands (NL)
10. France (FR)
11. Sweden (SE)
12. Norway (NO)
13. Italy (I)
14. United Kingdom (UK)
15. Ukraine (*permitted to participate in Workshop 1 as self-financed external participant*)

In addition, the European Commission (DG SANTE), The European Centre for Disease Prevention and Control (ECDC) and the WHO Regional Office for Europe and the WHO Office for the Ukraine took part.

Structured to engage countries into discussion and information sharing on the IHR Core Capacity topics, the workshop focused on four IHR capacities in need of strengthening and on sharing experiences on Joint External Evaluations. Although important, the workshop did not include technical training but rather focused on the process of moving core capacities forward. Advancing core capacities is context-specific and requires assessing where countries stand today, identifying and addressing barriers and determining facilitators.

After an introduction that reviewed the analysis of strengths and weaknesses there was time allotted to discuss how countries are managing COVID-19. Thereafter the agenda continued as planned, although the topic of COVID-19 emerged throughout the two days with examples during the table discussions.

Each Block started with a country presentation providing an example in the specific IHR Capacity. A presentation by a WHO topic expert to explain the IHR and SPAR standards followed the introductory presentation. Next, table discussions, which were chaired and

reported back by WP5 colleagues, took place. As it was difficult to engage a topic expert at each of the four tables, one topic expert circulated among the tables to briefly join the discussion and to moderate the report back in plenary. The table seating was prepared in advance to ensure that countries that had undergone a JEE were represented at each table.

Workshop Block: AMR and the Animal-Human Interface

The block on AMR started with a presentation from a representative the Center for Disease Prevention and Control on Latvia's progress working on Antimicrobial Stewardship after the country's JEE. Here an important argument was explained on how to frame the issue of AMR as an urgent public health issue. A second point noted that a low JEE score on antimicrobial stewardship prompted planning and implementing a national plan on AMR. Finally, the importance of working in many areas from hospitals to the environment was emphasised. Latvia is moving forward with implementing their national AMR plan during the coming years.

An introductory presentation via weblink by the WHO on the IHR and JEE standards listed below followed the country presentation.

- SPAR C3: Zoonotic events and the human-animal interface,
- JEE P3.1: Effective multisectoral coordination on AMR,
- JEE P3.2: Surveillance of AMR,
- JEE P3.3: Infection prevention and control,
- JEE P3.4: Optimize use of antimicrobial medicines in human and animal health & agriculture.

In addition, the WHO presentation reviewed global initiatives, activities and resources available for working in this area. The table discussions, chaired by WP5 partners, started thereafter.

A representative from the Ministry of Health in France moderated the plenary session involving a report back of the group discussions. The moderator selected had a key liaison role as the MOH in France is involved in the coordination team of the European joint action EU-JAMRAI on AMR and Healthcare acquired infections, and leads the SHARP Work Package 4 on sustainability. The following points from the report back were summarised:

- Multisectoral collaboration is fundamental for this area. The importance of coming to a common agreement in the human and animal health sectors is important as the One Health approach does not seem to be commonly accepted.
- The degree of collaboration varied between the countries where, for example, animal health integrated into the health sector, other countries had weekly meetings between the sectors and other countries saw the need to build collaborations, which do not exist today.
- Surveillance of AMR pathogens in humans and animals were either established or needed to improve. Some countries reported upon networks of laboratories (for animal and human health)

- AMR national plans existed in some countries with varying degrees of implementation. Importantly noted was that even if a national plan was nonexistent, AMR work still occurs at, for example, local levels.

The session ended with a summary of the main points from the discussion and informing the group of outcomes from EU-JAMRAI that could support WP5 during the SHARP Joint Action. These outcomes include 1) An assessment tool to measure AMR work done in a country, 2) Training tools within health care settings, 3) A practice in JAMRAI deemed valuable were the country-to-country visits over the course of the JA. The country visits provided a valuable learning opportunity to gain close insight on a country's AMR work. As well, the country visits were mutually supportive whereby countries could generalise relevant components from one country into their own as well as identify challenges or factors that would not work in its own country and finally 4) A new network (EARS-VET) for the surveillance of AMR pathogens in animals.

Workshop Block: Risk Communication

The second block focused on Risk Communication. This session started with a presentation by Berta Suárez from the Ministry of Health in Spain on the emergence of Crimean Congo in the country. The importance of communication between sectors, for example, the scientific and the public health sectors was emphasised for promoting health protection. As well, determining what constitutes a risk (during a risk assessment) and communicating to the appropriate target groups was emphasised. Finally, improvements made in coordinating risk communication learned from this experience were further analysed in a thorough After Action Review.

A presentation from the WHO on SPAR and JEE standards for Risk Communication followed the country presentation. These indicators are:

- SPAR C10: Risk Communication,
- JEE: R.5.1: Risk communication systems for unusual/unexpected events and emergencies,
- JEE: R.5.2 Internal and partner coordination for emergency risk communication,
- JEE: R.5.3 Public communication for emergencies,
- JEE: R.5.4 Communication Engagement with Affected Communities,
- JEE: R.5.5 Addressing perceptions, risky behaviours and misinformation.

In addition, the WHO presented on Risk Communication and Community Engagement (RCCE) in health emergencies and ongoing activities in this area. The introductory presentations were followed by round table discussions to determine strengths and barriers as well as the general function of risk communication in countries.

Leah Morantz, the Head of Communications for Public Health Wales and leader of SHARP WP2 on dissemination, moderated the plenary report back session.

The following points were raised:

- Countries determine that they are coordinated appropriately related to risk communication. For example, pre-determined spokespersons or expert leads for the different IHR issues are in place. Communications pieces, strategies and messages

such as FAQs and news releases are prepared in advanced and continuously revisited.

- Risk communication teams or persons responsible for risk communication are available in different government agencies for the specific health issues. Regardless of pre-planning, examples were raised when in practice authorities responsible to lead in communication delegate this task or other actors take on this role.
- Communications channels between sectors and agencies exist as well as vertically from local to national. Some countries structured these channels in an Emergency Risk Communication Plan while other countries did not have a formalised plan.
- The dynamics of risk communication continuously fluctuate as emergencies evolve. This poses a challenge to ensure that spokespersons have the most current information prior to speaking with media and means that risk communications expertise needs to form part of emergency response.
- Fake news and misleading information on social media is an increasing threat to public health. It is a challenge to mitigate media publications that not based on fact or social media posts that occur extemporaneously. Examples from this early era of COVID-19 were provided.
- Risk communication coordination, transparency and message consistency was important when communicating to the public in an emergency. As well, it is important to monitor media and evaluate media strategies during and after emergencies. Critically, countries agreed that building trust with their local populations in 'non-emergency' times is essential to ensuring that populations have trust in institutions during a crisis.
- There was a view that further training in this area for specific stakeholders in countries would be beneficial.

The moderator closed the session by providing a perspective on Risk Communication related to the COVID-19 and the importance of contingency planning. Points made included anticipating and preparing structures for communication in a crisis, setting out clear roles and processes before a crisis emerges.

Workshop Block: JEEs

The first day ended with a panel discussion on Joint External Evaluations. The panel opened with a presentation by the WHO Regional Office for Europe on the JEE process and the state of implementation across the world. The JEE process starts with an official request from a country to the WHO, continues with a self-assessment launched with an orientation workshop for relevant stakeholders and then a 5-day external evaluation of a team of experts. Afterward, a country report is provided, which would subsequently inform a national action plan for health security. All final JEE mission reports are published on the WHO website. As of 28 February 2020, there are 112 JEEs completed and 9 in the pipeline globally. In the European Region, 18 of 53 member states have completed a JEE.

There are seven countries in WP5 that have undergone a JEE and two countries (Bosnia and Herzegovina and the Netherlands) that are in the pipeline to conduct a JEE as well as the Ukraine.

During the JEE Panel workshop representatives from Latvia, Finland, Serbia and Slovenia shared their country's experience in preparing, implementing and following up with the JEE. Questions on pre-, during and post- JEE phases were posed by those countries that have not undergone a JEE.

Some of the points made by the post-JEE countries:

- Countries agreed that the main “job” of the JEE was the self-assessment. Conducting an accurate self-assessment of the 19 technical areas was a very challenging task which required a lot of time to plan and coordinate many persons representing multiple sectors. For example, Finland involved 250 persons into the self-evaluation process. Nonetheless, the JEE process was helped by inviting stakeholders around the table.
- The self-assessment tool to determine a representative level of the capabilities in the country was difficult to interpret. This was partly due to a slightly different and more broad formulation of questions when compared to the SPAR annual assessment. An illustration of overall situation required clear guidelines to ensure a consistent interpretation of the questions by the multiple sectors involved.
- In addition, one of the first countries that undertook a JEE noted that it was a challenge to interpret the entire JEE process, including role and responsibilities of different partners including the country, the WHO and external experts. At that time, there were few country examples of JEE experiences available and JEE orientation workshop was not in place.
- The credibility and professionalism of the team that conducted that JEE was fundamental for outcome of the external assessment.
- It was important and worth the effort to prepare a JEE. The JEE prompted implementation of recommendations which is essential as there is no purpose to assess a country's preparedness without the intention to make improvements. For example, Latvia noted that they thoroughly assessed the capabilities of the country to realise the weakest areas.

Noting that the first cohort of countries are reaching the 5-year post-JEE point, a question on JEE II was posed. WHO will be contacting relevant countries by the end of the year to determine which countries plan to undergo the second JEE round in order to support countries in this process in the coming year.

Workshop Block: Chemicals

The block on chemicals opened with a presentation from the National Institute of Public Health in Slovenia on advancing preparedness in the area of chemicals. This presentation reviewed the national structure, which is led by the Ministry of Defence which includes an electronic real-time surveillance tool for the monitoring chemical hazards and emergency events as well as for conducting a risk assessment and coordinating emergency response. The presentation ended with an example of a large chemical emergency and the resulting response.

The SPAR and IHR standards were reviewed via link by the WHO European Centre for Environment and Health (ECEH), Bonn, Germany:

- SPAR: C12 Chemical events,
- JEE: C12.1 Resources for detection and alert,
- JEE: CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies.
- JEE: CE.2 Enabling environment is in place for management of chemical Events

The presentation by the WHO emphasised the breadth of this IHR area and current international activities.

The group discussion pointed to the following common points:

- There is a need for cohesion to better monitor and identify problems with chemical surveillance.
- Improved connection between industry and public health response is needed.
- Better health sector involvement is needed both in data exchange, for example with poison control centres and in the operational management of chemical emergencies and non-emergencies.
- Questions were raised on a need for laboratory mapping to determine lab capacity in countries.
- There is a varying degree of chemical expertise between organisations and little communication between these experts. There were examples from countries indicating that coordination works well at the local level yet not at the national level.

Workshop Block: Biosafety and Biosecurity

The country presentation was by a representative from Department for Epidemiological Surveillance, Centre for Disease Control and Prevention, Institute of Public Health of Serbia. The presentation focused on the newly developed National Action Plan for Health Security with several identified key stakeholders after Serbia's Joint External Evaluation. The legislation on biosafety and biosecurity and the strategic steps to achieve future goals were outlined. Some important recommended measures regarding biosafety and biosecurity in the Serbian national plan are: improvement of legislation regarding biosafety and laboratory licensing, establishing records and inventories of dangerous pathogens and toxins and improvement of the capacity of existing laboratories due to the establishment of Level 3 biosafety.

The standards for the IHR and JEE were reported upon by a representative from the Department of Microbiology at the Public Health Agency of Sweden with a presentation prepared by the WHO. As well activities that are taking place within WP7 with regard to tools and recommendations for laboratory biosafety and biosecurity were presented.

These indicators are:

- SPAR C.5.2 Implementation of a laboratory biosafety and biosecurity regime,
- JEE P.6.1 Whole-of-Government biosafety and biosecurity system is in place for human, animal, and agriculture facilities,
- JEE P.6.2 Biosafety and biosecurity training and practices,

Round table discussions followed the introductory presentations and the moderator summarised the discussions in the plenary session that followed.

The main points made from the group discussions:

- A distinction between biosafety and biosecurity was made whereby the latter is focused on policies and regulations for minimizing risks of unlawful access to, and misuse (including deliberate release) of, biological agents or information related to them.
- Countries would like to advance laboratory capacity levels or develop agreements with other countries for allowing rapid diagnostics of high consequence pathogens (i.e. risk group 3 and 4 pathogens)
- Among the countries, it is standard that a list of human pathogens exists and often lists of animal and crop pathogens. Nevertheless, there is a need to prioritize pathogens as a base for planning preparedness. In addition, sharing lists between countries could be beneficial.
- Although there is usually national legislation that covers the aspects of biosafety, a specific legislation for biosecurity is often lacking.
- Training in biosafety and biosecurity was deemed necessary for workers across the system, from first responders to laboratory staff.

Workshop Evaluation Survey

A pre-survey developed by WP3 was sent to participants determine baseline knowledge in IHR core capacities and on Joint External Evaluation. The results of this survey will inform the planning of workshop 2 of 3.

Way Forward

The workshop ended with a session to discuss the way forward toward workshop two in Warsaw. This session included presentations by ECDC, the European Commission and the WHO on resources and upcoming planned activities and initiatives that can support countries in IHR strengthening during the next year.

As well, the National Institute for Public Health and the Environment in the Netherlands (RIVM) presented an e-SPAR mapping project. In this project the scores on the core capacities were assessed by looking at the 'level not reached' and the keywords that are additional to the 'level not reached' compared to 'the level that was reached'. This was done for two groups of countries, countries that score below the general average and countries that score above the general average. This analysis provides information on what type of activities are needed to be able to generate higher scores. The presentation reported on the four IHR areas with an analysis based on country SPAR reports with examples of common structures and initiatives undertaken by countries.

The Institute of Public Health of Serbia who is leading the training Work Package (WP8), noted that there will be a basic training and an advanced training planned to cover technical areas in IHR core capacities for both biosafety and biosecurity and chemicals. Related to risk communication, they are investigating planned training sessions in this area led by ECDC and WHO.

The workshop ended with a short discussion on how the information could feed into the other Work Packages. Notably, the workshop provided an opportunity for collaborative links as representatives from WP1, WP2, WP4, WP6, WP7, WP8 and WP9 were present.

Partners were encouraged to continue work in respective countries prior to the next workshop. For example, the use of an excel tool based on IHR measurement surveys and a benchmarking resource was emphasised to structure relevant country initiatives. As well, future contact with the Work Package leaders would take place by way of bilateral telephone calls with countries or a webinar with the group. Finally, continued contact with countries that had worked together was encouraged.

The next steps until the workshop in Warsaw, Poland:

February-May 2020: Planning and implementation by focus countries to select and prioritise timely and appropriate activities and initiatives in the four IHR Core Capacity areas.

May-June 2021: A webinar and/or an ancillary meeting during the upcoming SHARP Partnership Forum for WP5 Partners.

June-August 2020: Bilateral telephone interviews with the focus countries aimed to gauge progress, challenges as well as viewpoints for the theme of the workshop in Warsaw, Poland

February or March 2021: Workshop two in Warsaw, Poland

Action Points

AMR and the Animal-Human Interface

- Take steps to build alliances or increase the degree of cooperation with animal and human health sectors toward a common view of AMR challenges and solutions. For example, weekly meetings between the human and animal sectors.
- Establish or improve surveillance for AMR pathogens in humans and animals. This may include building laboratory networks.
- Establish and implement AMR national plans, which build upon AMR work that is currently in place and takes into consideration the situation of individual countries.

Risk Communication

- Maintain functioning risk communication coordination in countries and continued efforts for improvement. For example coordination, transparency, message consistency, media monitoring and evaluating media strategies during and after emergencies.
- Maintain designated risk communication teams or persons in different government agencies for the variety of IHR issues.
- Strengthen communications channels horizontally between sectors and agencies and vertically from local to national levels.
- Establish and test Emergency Risk Communication Plans.
- Participate in training in Risk Communication should this need be identified in countries.

Chemicals

- Improve interconnections for chemical surveillance to better monitor and identify problems.
- Establish or strengthen networks between industry and public health response.
- Improve health sector involvement both in data exchange for example, with poison control centres and in the operational management of chemical emergencies and non-emergencies.
- Map laboratory capacity in countries to determine areas for improvement.
- Establish communications between persons and organisations with chemical expertise horizontally across sectors and vertically from local to national levels.

Biosafety and Biosecurity

- Establish specific legislation or policy for biosecurity. Underline a distinction between biosafety and biosecurity.
- Advance laboratory capacity levels within countries and/or develop agreements with other countries for allowing rapid diagnostics of high consequence pathogens.
- Prioritise pathogens as a base for planning preparedness. This could include maintaining a list of human pathogens and developing lists for animal and crop pathogens. Consider sharing lists between countries.
- Participate or make available training in biosafety and biosecurity for workers across the system, from first responders to laboratory staff.

ANNEX III – Workshop 2 of 3 Report – Online (Warsaw, Poland)

IHR Core Capacity Strengthening and Assessment

Workshop Report
Annual Workshop 2 of 3
Work Package 5 - Task 5.1

Online, 22 March 2021

A report on knowledge and practices and added value of external evaluation processes and facilitating strengthening of selected core capacities in the EU and neighbouring countries

Publication date: November 2021

SUMMARY

Annual workshop two of three within Work Package 5 (WP5) - *IHR Core Capacity Strengthening and Assessment* took place online on the 22 March 2021. Due to the ongoing COVID-19 pandemic, consensus was gathered among WP5 partners to proceed with a brief virtual workshop as scheduled during the first quarter of 2021. The workshop was planned to involve a maximum of 50 participants representing IHR focal points and/or EWRS focal points. Furthermore, the workshop topic was narrowed to one IHR core capacity: Risk Communication.

Thirty-seven professionals representing 14 countries, the European Centre for Disease Prevention and Control and the World Health Organisation participated. Voluntary contributions from all participants and the possibility to meet online led to a successful second annual workshop. Profiling country examples, moderating sessions, facilitating discussions and importantly sharing country experiences structured the workshop format.

Country presentations were made by partners in Poland, Slovenia, Serbia, Greece and Sweden on risk communication in the context of the COVID-19 pandemic. During the moderated break out discussions participants raised pertinent communication matters related to COVID-19 in respective countries. Participants selected two topics to discuss further the closing plenary discussion. These topics were gaining trust among the population and measuring this and communication related to COVID-19 vaccination.

The session ended with brief remarks from the work package leaders toward the next year for the third annual workshop.

BACKGROUND

The following countries are prioritised in Work Package 5 (WP5) Task 5.1: Bosnia and Herzegovina, Croatia, Greece, Latvia, Lithuania, Malta, Moldova, Poland, Portugal, Serbia, Slovenia and Spain. The task aims to *“further enable exchange of knowledge between countries”* taking into consideration country experience such as Joint External Evaluation (JEE) and work to advance specific Core Capacities of the international health regulations (IHR). The outcome of Task 5.1 is for *“practical sharing of best practices for a better understanding on how to proceed to increase preparedness in identified areas in need of strengthening.”*

From July to September 2019, WP5 conducted an analysis, which involved reviewing IHR State Party Annual Reports, JEE Country reports and the EU Decision 1082/2013 report summary among the 12 focus countries. In addition, bilateral telephone interviews took place with each country to gain insight on the present status of IHR implementation, recent accomplishments and to identify possible barriers.

These steps led to prioritising of the following four IHR areas: Risk Communication, Chemicals, Biosafety and Biosecurity and AMR-One Health within WP5 over the duration of the JA. In addition, WP5 Partners agreed that annual workshops should include both countries that have undertaken JEE and those that have not. These decisions led WP5 Partners to implement the first of three annual workshops.

The first annual workshop in January 2020, focused on AMR-Stewardship, Risk Communication, Chemicals and Biosafety and Biosecurity. In addition, a panel shared country experiences of conducting a Joint External Evaluations. The workshop included as well break out sessions to further share experiences in these IHR areas and thereby learn from one another.

The subsequent annual workshop was originally planned to occur in Warsaw, Poland over a two-day period and involve up to 100 participants from multiple sectors to work collaboratively on one IHR Core Capacity. During August - September 2020 the WP5 Partners were contacted by the Work Package leaders in a planned checkpoint. The checkpoint provided a forum to determine progress made in advancing IHR Core Capacity by partners since January 2020. The checkpoint also provided an opportunity to revisit IHR priorities and need for support in light of the COVID-19 pandemic. Participants expressed a preference to proceed with short workshop to share experiences and support one another with a narrowed focus on risk communication.

Thereafter, the Task 5.1 workgroup wrote a proposal for the second workshop which was agreed upon by all WP5 partners. Although partners were still occupied with managing the ongoing COVID-19 pandemic, planning and implementing this workshop was deemed important to mutually support one another in continued efforts. The format of the workshop was altered to involve up to 50 participants from IHR Focal Points or EWRS Focal Points and meet online for a half day.

WORKSHOP REPORT

The Task 5.1 workgroup is composed of WP5 partners from Latvia, Poland and Slovenia as well WP5 leaders at the Public Health Agency of Sweden. This advisory group is responsible for preparing the annual workshops, communicating to the broader WP5 partners and analyse eventual results with the task.

Twenty SHARP partner-countries are involved in the WP5 whereby 14 countries participated in the workshop.

Participating countries:

1. Croatia (HR)
2. Greece (GR)
3. Latvia (LV)
4. Poland (PL)
5. Serbia (RS)
6. Slovenia (SI)
7. Spain (ES)
8. Netherlands (NL)
9. Finland (FI)
10. Germany (DE)
11. Sweden (SE)
12. Norway (NO)
13. Italy (I)
14. United Kingdom (UK)

In addition representatives from the European Centre for Disease Prevention and Control (ECDC) and the World Health Organization (WHO) took part.

Workshop Aim:

To gain insight on Risk Communication implementation among countries during COVID-19.

Workshop Objectives:

- To share country experiences of the IHR Core Capacity Risk Communication applied to the country context during the COVID-19 pandemic.
- To discuss recent progress and current challenges for Risk Communication in the context of countries and related to the IHR, JEE:s during the COVID-19 pandemic.

Workshop Outcomes:

- Acquiring contacts with WP5 Partner countries as well as the ECDC, EC and WHO.
- Gaining insight on country efforts aimed to strengthen surveillance and risk communication.

Country Presentations

The country presentations were structured using a common template to describe how risk communication evolved over the pandemic with descriptions of actual examples and learnings. The components of the country presentations included describing existing mechanisms or frameworks, examples of risk communication efforts during the pandemic and how risk communication evolved over the course of the pandemic. The workshop also included break out sessions to engage participants into dialog by sharing country experiences.

As Poland hosted this annual workshop a representative from the Epidemiologist at the National Institute of Public Health in Poland welcomed the participants. An example on risk communication during the pandemic in Poland followed. The presentation focused on key messages from credible stakeholders including consistent communication when announcing each population based measure. He also noted the importance of infographics and epidemiological graphs to explain the course of the epidemic and remind people of measures to stop the spread of infection. Finally examples of specialised campaigns were described.

The second presentation was by the Communication Department at the National Institute of Public Health in Slovenia. The presentation described the evolving communication efforts during the COVID-19 pandemic. As well governmental structures and ongoing crisis communication as well as planned communication campaigns tailored to specific population groups, such as younger audiences, and on specific topics such as vaccination were explained. The presentation ended by describing how they continually gather feedback from the public on the communication efforts to determine their effect and hence alter them in the future.

The group then proceeded to a moderated break out session.

After the breakout, the plenary session recommenced with a presentation by a representative from the Institute of Public Health Serbia. The presentation started by describing the components of risk communication, the multi-sectoral structure and strategic communication documents and policies that guide COVID-19 related communications in the country. The presentation then proceeded to report on communication related to vaccine including strategically planning of communication with experts involved in multiple sectors and changes in perceptions among the population over time. Finally, feedback mechanisms from the population such as telephone lines, surveys and focus groups to both immediately respond to concerns by the population as well as to modify communication messages related to COVID-19 were presented.

The presentation by colleagues from the National Public Health Organization in Greece emphasized planning and coordinating risk communication in the country. This presentation explained the structure of risk communication in Greece including the establishment of an advisory committee to the Ministry of Health and contact points such as telephone numbers for the public. The presentation also focused on timely and correct information on COVID-19 in the media.

The final presentation was by a representative from the Unit for Press and Media at the Public Health Agency of Sweden. The presentation described the structure of crisis communications related to press and media at the Agency. During the pandemic it was a challenge to meet requests by the media on this new disease given that there were so few credible experts and a great number of requests. There were also active efforts made to respond in social media during the pandemic to ensure correct information was available in these forums. As well feedback structures for the public to contact the Agency and other authorities for credible information including a website on COVID-19 information continue to be important.

Moderated Break Out sessions

The first two country presentations and the subsequent three country presentations were followed by break-out sessions. The moderators for these sessions were from NIJZ-SI, NIZP-PZH PL, DH-UK, RKI-DE, THL-FI and Fohm-SE.

In line with the first annual workshop, the break out groups were composed of partners from focus and non-focus countries as well as countries that had experiences from Joint External Evaluations. The break out sessions were informed with open-ended questions which were led by the moderators. The group itself steered the issues within risk communication and were invited to share insights from their country in relation to the preceding presentations or in general.

Issues raised by the break out groups included:

- The influence on the public of communication from both within the country and outside of the country (i.e.: what are public health measures elsewhere, how do the statistics such as death rates compare).
- International communication between authorities and the importance of gathering international consensus on COVID-19 (i.e.: case definitions and common measures at borders).
- Sustained efforts to communicate and prepare the population for measures to be implemented and promote adherence to measures
- Perceptions of risk for acquiring COVID-19 over time.
- Monitoring and analysing information arising through different communications channels as well as reactions of communication efforts by the public over time. For example changes or new trends and opinions arising in population sub-groups or communities.
- The importance of not only having a plan but also trained professionals to manage risk communication including rumor management.
- Communication pieces such as fact sheets, social media articles and reports written by credible authorities and delivered by credible spokespersons (i.e.: teachers) were deemed important. Moreover, the aim should be to educate and not merely instruct.
- Training in order to work effectively with media is necessary

Closing Plenary Session

The final plenary session was moderated by a colleague from the State Emergency Medical Service in Latvia and raised on two issues related to Risk Communication during the pandemic. The first discussion topic was Communication related to vaccination and the second was on Building Trust among the population and measuring this. In the final plenary participants posed questions related to means to build trust during the actual pandemic and tackling misinformation. Vaccine communication dominated the discussion give that many participants raised issues of trust in the safety and efficacy of the current vaccines within their respective populations.

ANNEX IV- Workshop 3 of 3 Report – Ljubljana, Slovenia Workshop Evaluation

A pre-post survey developed by WP3 was sent to participants before and after the workshop. The results of this survey will inform the planning of the final workshop.

Next steps

There will be a third annual checkpoint which includes bilateral meetings with the work package leader and focus countries is planned during 2021. The purpose of these checkpoints to determine advances IHR core capacities, including risk communication and implementation challenges. The checkpoint will also gather views for planning the third and final workshop.

Pending the 12-month extension for JA-SHARP, the final workshop for Task 5.1 is planned to take place in Slovenia in May 2022. The final report is due in October 2022.

Workshop Report Annual Workshop 3 of 3 Work Package 5 - Task 5.1

Slovenia, 19-20 September 2022

Publication date: January 2023

SUMMARY

The third and final annual workshop of three within Work Package 5 (WP5) - *IHR Core Capacity Strengthening and Assessment* took place in Ljubljana, Slovenia on 19-20 September 2022. The workshop was planned to involve a maximum of 50 participants representing IHR focal points and/or EWRS focal points over a two day period.

The workshop coordination group in consensus with the partner countries chose to focus on IHR topics of Surveillance and Risk Communication. These topics were selected based on checkpoint interviews, which noted that these core capacities have strengthened over the joint action. In addition, international policy structures such as revisions to Decision 1082/2013/EU and amendments to the IHR and changes to the JEE were selected as relevant topics for sustainability.

The workshop opened with a keynote speech from the Ministry of Health in Slovenia. Thereafter, presentations from the focus countries, in addition to presentations by the ECDC, WHO and on the WP5 SimEx feasibility study and WP4 on sustainability

led to a productive annual workshop. The structure of the workshop which profiled country examples, promoted discussion with moderated sessions and round table questions allowed for a lot of room to truly share country experiences structured the workshop format. Twenty-two professionals representing ten countries, the European Centre for Disease Prevention and Control (ECDC) and the World Health Organisation participated.

Country presentations were made by JA SHARP partners from Slovenia, Serbia, on risk communication and by Portugal and Latvia related to surveillance in the context of the COVID-19. During the moderated break out discussions, participants raised pertinent communication matters related to COVID-19 in respective countries. Participants selected two topics to discuss further in the closing plenary discussion. These topics were gaining trust among the population and measuring this and communication related to COVID-19 vaccination. The session ended with brief remarks from the work package leaders.

BACKGROUND

The following countries are prioritised in Work Package 5 (WP5) Task 5.1: Bosnia and Herzegovina, Croatia, Greece, Latvia, Lithuania, Malta, Moldova, Poland, Portugal, Serbia, Slovenia and Spain. Task 5.1 aims to *“further enable exchange of knowledge between countries”* taking into consideration country experience such as Joint External Evaluation (JEE) and work to advance specific Core Capacities of the international health regulations (IHR). The outcome of Task 5.1 is for *“practical sharing of best practices for a better understanding on how to proceed to increase preparedness in identified areas in need of strengthening.”*

From July to September 2019, WP5 conducted an analysis, which involved reviewing IHR State Party Annual Reports, JEE Country reports and the EU Decision 1082 report summary among the 12 focus countries. In addition, bilateral telephone interviews with each country provided insight on the status of IHR implementation..

These steps led to prioritising of the following four IHR areas: Risk Communication, Chemicals, Biosafety and Biosecurity and AMR-One Health within WP5 over the duration of the JA. In addition, the annual workshops would all partner countries; those that have undertaken a JEE and those that have not.

The first annual workshop (January 2020) focused on the four areas and featured country experiences in conducting a Joint External Evaluations. The subsequent annual workshop was originally planned to occur in Warsaw, Poland over a two-day period and involve up to 100 participants from multiple sectors to work collaboratively on one IHR Core Capacity. However after conducting a second checkpoint it was determined that countries were occupied with managing the COVID-19 pandemic but saw a value in meeting online.

Thereafter, the Task 5.1 workgroup in consultation with the partner countries planned the second workshop (22 March 2021) it was online and involved up to 50 participants from IHR Focal Points or EWRS Focal Points for a half day. This workshop focused on Risk Communication with country examples and a plenary discussion on building trust in communication as well as communication regarding vaccine.

Based on the outcomes of the two workshops, analysis of an additional check point among focus countries, a workshop workgroup planning meeting it was determined that the third and final workshop should focus on surveillance and risk communication. In addition international policy structures would be featured and discussed. The third and final workshop was originally planned to take place in the spring of 2022 but was rescheduled and implemented in September 2022.

WORKSHOP REPORT

The Task 5.1 workgroup is composed of WP5 partners from Latvia, Poland and Slovenia as well WP5 leaders in Sweden. This advisory group is responsible for preparing the annual workshops, communicating to the broader WP5 partners and analysing results with the task.

Twenty SHARP partner-countries are involved in the WP5 whereby ten countries participated in the workshop 19-20 September:

1. Bosnia and Herzegovina
2. Croatia (HR)
3. Greece (GR)
4. Latvia (LV)
5. Poland (PL)
6. Slovenia (SI)
7. Finland (FI)
8. Germany (DE)
9. Sweden (SE)
10. Norway (NO)

In addition representatives from the European Centre for Disease Prevention and Control (ECDC) and the World Health Organization (WHO) took part.

Target Group: One to two experts per country. These persons should be familiar or work actively with capacities and challenges relating to the IHR and EWRS.

Workshop Objectives:

- To increase and share knowledge on better practices of the IHR capacities (Surveillance and Risk Communication) within the country context.
- To discuss moving forward and current challenges for sustaining the capacity advances in IHR areas of (Surveillance and Risk Communication) in the context of countries and internationally.
- To inform the final task 5.1 report including policy briefs for the policy makers.

Workshop Outcomes:

- Acquiring contacts with WP5 Partner countries as well as the ECDC, EC and WHO.
- Gaining insight on country efforts aimed to strengthen surveillance and risk communication.
- Gathering information for further analysis in the final report.

Introduction

The workshop opened with keynote remarks from the Director-General of the Directorate for Public Health at the Ministry of Health of Slovenia and Chair of the WHO Executive Board. Here the importance of the IHR and the role of the focal points was made distinct. As well, collaboration within country structures but also between countries will continue to be essential for the IHR. Notably, trust in and leadership by governments has been central in managing the pandemic.

Country Presentations

An active session walking through Ljubljana with icebreaking activities built a rapport among participants in order to facilitate dialog during the two days. This session was followed by two country presentations from Latvia and Portugal on surveillance.

A representative from the State Emergency Medical Services, Latvia presented on the establishment of a real-time surveillance system in the health care services. This automatic system allows for the monitoring of hospital beds as it is integrated with the hospital internal system. This system was constructed quickly based on the acute need to oversee the operational number of beds in hospital wards including ICU:s on a daily basis in managing COVID-19. Notably, this real-time surveillance system was a recommendation from Latvia's JEE.

The second presentation was by a representative from the Directorate-General for Health, Portugal. This presentation provided an overview and insight to the comprehensive surveillance system that had been implemented during the COVID-19 pandemic. There are legal structures which underpin the wide-scope surveillance system. The system is divided between indicator-based and event-based and collects and organises data from incidence rates, contact tracing, vaccination and real time data on causes of death. Data is entered by operational staff and analysed at the national level.

The presentations were followed by facilitated table discussions with structured questions.

The next session focused on Risk Communication. Two presentations from Serbia and Slovenia were a follow-up from the online IHR Strengthening workshop number 2 in March 2021.

A colleague from the Institute of Public Health Serbia gave examples of progress made in risk communication structures and design based on continual evaluation efforts. For example, a behavior insights survey provided information on vaccination and to learn from citizens on what is important when even reflecting on actual behaviours. As well there were six waves of cross-sectional surveys to understand

and follow the evolution of how the citizens were interpreting COVID-19 information and the severity of the disease.

The second presentation was by from the Communication Department at the National Institute of Public Health in Slovenia. The presentation described the evolving communication efforts during the COVID-19 pandemic. Examples from campaigns such as “Health is caring for all” and examples of health behaviours as well as infographics which are easy to understand. Importantly factors such as on transparency and trust are important in risk communication.

These presentations were followed by facilitated table discussions with structured questions.

Moderated Round Table Sessions

The first two country presentations on surveillance and the subsequent two country presentations on risk communication were followed by structured facilitated round table discussions. The moderators for these sessions were from SEMS-LV, ECDC, RKI-DE and Fohm-SE.

In line with the first and second annual workshops, the groups were composed of partners from focus and non-focus countries as well as countries that had experiences from Joint External Evaluations. The discussion was structured with open-ended questions which were led by the moderators. During the discussions countries raised examples from their own countries related to surveillance and risk communication.

A summary of issues raised among the four groups include:

Surveillance

- Some recommendations and results of country Joint External Evaluations were gained political support and were ultimately adopted and implemented after the start of the COVID-19 pandemic.
- Over the recent pandemic years surveillance systems have successively become more comprehensive, integrated and new surveillance structures have been constructed. Sustaining and maintaining these systems should be prioritised.
- Surveillance systems evolved according to the needs of the pandemic to gather data to guide decision making.
- In order to guide interventions and decisions, it is important to gather data where infections are actually occurring in real time as well with focus on different subgroups of the population.
- Different sectors are involved in surveillance. Important to determine which data and information are important to cross link and share this information in order to gain a useful picture of health.

- Data IT systems needed to be updated due to the amount of information being collected in order to cope with it.

Risk Communication

- As there was confusion experienced regarding non-pharmaceutical countermeasures and the changes in recommendations over a short period of time, it is fundamental to continually oversee the communications strategy and messaging.
- Communications strategy over the pandemic changed according to the public perception of the severity/risk and knowledge of the disease as well as when new information (for example vaccination) was disseminated.
- Risk Communication and Community Engagement as a core capacity is stronger today compared to start of COVID-19. For example, there are more human resources dedicated to risk communication, efficient processes established and improved media communication technology.
- Sustaining behaviour change over time is a challenge which in part require new communications messages based on the risks during the present day.
- Credible spokespersons, trust in the persons and institutes as well as consistent information are very important during crisis communication to the public.
- There was an immediate drive from the public for information on COVID-19. At the same time all groups in society, even the ones not demanding the information needed to be reached with information that they could understand and adopt.

International Structures

This session was focused on international policy structures that are currently changing in the area of preparedness and health security. Information on the IHR amendments, Pandemic Instrument, Preparedness 2.0, revisions to Decision 1082/2013 and ECDC's mandate were presented followed by a plenary discussion.

Nicholas Isla from the World Health Organisation EURO provided a comprehensive overview on the changes made to the SPAR and JEE tools. In addition he outline the processes forward regarding the IHR amendments, the pandemic instrument as well as at the European level: Preparedness 2.0 which aims to strengthen health security with practical activities in the EURO Region.

A representative from the Emergency Preparedness and Response Support section of the European Centre for Disease Prevention and Control presented on the new revised ECDC mandate with an emphasis on the preparedness structures. Coupled to the revised mandate is the revision of Decision 1082/2013/EU which stipulates more comprehensive reporting by the Member States as well as preparedness reviews.

These presentations were followed by questions in plenary by the participants.

Assessments and Analysis

A representative from the Norwegian Institute of Public Health presented preliminary findings from the feasibility study *Assessing public health preparedness and response in the EU: A review of EU-level Simulation Exercises and After Action Reviews*. The study analysed SimEx and AARs implemented from 2008-2017.

Among the findings it was determined that information sharing and standardisation of procedures across sectors and countries and role-clarity among EU agencies were areas that were frequently raised among the exercises and reviews. As well, clarity in language used could prompt recommendations into action after the exercise and reviews. Notably, ~~the majority of most~~ early lessons learnt during COVID-19 were already concluded during previous SimEx and AARs.

The following presentation was on the Joint External Evaluation in Germany. A representative from the Robert Koch Institute. Since the results of the evaluation had not been finally published at the time of the workshop, recommendations on the process were presented. The process involved over 100 technical experts from 31 different ministries and institutions and established a JEE office at RKI to coordinate the evaluation. The structure also included a steering committee and an expert network. The process within the country with the experts that had conducted the JEE between 25 and 29 November 2019 was also described. Recommendations included among other things that having a steering committee was helpful and information feedback loops to all stakeholders, especially ministries, were important and should be considered in the time planning.

These presentations were followed by a plenary discussion on ~~SimEx:s~~SimEx, ~~AARs:s~~ and ~~JEE:s~~.

Closing Session on Sustainability

A colleague from the Ministry of Health in France representing work package 4 provided an online presentation related to sustainability within the joint action. This includes sustainability through ongoing European policy changes such as the revision to Decision 1082/2013/EU as well as elements within the SHARP activities.

The partners discussed the importance of sustaining the strengthened IHR core capacities that have been experienced over the COVID-19 pandemic.

Workshop Evaluation

A post survey developed by WP3 was sent to participants after the workshop. Results of all of the workshop surveys will be included in the evaluation report and inform the final report from Task 5.1 of JA SHARP.

Next Steps

The three workshops are now completed. A final report will be written which benchmarks the IHR Core Capacity advances over the Joint Action among the focus countries. The final report will be informed by the checkpoint interviews, IHR – state annual party annual reports (SPAR), available Joint External Evaluations and the results of the three workshops.

The final report will include a review by the representatives of focus countries and possibly a webinar to ensure that the report clearly explains the occurrences of IHR core capacity strengthening and factors which have driven this in the final analysis. Pending the non-cost extension of the Joint Action to September 2023, a closing WP5 meeting with the partners may take place to launch the final analysis.