



EpiSouth

Network for the Control of Public Health Threats  
in the Mediterranean Region and South East Europe

## Episouth plus project

# EPISOUTH PLUS WP7

## NATIONAL SITUATION ANALYSIS ON COORDINATION OF SURVEILLANCE BETWEEN POINTS OF ENTRY AND NATIONAL HEALTH SYSTEMS

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Methodology

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## ACRONYMS

<b>CD</b>	Communicable Diseases
<b>CNESPS</b>	National Centre for Epidemiology Surveillance and Health Promotion
<b>DG</b>	Directorate General
<b>ECDC</b>	European Centre for Disease Control
<b>ENSA</b>	EpiSouth Plus National Situation Analysis on Coordination between surveillance at Points of Entry and National Health Systems in the EpiSouth Region
<b>IHR</b>	International health regulations
<b>ISS</b>	Italian National Institute of Health
<b>MD</b>	Medical Doctor
<b>MoH</b>	Ministry of Health
<b>NHS</b>	National Health System
<b>NFP</b>	National Focal Point
<b>PoE</b>	Point of Entry
<b>SA</b>	Situation Analysis
<b>SOP</b>	Standard Operating Procedures
<b>TC</b>	Teleconference
<b>WHO</b>	World Health Organization
<b>WP</b>	Work Package

## INTRODUCTION

Through its yearly monitoring, World Health Organization (WHO) assesses in each country the level of implementation of capacities required by the International Health Regulations 2005 (hereby IHR). However, the approach adopted is purely quantitative: no information on how the capacity was acquired is available.

In addition, disaggregated data by region or group of countries is usually not made available by WHO, the 1<sup>st</sup> report of the EpiSouth Plus Project<sup>1</sup> being an exception.

Activities performed by the EpiSouth Work Package 7 (WP7) during the first two years of the EpiSouth Plus project led to the **identification of coordination of surveillance between Points of Entry (PoE) and National Health Systems** as a priority for implementation of IHR in the EpiSouth Region.

This aspect, is recognized not only as a Mediterranean but also as a global priority. For this reason WHO is contextually developing a global guidance on coordination of surveillance between PoE and National Health Systems. The EpiSouth WP7 Steering Team has been among the expert groups consulted in this process.

Literature on the topic is very scarce<sup>2</sup> and there is an evident gap in sharing experiences and know how among countries<sup>1</sup>. As stated by the WP7 ST in two meeting occasions (July 2011 and July 2012), there is an added value in sharing examples of how countries needing to coordinate surveillance between Points of Entry and National Health Systems, approached and managed the functions required under IHR.

EpiSouth, as the largest inter-country collaborative network in the Mediterranean, was in a unique position to contribute to the work being carried out internationally on coordination between PoE and National surveillance systems, by documenting success stories of how processes and procedures have been established in selected countries of the EpiSouth network.

**For this reason EpiSouth WP7 conducted a national situation analysis (ENSA) in four countries on coordination of surveillance between Points of Entry and National Health Systems.**

In preparation to this study, the EpiSouth WP7 Team performed a literature review on IHR implementation with a special focus on Capacities at Points of Entry<sup>2</sup> and mapped key activities, stakeholders and interrelationships for coordination of surveillance between Points of Entry and National surveillance systems in EpiSouth countries (Annex 1).

This protocol was drafted by the co-leaders of the EpiSouth Plus WP7 based on these reports as well as on the outputs of the WP7 Steering Team Meeting held in Rome in December 2012. The protocol was reviewed and approved by the WP7 ST and by WHO subject matter experts between January and April 2013.

The general approach chosen is that of a **national situation analysis of selected countries in the EpiSouth Region**. To keep the effort cost effective the analysis was not carried out on all the 27 countries of the network but on four countries, chosen on the basis of their know-how on coordination of surveillance between PoE and the National Health System (NHS), of their national demographic and geo-political characteristics and their willingness to be part of the study.

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<sup>1</sup> "Level of implementation of IHR 2005 in the EpiSouth Region: Analysis of WHO data and identification of priority areas", July 2011 available on the EpiSouth Plus website [http://www.episouthnetwork.org/sites/default/files/outputs/wp7-episouth\\_ihr\\_assessment\\_final-final.pdf](http://www.episouthnetwork.org/sites/default/files/outputs/wp7-episouth_ihr_assessment_final-final.pdf)

<sup>2</sup> "In depth analysis of coordination of surveillance and response between points of entry and national systems in the EpiSouth region. Review of relevant scientific literature and of existing monitoring frameworks", December 2011 available on the EpiSouth Plus website [http://www.episouthnetwork.org/sites/default/files/outputs/wp7-in\\_depth\\_analysis\\_of\\_coordination\\_of\\_surveillance\\_and\\_response\\_between\\_points\\_of\\_entry\\_and\\_national\\_system.pdf](http://www.episouthnetwork.org/sites/default/files/outputs/wp7-in_depth_analysis_of_coordination_of_surveillance_and_response_between_points_of_entry_and_national_system.pdf)

One country report was written for each country participating in the study with details on the data flows, processes and procedures analysed. All the activities performed by WP7, including the results of the EpiSouth National Situation Analysis, are the knowledge basis upon which this team elaborated a “Strategic Document on coordination of surveillance between Points of Entry and National Health Systems” that is this work-package’s project deliverable.

In addition, the findings of the EpiSouth National Situation Analysis will serve to enrich the contents of the mentioned WHO global guidance.

## **General objective of the EpiSouth Plus National Situation Analysis (ENSA)**

Contribute to improve the coordination of surveillance between Points of Entry (PoE) and National Health Systems (NHS) in the EpiSouth region, in the framework of the IHR 2005.

### **Specific objectives of the ENSA**

1. Describe how the exchange of information is organized between PoE and NHS in four countries representative of the diversity of the EpiSouth region;
2. Identify formal procedures in place and legal constraints in these four countries,
3. Describe main challenges and success stories in establishing a functional coordination of surveillance between PoE and national health systems in these four countries.

### **The ENSA Investigators**

The national situation analysis was performed by a team of investigators (hereby Situation analysis investigators) comprising EpiSouth Focal Points of participating countries, the WP7 coleaders and WHO and EpiSouth subject matter experts. The National Focal Points of participating countries participated in all the study phases and all involved the IHR National Focal Point responsible persons of their countries in the study.

## METHODOLOGY

The national situation analysis on coordination between surveillance at Points of Entry and National Health Systems in the EpiSouth Region (ENSA) is structured in four phases:

1. **Selection:** Selection of four countries to involve in the study (hereby called “participating countries”).
2. **Country Portfolios:** Development of study tools and collation for each country, in advance of the site visit, of available data/documents to build a country portfolio including specific scenarios for each PoE to be visited.
3. **Site Visits:** Conduction of a site visit in each participating country to investigate processes, procedures and performance in the field of coordination between different types of Points of Entry and the National Surveillance Systems,
4. **Reporting:** Preparation of a country report for each visited country and distillation of main findings in a strategic document on coordination of surveillance between PoEs and the National Health System.

The methodology of each phase is described in this section.

### 1. *Selection of EpiSouth countries participating to the ENSA*

The relevance of the different types of PoEs (ports/airports/ground crossings) in countries of the EpiSouth Region is not equal. Most island states, for example, do not have ground crossings, while some countries have very little or no coast line/rivers, making ports absent or very limited in number.

In addition, coordination complexity among stakeholders involved in surveillance activities in PoEs and the National Surveillance System varies according to the size of the country and its type of health system (centralized vs federal for example). This means that what is seen in large countries with many ports, crossings and airports and a federal organization with many intermediate levels of competency, may not reflect the situation in smaller settings where functions are aggregated with fewer levels of competence and where the same professionals cumulate many functions and have more chances of interacting routinely.

These considerations were taken into account in the selection phase. Enrolment criteria were defined to select four countries that could reflect the demographic, geographical and governmental diversity of the Mediterranean.

Another early consideration made by investigators was that the success of the Situation Analysis would depend on the commitment of the EpiSouth Focal Points of participating countries. In fact, these EpiSouth Focal Points have been charged of organizing the site visits in their Ministry of Health and in relevant Points of Entry, of planning all internal travel and of organizing meetings with the most appropriate actors and informants. For this reason, terms of reference were developed early in the process so that Countries through the EpiSouth Focal Points would be aware of the amount of work required before deciding whether or not to agree to participate in the study.

## 1.1 Terms of Reference

### EPISOUTH KEY COUNTRY SITUATIONAL ANALYSIS OF COORDINATION OF SURVEILLANCE BETWEEN POINTS OF ENTRY AND NATIONAL SURVEILLANCE SYSTEMS

#### TERMS OF REFERENCE

Proposing	World Health Organization and Italian Health Institute as coleaders of the EpiSouth Plus Project WP7
Object	Participating as one of the four identified key countries in the EpiSouth region in a situational analysis on coordination of surveillance between points of entry and national surveillance systems. Findings will be shared, as part of the situation analysis study, with the countries part of the EpiSouth network and published as reports on the EpiSouth website
Purpose	<ol style="list-style-type: none"> <li>1. Describe the country profile on coordination of surveillance between Points of Entry (PoE) and the National Health System (NHS);</li> <li>2. Map how the exchange of information is organized between PoE and NHS, with a special focus on procedures in place and legal constraints if present.</li> </ol>
Eligibility	During the 1 <sup>st</sup> EpiSouth Plus project meeting the WP7 ST categorized EpiSouth countries in four groups that reflect the demographic, geographical and governmental diversity of the Mediterranean. Candidate countries were identified for each group based on their <u>relevant national know-how</u> . The selection process was aimed at identifying a rose of candidate countries with experiences and lessons learned that, if shared, could be useful to EpiSouth network participants in strengthening coordination of surveillance at Points of Entry.
Duration	Mar-Dec 2013
Activities	<p>The assessment of existing coordination methods between surveillance at Points of Entry and National Surveillance Systems in key EpiSouth countries is structured in four phases:</p> <ol style="list-style-type: none"> <li>1. <b>Selection:</b> Selection of four countries to involve in the study (hereby called “participating countries”).</li> <li>2. <b>Country Portfolios:</b> Development of study tools and collation for each country, in advance of the site visit, of available data/documents to build a country portfolio including specific scenarios for each PoE to be visited.</li> <li>3. <b>Site Visits:</b> Conduction of a site visit in each participating country to investigate processes, procedures and performance in the field of coordination between different types of Points of Entry and the National Surveillance Systems,</li> <li>4. <b>Reporting:</b> Preparation of a country report for each visited country and distillation of main findings in a strategic document on coordination of surveillance between PoEs and the National Health System.</li> </ol> <p>The EpiSouth Focal point of the participating key country will be asked to:</p> <ol style="list-style-type: none"> <li>1. <u>Collaborate</u> as investigator in all the study phases including the development of the study methodology and tools,</li> <li>2. <u>Provide input on/share</u> relevant sources and documents for the compilation of background information on his/her country (including, if possible, access to assessments on IHR implementation carried out for WHO);</li> <li>3. <u>Identify key informants</u> in the surveillance process both within the national health systems and in one of each type of Point of Entry present in the country (including staff at Points of Entry and the IHR 2005 National Focal Point unit) at</li> </ol>

	<p>national, intermediate and local level to involve in the study;</p> <ol style="list-style-type: none"> <li>4. <u>Organize with the investigator team a short site visit</u> (approx. 3-4 days) in the participating Country designed to: <ul style="list-style-type: none"> <li>- Visit the office in charge of national human health surveillance (central level) and one of each type of PoE in Country meeting with key informants,</li> <li>- Discuss a real life event or a pre-defined scenario with key informants in each PoE and at central level to explore the procedures, processes and performance of two way communication between PoE and the NHS on aspects related to human health surveillance.</li> </ul> </li> <li>5. During action 4, collaborate with the WP7 team in <u>mapping</u> how communication flows should take place for each PoE involving the informants (process analysis);</li> <li>6. <u>Validate findings and provide comments</u> on the draft reports that will summarize findings of the situation analysis.</li> </ol>
Costs	No additional costs are foreseen for Countries that will accept to participate in the study.

### 1.2 The selection process

During the 1<sup>st</sup> EpiSouth Plus project meeting, the WP7 ST identified determinants affecting coordination of surveillance between Points of Entry and National Health Systems and, according to those, categorized EpiSouth countries in four groups (Table 1).

Candidate countries belonging to these four categories were then preselected by the WP7 ST based on the participant's subject matter expertise and on the research activities performed in advance of this study by WP7 (see Introduction). Initial expressions of interest were individually collected from candidate countries. Only countries who agreed to be invited to participate in the study were included in the pre-selection roster.

The following selection criteria were defined:

#### BOX 1: ENSA ENROLMENT CRITERIA FOR COUNTRY PARTICIPATION

- Two countries should be EU and two non EU member states;
- The four countries should represent the variety of the EpiSouth Region (i.e. each of the categories identified in Table 1 should be represented);
- The level of coordination of surveillance in the selected country is known to be high (according to the WP7 ST subject matter experts and the EpiSouth FPs of candidate countries).
- The focal point considers the sharing of lessons learned and experiences matured nationally to be useful for the network;
- There is internal national capacity to meet the study's terms of reference requirements;
- Preference will be given to countries where the EpiSouth Focal Point coincides, is able to involve, or works in close contact with, the IHR 2005 National Focal point;
- Preference will be given to countries which are not also acting as coleaders of other EpiSouth Work Packages (to avoid overburdening).

As shown in Table 1, four countries were selected and accepted to participate in the ENSA.

TABLE 1 - SCENARIO CATEGORIZATION AND ENSA PARTICIPATING COUNTRIES

Category	Expected impact on coordination between PoEs and National Surveillance System	Participating countries
Small coastal states and islands	No or few ground crossings, numerous ports, few airports. Small countries with possibly fewer administrative levels/ overlapping professional functions.	Malta
Large States with extensive coastlines and federal or strongly decentralized health systems	All PoE present in large numbers, numerous administrative levels with diversification of competencies and greater coordination complexities.	Italy
States with no or little coastlines	Ports absent or very limited, higher importance of airports and ground crossings for which greater experience may have been gathered.	Jordan
Large States with extensive coastlines and more centralized health systems	All PoE present in large numbers, numerous administrative levels but central bodies	Morocco

## 2. Development of a Country Portfolio

With the objective of providing the investigators in advance of each site visit with a document containing key information on the country PoEs that would be visited and tools to guide discussions, a country specific portfolio was assembled. This included details on the visit duration, aims and agenda as well as a stakeholder table and checklist for each environment to be visited (MoH and PoEs) as well as one scenario for each PoE.

All the investigators involved in the ENSA (WP7 experts and participating country EpiSouth Focal Points) discussed and developed the study tools. Between March and December 2013 a comprehensive checklist, a stakeholder table and two or three scenarios for each country were developed and discussed through Teleconferences (TCs). The performance of the study tools was also assessed in the context of dedicated debriefing TCs held after each site visit.

### 2.2 Identification of in-country participants to involve in the study and development of Stakeholder Tables

Each Participating Country's EpiSouth Focal Point, was in charge of identifying and involving concerned actors and informants that could provide information and insights on the processes, procedures and performance of coordination between Points of Entry and National Surveillance Systems in his/her country.

To aid this process, stakeholder tables were developed in agreement with all the investigators, one for each type of Point of Entry (Annex 2).

All participating countries were asked to involve, among others, the following informants:

- At least one actor in charge of health surveillance of in each designated PoE to be visited (airport, port and ground crossing),
- The IHR national focal point responsible person,
- Relevant national, intermediate and/or local level operators of the human health surveillance system.

### *2.3 The ENSA checklist*

A semi structured check list was developed to guide interviews with actors and informants during the site visit. This tool was developed by the investigators in advance and a short version was circulated before the visit to informants to enable them to understand better the scope of the study and the type of information that would be requested.

The aim of the checklist was to provide a guide to follow in analysing the procedures and processes in place for coordination of surveillance between Points of Entry and National Health Systems.

The checklist was developed in English. In countries where English is not a used language, EpiSouth Focal Points were in charge of explaining and, if needed, translating the checklist in advance of the visit to facilitate the work of the investigators.

The checklist was structures in two separate sections directed specifically either to national actors involved in surveillance or to actors at Points of Entry (Annex 3).

### *2.1 The ENSA Scenarios*

The use of scenarios was envisioned during the face to face round-tables with informants in each PoE visited during the site visits and therefore they were included in the country portfolio. Scenarios were developed in agreement with the EpiSouth Focal Points of each country and designed to be credible as well as relevant to coordination of communication on human health events between the PoE and the National Surveillance System.

The reason why scenarios were chosen among the data acquisition tools of the study, is that credible situations provide a contextualized analysis environment. Scenarios recreate a problem (e.g. a Public Health Emergency of International Concern at a PoE) and set the scene for actors to focus on the tools in place to detect it (in this case human health surveillance) and initiate action.

The scenarios in the ENSA were therefore intended to simplify the work of the investigators and informants in participating countries by focussing the discussions on realistic situations that, step by step, could set a pace and facilitate a systematic analysis of the protocols, Standard Operating Procedures (SOP) and processes of the communication flows relevant to the study.

### 3. The ENSA Site Visits

Site visits were planned in each participating country from June to December 2013. During each visit, the investigators the study investigation team were to:

- Visit the office in charge of national human health surveillance (MoH central level) meeting with key informants and conduct a briefing,
- Visit one of each type of designated PoE in the country meeting with key informants,
- Discuss a real life event or a pre-defined scenario with key informants in each PoE to explore the procedures, processes and performance of two way communication between PoE and the NHS on aspects related to human health surveillance,
- Conduct a debriefing in the office in charge of national human health surveillance.

The country portfolio was used to guide discussions.

The EpiSouth Focal Point of each participating country was in charge of organizing the site visits in the Ministry of Health and in relevant Points of Entry, of planning all internal travel and of organizing meetings with the most appropriate actors and informants. In all the participating countries, EpiSouth Focal Points were invited to involve the IHR National Focal Point responsible person.

### 4. Reporting

After each site visit a country report was developed in collaboration with all the investigators involved.

After a revision phase the report was shared with the WP7 Steering Team and cleared for publication in the EpiSouth Website. Teleconferences (TCs) and emails were the preferred communication tools to share and discuss the reports.

All the activities performed by WP7, including the results of the EpiSouth National Situation Analysis, are the knowledge basis upon which this team elaborated a “Strategic Document on coordination of surveillance between Points of Entry and National Health Systems” that is this work-package’s project deliverable.

# ANNEXES

## 1. Mapping of relevant information concerning coordination of surveillance between Points of Entry and National Health Systems in the EpiSouth Region

### *Methodology*

The level of implementation of IHR in the EpiSouth Region was assessed through the regional analysis of WHO data collected in 2010 as part of the IHR annual implementation monitoring.

In addition, feedback on key activities, stakeholders and interrelationships for coordination of surveillance between Points of Entry and National surveillance systems have been collected during the two WP7 ST meetings. The methods used were: country presentations, post-it sessions, case studies, world café and group work (see reports of the 1<sup>st</sup> WP7 ST meeting, Rome 2011<sup>3</sup> and of the WHO expert consultation to develop Guidance on coordination between Points of Entry and National Surveillance Systems, Lyon 2012<sup>4</sup>). Data acquired has been presented during the 1<sup>st</sup> EpiSouth Plus project meeting (5-7 December 2012).

Relevant data was also collected by the EpiSouth WP5 team and reported in EpiSouth report 4/2012 “Public Health Preparedness and Response Core Capacity Assessment”.

Findings from all these activities constitute the factual basis upon which the situation analysis on coordination of surveillance between Points of Entry and National Health Systems have been designed. Main points are reported in the following section.

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<sup>3</sup> “1<sup>st</sup> Work Package 7 Steering Team Meeting. Main findings”, July 2011 available on the EpiSouth WP7 STWA

<sup>4</sup> “WHO Expert Consultation to develop Guidance on coordination between PoE and national surveillance systems”, July 2012 available to meeting participants

## Results

### Main findings of the analysis of the level of IHR implementation in the EpiSouth Region

Data from 18 of the 27 EpiSouth countries (67%) was available. Among those 50% have assessed core capacities and 61% have developed a national plan for IHR implementation.

#### Capacities acquired in the region are:

- Coordination on events that may constitute a PHEIC,
- Event-based surveillance functions, and
- Resources and management procedures for rapid response.

#### Missing capacities in the region are:

- Reactive surveillance systems
- Human resources

In addition, sharing of experiences & resources between countries and documentation availability (Reports & SOPs) have been identified by EpiSouth countries as weaknesses that occur across all capacities.

#### Capacities at Points of Entry:

Seventy-eight per cent of countries have identified designated ports (/airports) for development of capacities as specified in Annex 1 of IHR, and have sent the list of ports authorized to offer ship sanitation certificates to WHO. Fifty per cent and 33% of countries have a competent authority in all designated airports and ports, respectively.

Thirty-three per cent and 22% of countries have assessed all their designated airports and ports, respectively.

Experience and findings about the process of meeting PoE requirements were shared and documented by 28% of countries.

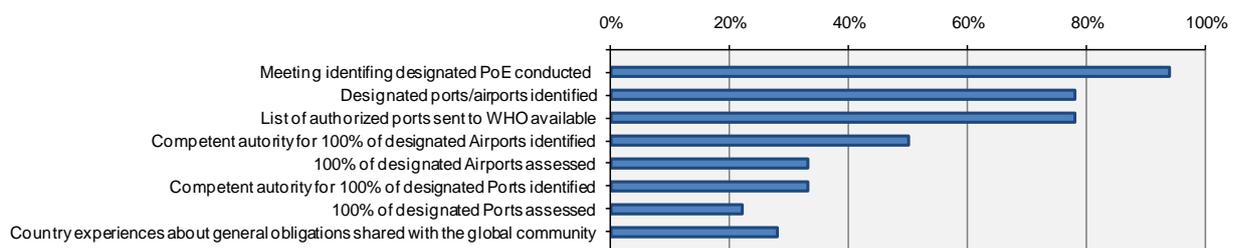


Figure 1 - Assessment of core capacities in EpiSouth countries 2010 (n=18) / cc9: Points of Entry, general requirements at PoE

Sixty-one per cent of countries have identified priority conditions for surveillance at PoE. Sharing of surveillance information between the designated PoE and the national surveillance unit, and mechanisms for the exchange of information between PoE and medical facilities exist in 67% and 78% of countries, respectively.

In the 12 months preceding the completion of the survey, 28% of countries carried out an analysis of the surveillance of health threats at PoE and had published the results.

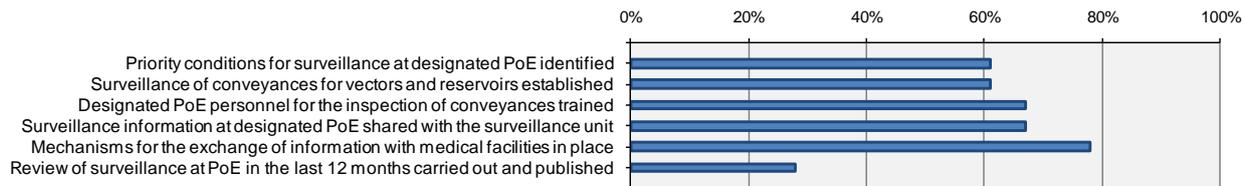


Figure 2 - Assessment of core capacities in EpiSouth countries 2010 (n=18) / cc9: Points of Entry, surveillance at PoE

Thirty-nine per cent of countries have developed SOPs for response and 33% a contingency response plan at PoE. When it exists, this plan is integrated with other response plans in 66% of countries.

A referral system for the transport of sick travellers to medical facilities is in place in 72% of countries.

Eleven per cent of countries have published the results of the evaluation of response effectiveness to public health events at PoE.



Figure 3 - Assessment of core capacities in EpiSouth countries 2010 (n=18) / cc9: Points of Entry, response at PoE

For further details consult "Level of implementation of IHR 2005 in the EpiSouth Region: Analysis of WHO data and identification of priority areas", July 2011 available on the EpiSouth Plus website [http://www.episouthnetwork.org/sites/default/files/outputs/wp7-episouth\\_ihr\\_assessment\\_final-final.pdf](http://www.episouthnetwork.org/sites/default/files/outputs/wp7-episouth_ihr_assessment_final-final.pdf)

### WP7 ST Meeting, Rome 2011

Priorities for IHR implementation in the Episouth region were identified by the network participants through a consensus building process that culminated in the 1<sup>st</sup> ST meeting in Rome in 2011. This process was instrumental to the identification of the priority aspect currently tackled by the WP7. Some of the other issues raised are also relevant to this study because they are cross-cutting. The gaps identified should be kept in mind in the overall study design and are therefore reported in this document.

**Table 2 – National perception of priorities in IHR implementation**

Country	Priority areas for IHR implementation
Greece	Preparedness, Risk Communication, Points of Entry (evaluation)
Tunisia	Connecting Laboratories and Clinics, Cross-border surveillance, Points of Entry (training), Legislation
Cyprus	Human Resources, Coordination, Management Plans, Communication
Jordan	Coordination, IHR awareness, Human Resources, Management Plans
Albania	Coordination, Points of Entry (coordination, training)
Israel	Cross-border surveillance
Morocco	Laboratory, Cross-border surveillance
Malta	Laboratory, Management Plans, Training, Human Resources
Algeria	Management Plans, Communication, Laboratory (quality), Points of Entry, Coordination/Legislation

## WP7 ST meeting and WHO expert consultation, France 2012

During the WHO expert consultation held in Lyon in July 2012, the EpiSouth WP7 team was consulted on coordination of surveillance between Points of Entry and National Surveillance Systems. Specific aspects to consider related to coordination of surveillance in each type of PoE (ports/airports/ground crossings) were identified:

1. Actors<sup>5</sup>
2. Type of information collected
3. Sources of information
4. Available facilities
5. Flow of information
6. Relevant guidelines used<sup>6</sup>
7. How the information is used

In addition, communication content, flow and mechanisms were discussed in depth. A post it session conducted in the expert meeting highlighted similarities in activities performed in the different types of PoE.

Key points to consider are that:

- Actors in surveillance at PoE are not limited to the public health sector but also belong to other sectors and disciplines.
- Information to be collected depends on the type of threat and can come from outside or inside the country. There are links with specific networks (food, water, etc.). At a country level, all sectors contribute to providing information.

Conversely the flow of surveillance information is specific to the type of PoE:

- a) For ports, communication is organized from ship to port, from port to competent health authority, from port health authority to other local level authorities, from local authority to intermediate authority or directly to the national authority, from port to port (directly or through the national authority), from laboratories to other authorities, and from inspector to captain.
- b) For airports, communication is between the pilot and the competent authority through the control tower, between airlines and national authorities (including IHR National Focal Points -NFP) through airport health, and between clinicians/laboratories and the public health system. This communication is not regular.
- c) For ground crossings, communication is from ground crossings to relevant authorities, between neighbouring countries, from the border public health authority to the local governmental

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<sup>5</sup> All actors at all levels (local, national, international) contribute to decisions. Information is used for preventing expansion of outbreaks (early detection and case management), for risk assessment, to identify risk profiles and disease trends, hence contributing to the national surveillance system.

<sup>6</sup> Numerous guidelines are used produced by WHO, international agencies and projects (e.g. ECDC, IATA, Shipsan, maritime companies), or ministries. They are either technical (surveillance, risk assessment, preparedness) or related to legislation (IHR, quarantine act, public health law, etc.).

authority (e.g. prefecture), to the local hospital and to the ministry of health. Connection is established with airport, port, and road police.

### Communication mechanisms

In the WHO hosted expert meeting in Lyon, a session was organized to define communication mechanisms in each type of PoE. The audience was divided into three groups and asked to describe usual communication mechanisms between PoE and National Health Systems through work on 2 case studies. The results are summarized below. The concerns raised should all be taken into account and investigated in the situational analysis of key countries. The aim would be to assess whether these are issues also in the national settings examined or if effective solutions have been found that could be shared with the participants of the EpiSouth Network.

#### *Communication from/with ports and ships*

Outbreak of a communicable disease on board a ship is first reported to the ship's captain, then to the port health authorities, followed by the relevant level of the national surveillance system, the national level, and then the IHR NFP.

Local hospitals and laboratories should be alerted in the case of a severe outbreak. An investigation and a risk assessment need to be conducted in order to evaluate potential disease transmission.

Distinction is made between the national level of the surveillance system and the IHR NFP. Procedures should foresee the possibility for local authorities to directly inform the NFP, simultaneously with other authorities.

Communication flow is unclear: the authority in charge of communicating the event to countries of previous and subsequent ports of call, as well as the recipients of the information, need to be defined.

The place of direct port-to-port communication, inside a country and between countries, needs to be clarified. Magnitude, severity, media profile, would determine whether port-to-port communication of health information is justified. Port-to-port communication (in particular in federal countries or between countries) should be permitted without requiring authorization each time. However, the public health system has supremacy over port-to-port networks, and port-to-port communication should be restricted to operational purposes.

Inter-sectorial communication must be planned in the port contingency plan and related to the national plan.

After risk assessment, major outbreaks occurring on ships need to be reported to WHO through the NFP for coordination of the response and possible request of assistance. Networks such as Shispan which can provide support should also be informed.

It is suggested that outbreaks of communicable diseases occurring on board ships should be reported immediately and not through routine reporting channels.

It is clear that there is a recognized lack of guidance on whether events should be notified under IHR and identifying which authorities should be communicating information on events and which authorities should be notified.

#### *Communication from/with airports and planes*

A case of a communicable disease occurring on board a plane should be reported to the airport competent authority and then, to the local competent authority who will report it to the national surveillance unit in the MOH. The flight will continue but the patient will receive control measures (mask

and isolation); passengers in contact with the patient and crew will be given a health alert card. Travel history must be reconstructed.

Depending on the context and the result of the investigation (e.g. existence of an outbreak in the country of departure), the decision to report or not to report the case to the IHR NFP will be taken.

In the case of a suspected severe disease, such as avian influenza, laboratory confirmation is needed. Other passengers must be advised of possible exposure and the IHR NFP must be informed. A delay in reporting a suspected severe case of a disease to the NFP was questioned: should it be before or after laboratory confirmation? This question should be addressed and answered in the future guidance.

Communication flow depends on the results of the investigation: if no unusual risk has been identified, there is no need for further action, or only the local public health authority and the local hospital can be advised.

Main challenges are the difficulty to get the passenger list with contact information from the airline company and the fact that, unlike ships, planes spend very little time at PoE.

Decision to report immediately or through routine reporting channels depends on the context and the results of the investigation. As individual cases of communicable diseases are not rare, immediate reporting could overload the disease surveillance system. If a mild disease is suspected, it will be reported through routine communication channels, and there will be no need to communicate at an international level.

If a severe communicable disease is diagnosed in a patient after landing, the national surveillance system must be immediately notified. Public health investigators at a national level will organize the contact tracing and propose prophylactic measures to exposed passengers. The national public health authorities will inform the country of origin of the patient.

Notification of the NFP depends on the country. Main measures take place in the plane. Communication to the surveillance system is made usually after laboratory confirmation.

#### *Communication from/with ground crossings*

If a patient is admitted to hospital with a severe communicable disease after a trip between two neighbouring countries, the surveillance system needs to be informed in order to identify additional cases and make a risk assessment. Actions will vary if the case is isolated or part of an outbreak.

In case of a foodborne outbreak, food samples in the transport restaurant must be collected.

There is no consensus on the need to report the event to the IHR NFP but coordination between health authorities in the two countries and from other sectors such as transport must be established. In case of travel by train, the rail station in the country of origin must be informed so that it can take control measures.

No particular involvement of PoE is expected unless the situation persists. In case of a radioactive event occurring at a border, competent authorities need to be contacted. These authorities vary among countries (Ministry of Labour, of Environment, Civil Protection, specific departments within the MoH, etc.).

The inter-sectorial response should be under MoH coordination.

#### Actors and roles in communication of information for surveillance purposes

Identification of capacities needed for improving communication between PoE and national surveillance systems was done through the “World café” method. Of particular relevance to the current study design are the aspects raised concerning actors and roles.

The actors were grouped into three groups: actors involved in routine operations, actors involved during an emergency (including emergency response) and actors responsible for the implementation of IHR. As expected, many of the same actors perform in routine and in times of emergency with some changes in roles to response. One of the important actors in routine are training providers who were identified as persons who would train the transportation and health sectors not only on their roles, but importantly, on what and how to report using exercises to evaluate their capacity to communicate in preparation for an emergency.

The general public and travellers in transit were considered to have roles in self-reporting any health or risks and as a source of information to the media.

**Table 3 – Stakeholder analysis performed during the WHO Expert Consultation**

	<b>Actors</b>	<b>Roles</b>
<b>Routine</b>	Private Sector	Primary Data Provider / Detection
	General Public	Self-Reporting / Media
	Primary Provider	Primary Data Provider / Detection
	Professionals	Surveillance System
	Training Providers	Training for Transportation and Health
	International Bodies	Local Regional national standards / IHR
<b>Emergency</b>	Professionals <ul style="list-style-type: none"> <li>• Transport</li> <li>• Health</li> <li>• Environment</li> <li>• Agriculture</li> <li>• Police / Fire / Ambulance</li> <li>• Border Control</li> </ul>	Response / Risk Assessment / Data Collection and analysis / Continuous assessment
	Passengers / People in transit	Self-Reporting / Media
<b>IHR</b>	National IHR –NFP International Bodies NGO's	Quality of data and monitoring and evaluation / Dissemination of official information / Guidelines / Coordination / Risk Assessment / Contribute expertise

## Public Health Preparedness and response core capacity assessment (WP5 2012)

21 out of 27 EpiSouth countries participated in the EpiSouth PH preparedness and response assessment. One third of the participating countries (7/21) were EU members, two thirds (14/21) from non EU parts of the EpiSouth region including one acceding EU country, four EU candidate countries and 2 potential EU candidates. All geographic regions and continents belonging to EpiSouth were represented in the final sample.

Participants were invited to contact professionals working within national PH institutions or the surveillance system in order to obtain all the information requested. 12/21 countries indicated that they have done so, contacting a range of 2 to 9 experts (mean=3,9; median=3).

One country indicated that the questionnaire was filled out by only one person, while 8 countries did not mention the quantity of experts and institutions involved. Nevertheless it can be claimed that this survey generated an institutional point of view and not only expert opinions.

20 out of 21 participating countries have experienced at least one possible or real PHEIC in any phase of the preparedness plan since 2009. In most of the cases, it included international cooperation.

Influenza was the most often reported PH risk identified in the EpiSouth Region. Zoonotic PH events include food borne risks and vector borne risks with West Nile Virus as the leading risk identified in this category. Beside these two leading groups of identified PH risks, 4 other PH events have been identified to a lesser extent: environmental PH risks (water pollution, cholera and legionella), vaccine preventable PH risks (measles, polio), disasters (floods, chemical or nuclear incidents) and health of migrants and mobile populations. Terrorism has only been mentioned by one country.

Risk communication with vulnerable groups, scientific risk assessment and epidemiological intelligence were identified as top training priorities. Conversely, vaccines and vaccination programmes, reporting systems and post-event-surveillance are the areas with best-developed capacities in the Region. Scientific risk assessment is not only a topic that scores high in the overall summary of the training needs, but also ranks in first position in terms of urgency. Further issues identified for urgent training include also command and control structures, rapid consultations and epidemiological intelligence. In addition, evaluation seems to be a crucial point to address as it was identified as a missed opportunity during past PHEIC response.

Hazard maps, standardized investigation protocols for a quick start in order to analyse an unusual PHEIC, formal coordination with neighbouring countries, determination of potential vulnerable populations and systematic rumour screening are the activities that exist to a lesser extent in the EpiSouth region. Most reported descriptions refer to a reaction of the PH system to rumours without supporting an early detection of those, which would allow a preventive counteraction by the PH system.

Conclusions of the Mapping Exercise of use for the National Situation Analysis

Source	Taking home point	Integration in the study protocol	Action required from:
Analysis of the level of IHR implementation in the EpiSouth Region	Data on IHR implementation is collected annually but is not available in disaggregated fashion.	Ask countries participating to the study to share WHO monitoring questionnaire compiled for the latest available date with the EpiSouth WP7 team.	EpiSouth Focal Point involving IHR NFP
Analysis of the level of IHR implementation in the EpiSouth Region	In the assessment some episouth countries have declared to have assessed designated PoE, identified priorities for surveillance and analysed surveillance of health threats at PoE.	Ask countries participating in the study to : <ul style="list-style-type: none"> <li>- Share assessments of designated PoEs if available.</li> <li>- Share identified priority conditions for surveillance at PoE and the analysis of the surveillance of health threats at PoE if available.</li> <li>- Share, if available, national guidelines for surveillance, SOPs for response/ contingency response plan at PoE/ evaluations conducted on detection and surge capacity at PoE</li> </ul>	EpiSouth Focal Point involving IHR NFP
1 <sup>st</sup> WP7 ST Meeting	Countries have declared existing gaps in IHR implementations	Take those gaps into account for each participating country when designing data collection tools	EpiSouth WP7 team designing tools for situational analysis
WHO expert consultation	Experts have performed stakeholder analysis and have defined characteristics of actors involved in the surveillance process	<ol style="list-style-type: none"> <li>1. national/intermediate/local</li> <li>2. not limited to the public health sector but also belong to other sectors and disciplines</li> <li>3. stakeholder analysis (Table 2)</li> </ol>	EpiSouth WP7 team designing tools for situational analysis EpiSouth Focal Point of participating country in identifying <u>key informants</u>
WHO expert consultation	Experts have assessed aspects to consider in analysing the surveillance process	<ol style="list-style-type: none"> <li>1. Type of information collected depending on the type of threat</li> <li>2. Sources of information</li> <li>3. Available facilities</li> <li>4. Flow of information specific to the type of PoE</li> <li>5. Guidelines used</li> <li>6. How the information is used</li> </ol>	EpiSouth WP7 team designing tools for situational analysis
Public Health Preparedness and response core capacity assessment (WP5 2012)	The survey has identified the major Public Health Risks in the EpiSouth Region.	Questionnaire and case study design should take into account the following public health risks: <ol style="list-style-type: none"> <li>1. Influenza</li> <li>2. Zoonotic PH events (food borne risks and vector borne risks)</li> <li>3. Environmental PH risks (water pollution, cholera and legionella)</li> <li>4. Vaccine preventable PH risks (measles, polio)</li> <li>5. Disasters (floods, chemical or nuclear incidents)</li> <li>6. Health of migrants and mobile populations</li> <li>7. Terrorism</li> </ol>	EpiSouth WP7 team designing tools for situational analysis

## 2. The ENSA Stakeholder Tables

### Scope

The scope of the investigation should be limited to surveillance activities focussed on health threats to human health that involve PoEs on one side and the National Health System of the other. Excluding other surveillance systems that could be in place at PoE but are not directed to the NHS.

Different countries could have different stakeholders to involve first in the telephone interviews and then in the site visits, that would be relevant to the scope of the Situation Analysis. These tables should facilitate their identification in each specific context (port/airport/ground crossing/ NHS).

### Ports

Actor	Present in the Port be visited?	Possible to involve?	Relevant to the study?
Person in charge of human health surveillance			
Person in charge of animal health surveillance			
Person in charge of surveillance of food safety			
Person in charge for surveillance of health hazards related to cargo			
NGOs			
Medical staff on conveyance (private/public)			
People in charge of conveyances			
Border control professionals			
People in charge of the port infrastructure (hub)			
Other?			
Other?			

*Airports*

Actor	Present the airport to be visited?	Possible to involve?	Relevant to the study?
Person in charge of human health surveillance			
Person in charge of animal health surveillance			
Person in charge of surveillance of food safety			
Person in charge for surveillance of health hazards related to cargo			
NGOs			
Medical staff on conveyance (private/public)			
People in charge of conveyances			
Border control professionals			
People in charge of the airport infrastructure (hub)			
Other?			
Other?			

*Ground crossings*

Actor	Present the ground crossing to be visited?	Possible to involve?	Relevant to the study?
Person in charge of human health surveillance			
Person in charge of animal health surveillance			
Person in charge of surveillance of food safety			
Person in charge for surveillance of health hazards related to cargo			
NGOs			
Medical staff on conveyance (private/public)			
People in charge of conveyances			
Border control professionals			
People in charge of the crossing infrastructure (hub)			
Other?			
Other?			

*National health system (NHS)- national/intermediate/local level*

Actor	Present in the MoH?	Present at local/intermediate level?	Possible to involve?
IHR NFP			
Operators in Public Health Surveillance			
People in charge of PoE surveillance data management			
Others?			

### 3. The ENSA Checklist

#### *General structure of the ENSA site visits*

- Duration of the site visit 4-5 days
- During each visit it will be necessary to perform the following activities (as per point 11 of the ToR):
  - a. Visit one of each type of PoE in Country and meet with key stakeholders in each setting,
  - b. Carry out a scenarios in each PoE and at central level as appropriate involving key stakeholders and exploring the surveillance process and two way communication mechanisms.

**TABLE 4 – GENERAL STRUCTURE OF THE SITE VISITS OF THE EPISOUTH WP7 NATIONAL SITUATION ANALYSIS**

<b>DAY</b>	<b>Activities</b>
<b>1</b>	Morning: Arrival of participants Afternoon: Briefing meeting at MoH
<b>2 -4</b>	Site visits at PoE
<b>5</b>	Debriefing at the MoH; Debriefing of co-investigators team and planning for next phase Departure of participants

## Checklist used for the briefings at the MoH

This checklist includes a list of questions aimed at collecting the information needed to set the scene and understand (from the standpoint of the MoH) how coordination of surveillance activities at PoE is functioning. These aspects could either be prepared in advance in the participating country MoH and presented by the members of the MoH briefing team or discussed with the team during the briefing itself.

Modalities and specificities can be arranged with the EpiSouth focal points of the participating countries as best suits their national context.

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### 1. CHARACTERIZATION OF THE NATIONAL SURVEILLANCE SYSTEMS AND COORDINATION BETWEEN POE AND NHS

- 1.1) Please indicate the number of designated PoE (provide a map if possible)
  - a. Ports
  - b. Airports
  - c. Ground crossings
  
- 1.2) The Competent Authorities of PoEs report:
  - a. Directly to the IHR NFP
  - b. To local health authorities
  - c. To intermediate level health authorities
  - d. To other authorities: specify
  
- 1.3) Are there laws/norms in place that regulate coordination of surveillance between PoE and the NHS?
  - Yes
  - NoIf yes can those laws/norms be made available to the investigator team?



1.5) Please indicate if there are legal constraints hindering coordination of surveillance between Points of Entry and National Health Systems.

1.6) Please indicate any interference/interaction/support of existing national plans in implementing/strengthening coordination of surveillance between Points of Entry and National Health Systems.

- Interference:
- Interaction:
- Support:

2. COMMUNICATION/COLLABORATION BETWEEN COMPETENT AUTHORITIES AT POINTS OF ENTRY, THE NATIONAL IHR FOCAL POINT AND HEALTH AUTHORITIES AT THE CENTRAL, INTERMEDIATE AND LOCAL LEVELS

- a) Does the National IHR Focal Point have current contact details of all competent authorities at points of entry?
- Yes
  - No
- b) Do local, intermediate and national Public Health officials involved in event surveillance and control have current contact details of all competent authorities at points of entry?
- Yes
  - No
- c) Are current, regularly updated, documented and tested procedures for routine and urgent communication and collaboration during a public health emergency of international concern in place between the competent authority at PoE and:
- 2.3.1) : the competent authority at other points of entry
    - Yes
    - No
  - 2.3.2) : health authorities (local, intermediate and national Public Health officials)
    - Yes
    - No
    - If needed specify
  - 2.3.3) : other relevant government ministries, agencies, government authorities and other partners involved in points of entry activities
    - Yes
    - No
    - If needed specify
- d) If the answer to questions 2.3.2 is “Yes”, please specify if the communication occurs exclusively with the National IHR Focal Point or if also other health authorities are involved.
- e) If the answer to questions 2.3.1- 2.3.3 is “Yes”, please specify if the communication occurs both ways or is unilateral.
- f) If the answer to questions 2.3.1- 2.3.3 is “No”, please specify
- g) Describe the mechanisms in place in case of a potential PHEIC at PoE for reporting, assessment, confirmation and response specifying who is in charge of what (upload document word or ppt)

**h) Do competent authorities at PoE:**

	Ports (Y/N)	Airports (Y/N)	Ground crossings (Y/N)
2.8.1) Use the IHR assessment tool to decide if an event should be reported?			
2.8.2) Use another decision making tool that is applied in the same way throughout the country?			
2.8.3) Each use different decision making tools?			
2.8.4) Are national decisional procedures available at PoE?			
2.8.5) Are sub-national decisional procedures available at PoE?			
2.8.6) Are competent authorities public health officials?			

**i) Is capacity for detecting, reporting (within 24 hrs) a potential PHEIC and initiating response present in designated PoE?**

- Fully
- Partially
- Not at all

**3. CONCRETE EXAMPLES**

**3.1) Have you assessed in your country the coordination of surveillance at designated PoE?**

- Yes
- No

If yes is it possible to access the results?

**3.2) Has an evaluation of effectiveness of surveillance and response to public health events at PoE been carried out in your country?**

- Yes
- No

3.2.1) :If yes is it possible to access the results?

**3.3) Please indicate the number of reports received per type of event in 2012 for each studied PoE and if receipt was timely:**

	Number	N. arrived within the timeframe of the surveillance system	N of individual events signaled	% of events for which feedback reports were sent to the PoE	N of events that qualified as PHEIC under IHR 2005
3.3.1) N. Reports for Communicable Disease Outbreaks					
3.3.2) N. Reports for food safety events					
3.3.3) N. Reports for Chemical threats					
3.3.4) N. Reports for Radio-nuclear threats					
3.3.5) N. Reports for zoonosis (animal)					
3.3.6) N. Reports for zoonosis (human)					
3.3.7) N. Reports for Chemical threats					
3.3.8) N. Reports for Radio-Nuclear threats					
3.3.9) N. Reports for Other (specify) threats					

### Checklist used during visits at the PoEs

This checklist includes a list of questions aimed at collecting the information needed to set the scene and understand (from the standpoint of the PoE) how coordination of surveillance activities with the NHS is functioning.

These aspects could either be prepared in advance in the participating PoE and presented by the stakeholders involved in the site visit or discussed with the study investigator team during the site visit itself.

Modalities and specificities can be arranged with the EpiSouth focal point of the participating country as best suits the national context.

#### *Identification of the PoE:*

<b>COUNTRY (CITY)</b>	
<b>TYPE (PORT/AIRPORT/GROUND CROSSING)</b>	
<b>NAME OF POE</b>	
<b>PUBLIC HEALTH COMPETENT AUTHORITY</b>	Name of Agency
	Contact Person
	Contact Details

#### 1. CHARACTERIZATION OF THE POE

- 1.1) Number of international entries and departures on average per month in 2012
- 1.2) Number of Passenger Conveyances on average per month in 2012
- 1.3) Number of Passengers and Crew on average per month in 2012
- 1.4) Number of Cargo Conveyances on average per month in 2012

#### 2. LEGAL FRAMEWORK FOR PUBLIC HEALTH SURVEILLANCE AT THE POE

- 2.1) What are the surveillance activities focused on health threats to human health that involve your PoE on one side and the National Health System on the other side?
- 2.2) Can reference documents that regulate surveillance involving the PoE and the NHS be provided to the investigator team during the site visit?

## Procedures and processes

### 3. STAFF

- 3.1) Who are the persons that collect data on human disease cases and on public health threats (Number and type of staff affected to public health surveillance. How many implicated full-time and how many part-time)
- 3.2) Who are the persons that centralize health data at the PoE.
- 3.3) Are these persons trained in public health surveillance?
- 3.4) How would you describe the number, training and knowledge of dedicated staff at you PoE:

	Scarce	Sufficient	Abundant
3.4.1) Number of trained staff assigned for Public Health detection/reporting/response at your PoE			
3.4.2) Staff's training possibilities on event surveillance, investigation and control at PoE (staff at your PoE trained on these topics for over three years)			
	Poor	Modest	Strong
3.4.3) Staff's knowledge of IHR and PHEIC			
3.4.4) Staff's knowledge of the epidemiological situation at PoE and capacity to assess PH risks			
3.4.5) Staff's knowledge of infection control techniques			
3.4.6) Staff's knowledge of reporting requirements of communicable diseases			
3.4.7) Staff's knowledge of CBRN threats			
3.4.8) Staff's knowledge of reporting requirements of CBRN threats			
3.4.9) Staff's knowledge of food safety measures			

### 4. DATA COLLECTION AND USE

- 4.1) List of hazards for which data is being collected
- 4.2) What are the data sources (conveyances, travelers, media, health facilities, etc) by type of surveillance
- 4.3) How are the data collected: forms, number of variables, individual and/or aggregated, paper and/or electronic, integrated or per disease or hazard.
- 4.4) Are case definitions established. Are there differences with the national surv. system in terms of data collection (methods, nature of data, etc). Are there decision trees.
- 4.5) Is there data analysis and reporting done at the PoE. By whom. Indicators and their construction. What is the output. What is the use.

### 5. DATA TRANSMISSION

- 5.1) How are data transmitted out. To whom, in what format.
- 5.2) Is there a different recipient by type of hazard?
- 5.3) What is the frequency of routine transmission.
- 5.4) What is the frequency of immediate transmission.
- 5.5) Means of transmission:
  - paper,
  - voice,

- tele-transmission: SMS, internet, web platform
  - other (please specify)
- 5.6) Is there feed-back for the PoE?
- 5.7) Data transmitted by the national surv. system to the PoE. Who receives it, in what format. How is it disseminated and to whom.

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## 6. SOPS AND GUIDELINES

- 6.1) What written SOPs exist? Are they standardized country-wide, region-wide, etc. Are they updated, user-friendly, complete, realistic, etc. List, describe, obtain copies.
- 6.2) What guidelines are known and used as reference.
- 6.3) Perception of guidance needed (to be asked at each aspect discussion)

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## 7. HEALTH EVENTS

- 7.1) What is considered an unusual health event? Could you please indicate some recent examples?
- 7.2) What is considered an emergency? What mechanisms take place in emergencies: coordination, external intervention, communication, etc.

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## 8. COMMUNICATION AND COORDINATION

- 8.1) Coordination mechanisms: internal to the PoE (within and between sectors), external to the PoE.
- 8.2) Regular meetings between actors involved in surveillance. Frequency. What is discussed/done.
- 8.3) Are there supervision activities of the surveillance functions? Frequency. Outcome.
- 8.4) Tools used to facilitate communication/coordination.
- 8.5) Communication with the national health surveillance system; SOPs? Lists of contacts available? What level? Transmission of structured data? Frequency. Obstacles.
- 8.6) Communication with other points of entry inside and outside the country; SOPs? Lists of contacts available? Does this type of communication need prior authorization? Transmission of structured data? Frequency. Obstacles.

9. CONCRETE EXAMPLES

9.1) Please indicate the number of reports per type of event in 2012 and if the report was transmitted:

	Number	Number of reports transmitted to PH authorities (local/intermediate)	N of reports transmitted to the National IHR Focal Point
9.1.1) Reports for Communicable Disease Outbreaks			
9.1.2) Reports for food safety events			
9.1.3) Reports for Chemical threats			
9.1.4) Reports for Radio-nuclear threats			
9.1.5) Reports for zoonosis (animal)			
9.1.6) Reports for zoonosis (human)			
9.1.7) Reports for Chemical threats			
9.1.8) Reports for RadioNuclear threats			
9.1.9) Reports for Other (specify) threats			

9.2) In your opinion are there gaps in surveillance and control of public health events at your designated PoE?

- Yes
- No

9.2.2) : If yes please detail

9.3) In your opinion have there been major improvements in surveillance and control of public health events at your designated PoE?

- Yes
- No

9.3.2) :If yes please detail