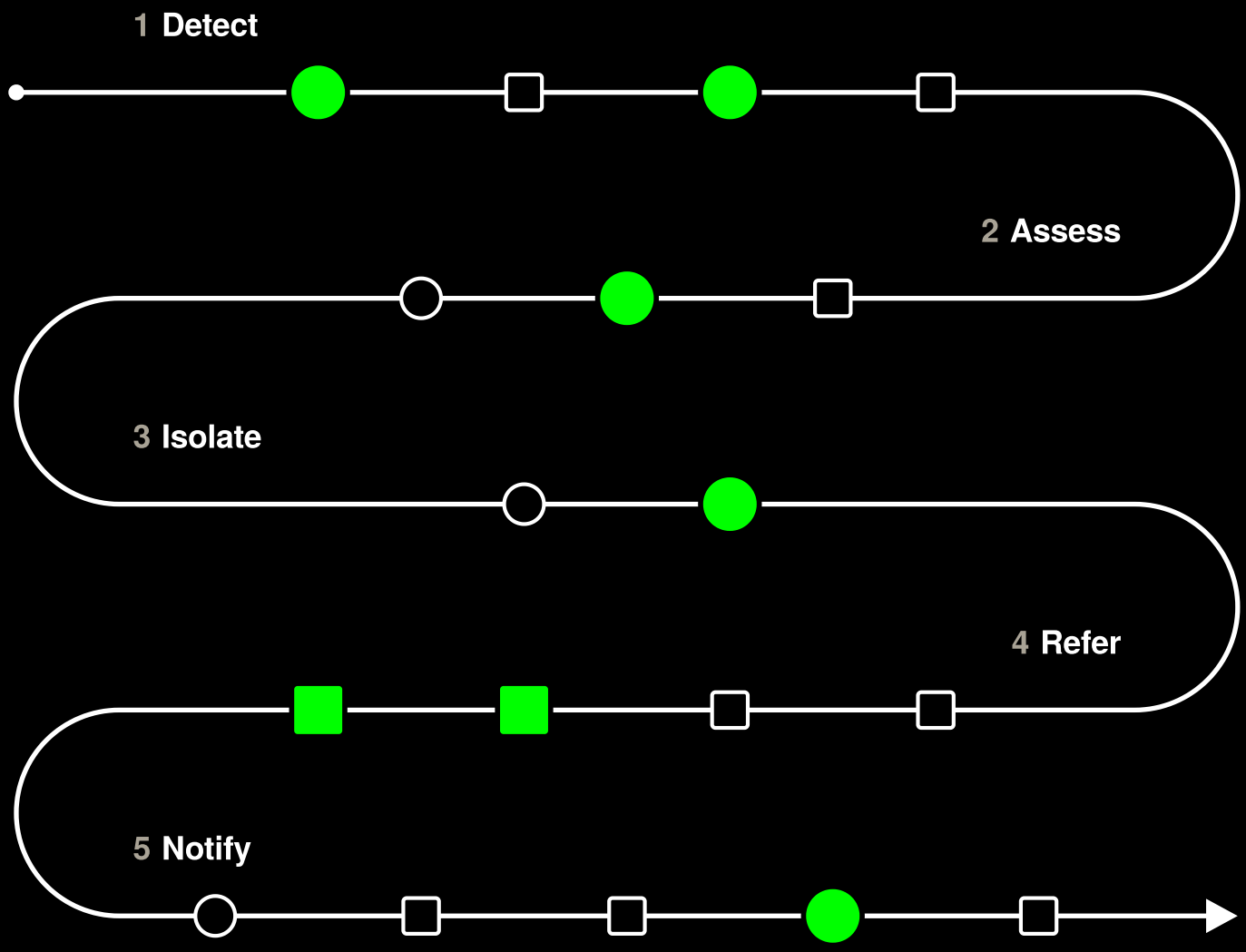
PRESENT LAB

# Rapid preparedness diagnostic for airports

Methodology note




Supporting functions



# Rapid preparedness diagnostic for airports

Methodology note
Version 1.0 (pilot)
October 2026

A one-day, evidence-based review of 31 items that checks whether an airport can detect, assess, isolate, refer and notify an ill traveller today, and decide what to fix first.

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PILOT VERSION

Published for use and feedback while testing continues. Thresholds and flags are working conventions (section 6); limitations are in section 9; changes from version 0.9 are in section 11.


**Resource.** Rapid preparedness diagnostic for airports: methodology note. Version 1.0 (pilot), October 2026.

**Companion files.** Assessor field pack, version 1.0: an editable workbook (XLSX) and printable field forms (PDF and DOCX).

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**Independence.** This resource has not been reviewed or endorsed by WHO, ICAO or any government, airport or aviation body. References to their publications do not imply endorsement.


**Feedback.** Tell us what worked, what did not, and any errors you find, by email to olaoluwa@presentlab.org. Corrections are recorded in the change log of the next version.

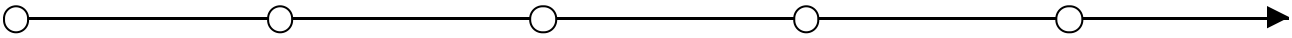
**Cover.** The five steps of the sequence as one route. Each mark is one of the 31 items: a circle is an on-site item, a square a record item, green a critical function. The row beneath holds the 13 supporting functions. Drawn from the item list in section 10.

**Design.** Present Lab report system. Layout and cover drawing prepared with the help of an AI assistant (Claude, Anthropic).

# Overview

A contingency plan on file does not show that it works with the staff on duty, at any hour, when a traveller falls ill. This diagnostic helps port health teams and their partners check the evidence for each step in one day, see which functions are in place and which are not, and decide what to fix first.

## The assessed sequence



**1 Detect**
Recognise an ill traveller

**2 Assess**
Interview and examine

**3 Isolate**
Separate safely

**4 Refer**
Transfer to care

**5 Notify**
Inform the health authority

The diagnostic checks the evidence that each step works, and the functions that support it.

| | |
|---|---|
| **What it is** | A one-day, evidence-based review of 31 items in six modules. Each item is scored 0, 1 or 2 against set criteria. |
| **Who it is for** | Port health and other competent authorities at designated international airports, the airport operator, the civil aviation authority and partner agencies, and the technical partners who support them. |
| **What you get** | Three separate results (capability, evidence confidence and coverage), flags on seven critical functions, and a prioritised list of actions with owners and closure tests. |
| **What it is not** | Certification, IHR designation, a finding of compliance, an aviation audit, an external evaluation or a ranking of airports. It does not replace the WHO assessment tool for designated points of entry. |
| **What you need** | This note, the assessor field pack (editable workbook and printable forms), two trained assessors, the agreement of the competent authority, and airside access arranged in advance with the airport operator. |

# 01 Purpose and boundaries

**31**

**items in six modules**

Each is scored 0, 1 or 2. The full list is in section 10.

## What the diagnostic is for

The International Health Regulations (IHR) require each State Party to develop, strengthen and maintain core capacities at designated airports, ports and ground crossings (Annex 1, Part B). Full assessments of these capacities are detailed and infrequent. Between them, port health teams need a quicker way to answer practical questions: can we detect, assess, isolate, refer and notify an ill traveller today; where would that sequence fail; who will fix it; and how will we know the fix works?

The diagnostic is a bounded review, normally completed in one day on site by two assessors. It examines 31 items in six modules. Each item is scored 0, 1 or 2 against set criteria, and every score must rest on recorded evidence. The method ensures three results can be judged separately: what the evidence shows is in place, how strong that evidence is, and how much of the review was completed.

## The assessed sequence

Eighteen of the 31 items test one of the five steps that must work at the airport when a traveller falls ill (Exhibit 1.1). The other thirteen test supporting functions. ▲ marks a critical function (section 6).

## What it can and cannot tell you

| IT CAN TELL YOU | IT CANNOT TELL YOU |
|---|---|
| Which of 31 functions are in place, partly in place or absent on the day, with the evidence for each. | Whether the airport has every capacity in Annex 1B. Some capacities are outside its scope (section 9). |
| Where the sequence from detection to notification is most likely to fail. | Whether the airport complies with the IHR, ICAO standards or national law, or should be designated. |
| How strong the evidence is, and what was not checked. | How the airport compares with others. Results depend on context and on the evidence available on the day. |
| Which gaps to address first, who owns each action, and how closure will be checked. | Whether health outcomes will improve. |

## Who it is for

Port health and other competent authorities that lead a review; the airport operator, the civil aviation authority and partner agencies that take part (airlines, ground handlers, immigration, customs, aviation

security and emergency medical services); and technical partners that support them. It is designed for designated international airports. Ports and ground crossings need adapted versions, which have not yet been developed or tested.

EXHIBIT 1.1

## Eighteen of the 31 items test one of five steps; thirteen test supporting functions

### 1 Detect
Recognise an ill traveller

- ● **3.1** ▲ Trained staff across operating hours
- □ **3.3** Roster covers arrivals and departures
- ● **4.1** ▲ Screening equipment and in-date PPE
- □ **5.5** Traveller information linked to surveillance

### 2 Assess
Interview and examine

- □ **3.2** Training in surveillance, case definitions and PPE
- ● **3.4** ▲ Initial assessment of an ill traveller
- ○ **4.3** Hand hygiene and infectious waste

### 3 Isolate
Separate safely

- ○ **2.5** Holding area and referral route found on site
- ● **4.2** ▲ Assessment and isolation space

### 4 Refer
Transfer to care

- □ **3.5** Referral focal point and procedure
- □ **4.4** Specimen collection and transport pathway
- ■ **4.5** ▲ Referral transport
- ■ **4.6** ▲ Designated receiving facility

### 5 Notify
Inform the health authority

- ○ **1.3** 24-hour contacts and escalation chain
- □ **5.1** Reporting into national surveillance
- □ **5.2** Events entered in the national event system
- ● **5.3** ▲ Immediate notification pathway
- □ **5.6** Ill-traveller register shared

## Supporting functions

13 items. These cover coordination, the contingency plan, feedback from the national system, procedures at the point of use, information for travellers, sanitation and the last real event or drill.

- □ **1.1** Competent authority and coordinator
- □ **1.2** Multi-agency coordination that meets
- □ **1.4** Public health roles known to partners
- □ **2.1** Contingency plan exists and is approved
- □ **2.2** Plan reviewed within cycle and after events
- □ **2.3** Plan tested in the past 24 months
- ○ **2.4** Plan known and usable by staff on duty
- ○ **2.6** Resource annex mapped and current
- □ **5.4** Feedback from national and subnational levels
- ○ **6.1** Procedures at the point of use
- ○ **6.2** Information for travellers
- ○ **6.3** Sanitation, water and vectors (light check)
- □ **6.4** Last real event or drill

○ On-site item  □ Record item  ● ■ Critical function (▲), either type

# 02

# How it fits with the IHR, WHO tools and aviation standards

The diagnostic is a voluntary technical method. It complements the IHR monitoring and evaluation framework and the civil aviation framework, and does not replace any part of either. Obligations under the IHR rest with States Parties. Obligations under the annexes to the Chicago Convention rest with States and, through national regulations, with aerodrome operators. Whether these obligations are met is judged through each framework's own processes, not by this diagnostic.

**Three sets of references** follow, in Exhibits 2.1 to 2.3.

**Public health instruments** — the IHR and its annexes, WHO assessment and planning tools, SPAR, the joint external evaluation and the WHO benchmarks.

**Civil aviation standards and joint mechanisms** — ICAO Annex 9, Annex 14, Doc 9137 and CAPSCA.

**Review and timeliness methods** — exercise and after-action guidance, the early action review and 7-1-7 target, and intra-action reviews.

EXHIBIT 2.1

## Public health instruments

| REFERENCE | WHAT IT IS | HOW THE DIAGNOSTIC RELATES TO IT |
|---|---|---|
| **IHR (2005), Articles 19–23 and Annex 1 [E1]** | Legal obligations for designated points of entry: capacities required at all times (Annex 1, Part B, paragraph 1) and for responding to events that may constitute a public health emergency of international concern (paragraph 2). Articles 22 and 23 cover competent authorities and health measures on arrival and departure; Annex 1, Part A sets the surveillance capacities that module 5 links to. | Items are written against these functions and cite the relevant provisions. A score is not a finding of compliance. |
| **WHO assessment tool for core capacity requirements at designated points of entry, 2009 [E2]** | Detailed assessment of core capacities at designated points of entry. | Use it for a full assessment. The diagnostic is a shorter screen of priority functions. |
| **WHO contingency planning guide, 2012, and air transport handbook, 2016 [E3, E4]** | Guidance on public health emergency contingency plans at points of entry, and on managing public health events in air transport. | Module 2 tests whether the plan is approved, current, tested and usable. Items on handling ill travellers draw on the handbook. |

| REFERENCE | WHAT IT IS | HOW THE DIAGNOSTIC RELATES TO IT |
|---|---|---|
| **WHO advising principles on surveillance coordination between points of entry and the national system, 2018 [E11]** | How points of entry and the national surveillance system share routine reports, event alerts, registers and feedback, with a toolbox for improving coordination. | Module 5 items (5.1–5.6) test these links. Use the toolbox to choose actions for module 5 gaps. |
| **SPAR, second edition: indicators C11.1 and C11.2 [E5]** | Annual national self-assessment reported to WHO. | Results can inform national reporting. They are not a SPAR submission. |
| **Joint external evaluation, third edition: points of entry technical area [E6]** | Voluntary external evaluation of national capacities. | The two work at different levels. Neither certifies an airport. |
| **WHO benchmarks, benchmark 17: points of entry and border health [E7]** | Actions that move a country from one capacity level to the next. | Use them to choose improvement actions after a diagnostic. |

Item references to the IHR use the consolidated text [E1]. Confirm which version of the Regulations applies to your State Party. Module-level links to SPAR indicators, and the references for each item, are given in the field pack.

EXHIBIT 2.2

## Civil aviation standards and joint mechanisms

| REFERENCE | WHAT IT IS | HOW THE DIAGNOSTIC RELATES TO IT |
|---|---|---|
| **ICAO Annex 9, Facilitation, Chapter 8 [E15]** | Requires each State to establish a national aviation plan in preparation for an outbreak of a communicable disease posing a public health risk or a public health emergency of international concern. | The airport public health contingency plan should be consistent with this plan. Item 2.1 checks consistency with national arrangements. |
| **ICAO Annex 14, Volume I, section 9.1, and Airport Services Manual, Doc 9137, Part 7 [E16, E17]** | Require an aerodrome emergency plan, coordinated with the agencies that would respond, and list public health emergencies among the emergencies it should cover. Doc 9137 gives guidance on preparing and testing the plan. | Item 2.1 checks that the public health plan is part of, or explicitly linked with, the aerodrome emergency plan. Module 1 checks that aviation partners take part in coordination. The diagnostic does not assess the aerodrome emergency plan as a whole. |
| **CAPSCA: Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation [E18]** | An ICAO-led programme, supported by WHO, that brings aviation and public health authorities together. Its assistance visits review national and airport preparedness plans against ICAO standards and the IHR. | CAPSCA visits review plans and coordination; the diagnostic tests whether the ill-traveller sequence works on a shift. Where a CAPSCA visit has taken place, use its report as evidence if the competent authority can share it, and do not repeat interviews it already covered unless arrangements have changed. |

In practice, the public health contingency plan works only if the airport emergency operations centre, aviation security and rescue services know when and how it is activated. Treat the civil aviation authority and the airport operator as partners in the review: invite them to the entry meeting and the readout, and share results with them where the competent authority agrees.

EXHIBIT 2.3

## Review and timeliness methods

| REFERENCE | WHAT IT IS | HOW THE DIAGNOSTIC RELATES TO IT |
|---|---|---|
| **WHO exercise and after-action review guidance [E8–E10]** | How to design, run and review exercises and real responses. | Use them to test functions during a sprint and to check that actions work. |
| **Early action review [E12] and the 7-1-7 target [E13]** | A rapid review of the timeliness of detection, notification and early response, using the 7-1-7 target: detection within 7 days of emergence, notification within 1 day of detection, and early response completed within 7 days of notification. The review names the bottlenecks and the actions to remove them. | Item 6.4 reconstructs the timeline of the last real event or drill, including the time from detection to notification. Sprints use the same logic: name the step that failed or caused delay, fix it and retest it. |
| **Intra-action reviews at points of entry [E14]** | Evidence from structured reviews held during the COVID-19 response at points of entry. | Reviews held during a response can supply evidence for items 2.3 and 6.4 and feed a sprint. |

**NOTE · THE AMENDED IHR**

The 2024 amendments to the IHR entered into force on 19 September 2025 for most States Parties. Eleven States Parties rejected them, and the date or terms differ for some others: for States Parties that rejected the 2022 amendments, the date is 19 September 2026. Check the position of your own State Party. The amendments add a ‘pandemic emergency’ alert level and provide for National IHR Authorities to coordinate implementation in each country. Many airport contingency plans were written before the amendments took effect. Item 2.2 records whether, and when, a plan has been reviewed.

# 03 Choosing a pathway

Present Lab's points of entry resources describe three connected ways of working. Two are assessments of different depth. The third is an improvement cycle, not a further level of assessment.

EXHIBIT 3.1

### Three connected ways of working

| | Rapid diagnostic | Full assessment | Preparedness sprint |
|---|---|---|---|
| WHAT IT IS | A one-day review of 31 items using this note and the field pack. | A deeper assessment of all Annex 1B capacities, with wider evidence and functional testing where feasible, normally based on the WHO 2009 tool [E2]. | A time-bounded cycle on a few priority gaps: make the change, test it, verify it. |
| USE IT WHEN | You need a structured, evidence-based view of readiness quickly: before a season or major event, when a new route opens, after new WHO temporary recommendations, or as a baseline. | You need a complete baseline, for example to inform designation, a national plan or a large investment. | You already know your priority gaps from recent evidence that covers the whole sequence (see the decision guide). |
| WHAT YOU GET | Scored items with evidence; capability, confidence and coverage; critical-function flags; a prioritised action list. | A full capacity profile against the chosen standard. | Changes made and verified, or left explicitly open with the remaining risk recorded. |
| TYPICAL EFFORT | One to two weeks of preparation; one day on site with two assessors (a day and a half at large airports); up to five working days for late evidence and the final scorecard. | Several days on site, depending on scope and tool. | A proposed four to six weeks, adjusted to local authority, resources and risk. |

EXHIBIT 3.2

## A quick decision guide

| | QUESTION | IF YES | IF NO |
|---|---|---|---|
| 1 | Do you need a complete baseline of every Annex 1B capacity, for example to inform designation, a national plan or a large investment? | Plan a full assessment [E2]. If existing evidence already shows a critical gap, start a sprint on it now; do not wait for the full report. | Go to question 2. |
| 2 | Do you have evidence from about the past 12 months (an assessment, exercise, after-action or early action review) that covers all five steps and the seven critical functions, and names your priority gaps? | Go to a preparedness sprint (section 8). Score the selected items against the field pack anchors at the start of the sprint; that record is the sprint baseline. | Go to question 3. |
| 3 | Does recent evidence cover some modules but not others? | Run a targeted diagnostic on the modules it does not cover, always including the seven critical functions, then a sprint. | Run the full rapid diagnostic, then a sprint on the gaps it finds. |

Treat evidence as out of date if it is older than about 12 months, or if staffing, leadership, the terminal layout or the flight schedule has changed substantially since it was gathered. A targeted diagnostic reports results for the modules it covers; it gives an overall capability percentage only if coverage of all applicable items reaches 80% (section 6).

A rapid diagnostic can also be repeated on selected items to verify progress after a sprint (section 8). Whichever pathway you choose, the competent authority owns the results and decides what happens next.

# 04 Preparing the visit

Agree authority, permissions, access and documents before the visit, so that the time on site goes to examining evidence rather than looking for it.

## Authority and permissions

- The competent authority for public health at the airport leads or requests the diagnostic. Partners take part at its invitation.
- Agree in writing: scope and dates; who will attend; access to restricted areas; what may be photographed; how records will be stored; and who will see the results, in what form.
- The competent authority sees the results first. Agree before the visit whether, and how, any results may be shared beyond it, including with the airport operator and the civil aviation authority.
- Never photograph travellers. Photograph rooms, stores and equipment only with permission.

## Airside access and the tests on the day

- Ask the airport operator, through the competent authority, which aviation security procedure applies to visiting assessors and how much notice it needs; this is often more than a week. Submit each assessor’s identity details in time for temporary airside passes to be ready on the day.
- Agree an escort, by role, for every airside block, and allow time for security screening between landside and airside.
- Confirm that the people who hold the keys to the assessment and isolation space, the PPE store and the screening equipment will be on duty as they would be on a normal shift. Do not ask for extra staff to be brought in: the visit tests the arrangements of a normal shift.
- Agree in advance which tests may be run, and who authorises each: a test call to the 24-hour contacts and to the notification point, a role-played traveller assessment, and a timed call to the referral transport provider.
- Agree what happens if a real event or a security incident interrupts the visit.

## The team and its roles

Use two assessors. Both attend every interview, inspection and demonstration together. Leading a module means asking the questions, keeping time and asking for the tests; the other assessor observes and takes their own notes. One leads modules 1, 2 and 5 (coordination, the plan and surveillance links); the other leads modules 3, 4 and 6 (staff, equipment and facilities, and enablers).

ASSESSOR A LEADS

**Modules 1, 2 and 5**

Coordination, the plan and surveillance links

ASSESSOR B LEADS

**Modules 3, 4 and 6**

Staff, equipment and facilities, and enablers

Each assessor scores the items of a module alone, on their own form, at the end of that module’s block and before any discussion. Scoring module by module keeps the evidence fresh and leaves the end of the day for reconciliation.

Do not split up to save time: an item that only one assessor saw cannot be checked independently. If a split cannot be avoided, for example at two terminals far apart, the assessor who did not see the evidence leaves their score blank and the reconciliation note says ‘single observer’. These items are left out of the agreement statistics. If only one assessor is available for the whole visit, record this in the visit details: there is then no independent check on the scores, and the scorecard says so.

## Documents to request in advance

Send the request with the notification letter and repeat it at the entry meeting. Both assessors read the pack before the day and list, for each item, what remains to be seen, tested or asked on site. Documents seen in advance are still checked on site, to confirm that the version in use is the version sent.

EXHIBIT 4.1

### Each document requested in advance, and the items it supports

| DOCUMENT | ITEMS IT SUPPORTS |
|---|---|
| Airport public health contingency plan, with approval and version pages, and the part of the aerodrome emergency plan that links to it | **2.1, 2.2, 2.4, 2.5** |
| Exercise reports, after-action or intra-action reviews and improvement plans from the past 24 months | **2.3, 6.4** |
| Duty rosters for a recent full week, and the international flight schedule for the same week | **3.1, 3.3** |
| Training records for staff on the roster | **3.2** |
| Procedures for detection, assessment, isolation, referral and notification | **3.5, 6.1** |
| The 24-hour contact directory and escalation chain | **1.3, 5.3** |

| DOCUMENT | ITEMS IT SUPPORTS |
|---|---|
| Agreements with the receiving facility, the ambulance service and the laboratory | **4.4, 4.5, 4.6** |
| Ill-traveller and event registers, recent surveillance returns, and the record of the last immediate notification | **5.1, 5.2, 5.3, 5.6** |
| Recent alerts or bulletins from national or subnational authorities | **5.4** |
| Traveller health declaration or locator forms in use, if any, and how they reach the surveillance team | **5.5** |
| Appointment of the competent authority's coordinator; terms of reference and recent minutes of the coordination mechanism | **1.1, 1.2, 1.4** |
| Resource annex and current stock records: PPE stock and expiry checks, and maintenance or calibration logs for screening equipment | **2.6, 4.1** |
| Infectious waste procedure, and the waste contractor's agreement or recent collection records | **4.3** |
| Recent inspection records for water, food outlets and washrooms, and the vector control programme | **6.3** |
| Copies of current information materials for travellers, with the languages used | **6.2** |
| The report and action plan of any CAPSCA assistance visit or earlier assessment, if the competent authority can share it | **All modules** |

**READ THIS AT THE ENTRY MEETING**

This is a rapid review of public health readiness at the airport, led by the competent authority. It records what is in place today and what is not, with the evidence for each.

It is not a regulatory inspection, an aviation audit or a certification. It assesses systems, not individuals.

The competent authority sees the results first and decides how they are used. Documents that already existed today can be provided for up to five working days after the visit. Anything that should be seen or tested on site can be checked only today.

## Calibration before the first visit

Before the first visit, every assessor who will take part in the same round of visits scores the same set of fictional cases independently. The set includes at least one case for each evidence method, one with conflicting sources, one on the boundary between 'not assessed' and a score of 0, and one on-site item and one record item that could score 2.

Compare the results, settle each rule on which assessors differ, and write it in a single rule log for the round. Issue the log to all teams before any team goes on site; teams do not add local rules of their own. When several teams work at the same time, hold a call after the first visits to check that the rules are applied the same way, and record any change in the log with its date.

# 05 Collecting evidence

Score what is in place and can be shown on the day, not what is planned. Every score needs a written evidence note, including scores of 2.

EXHIBIT 5.1

**Evidence methods, weaker to stronger**



### **Reported** (I)

METHOD

Interview, or a scenario talk-through

HOW

Someone describes the arrangement or talks through a scenario.

WHAT IT SHOWS

What people believe happens.

### **Documented** (D)

METHOD

Document

HOW

A plan, record, roster or agreement describes it.

WHAT IT SHOWS

What is intended and written down.

### **Observed** (O)

METHOD

Observation

HOW

The assessor sees it in place or in use.

WHAT IT SHOWS

That the arrangement exists in practice.

### **Tested** (T)

METHOD

Test or demonstration

HOW

The step is performed under stated conditions: a test call, a drill, or a practical demonstration such as assessing a role-played traveller.

WHAT IT SHOWS

That the function works under those conditions.

WEAKER — STRONGER

## A plan on file shows intent. It is not proof that a function works.

### Two kinds of item

Each item is either an on-site item or a record item. The type is shown in the field pack and in section 10. It sets the minimum evidence for a score of 2 and the basis for evidence confidence (section 6). It does not change the item’s anchors.

| TYPE | WHAT THE ITEM DESCRIBES | A SCORE OF 2 NEEDS | ITEMS |
|---|---|---|---|
| **On site** | Something that should be seen in place or done: a room, equipment, a call, a staff action. | Two methods that agree, one of which is an observation or a test. | 1.3, 2.4, 2.5, 2.6, 3.1, 3.4, 4.1, 4.2, 4.3, 5.3, 6.1, 6.2, 6.3 (13) |
| **Record** | An arrangement that exists mainly as a record or agreement: an appointment, minutes, an approved plan, returns, a signed agreement. | Two methods that agree, one of which is a dated document. The other is usually an interview with the person who would act, or an observation. | 1.1, 1.2, 1.4, 2.1, 2.2, 2.3, 3.2, 3.3, 3.5, 4.4, 4.5, 4.6, 5.1, 5.2, 5.4, 5.5, 5.6, 6.4 (18) |

## Rules for the day

**Triangulate.**

A score of 2 needs two methods that agree, including the method the item type requires. With a single method, the highest score is 1.

**Ask the person who would act.**

The duty officer's account is the evidence; the plan's author can only confirm the design. Ask a non-health partner, such as a ground handler, whom they would call.

**When sources conflict, score to the weaker position and record the conflict.**

**What the people on duty cannot do is evidence.**

If the duty staff cannot open the assessment room, find the plan or make the call, score what that shows. It is a finding about readiness, not missing evidence.

**Requested and not produced scores 0.**

A document requested in advance, or a person, room or test agreed in advance, that cannot be produced on the day scores 0, or 1 if other evidence meets the anchor for 1. 'Not assessed' is used only for the four reasons in section 6.

**Late evidence is limited to documents that already existed.**

For five working days after the visit, accept a document only if a date, signature or file record shows it existed on or before the visit day. Do not accept photographs, videos, new statements or documents created after the visit, and never accept late evidence in place of the observation or test that an on-site item needs.

**Check critical functions first.**

Within each block, check the critical functions before the other items, so that a shortage of time affects only non-critical items.

**Do not fix, then score.**

If you help the team find a procedure or prepare a room, score what you found and record the help separately.

**Score systems, not people.**

Record staffing and funding gaps as system issues. No individual's name appears against a score.

**Stop for a real event.**

If an ill traveller presents during the visit, pause the review. Give only the support the competent authority asks for, within your role, training and protective equipment.

## Provisional and final scores

At the readout, score each item on the evidence seen on site. Where a document has been promised under the late-evidence rule, score the item on what was seen (usually 0 or 1) and write 'late evidence expected' in the evidence note. The scorecard is marked provisional. When the five working days have passed, re-score only the items for which admissible late evidence arrived, record the document in the evidence log, and mark the scorecard final.

EXHIBIT 5.2

### A one-day schedule

| WHEN | ACTIVITY |
|---|---|
| **Before the day** | Both assessors read the document pack and list what remains to be seen, tested or asked for each item. Confirm airside passes, escorts, keyholders and the agreed tests. Prepare the field pack. |
| **08:00** | Arrival, passes and security screening. |
| **08:30** | Entry meeting: scope, confidentiality, entry statement, document list and the plan for the day. |
| **09:00** | Modules 1–2 (landside): coordination and the contingency plan. Interviews and documents, including the non-health partner for item 1.4. |
| **10:45** | Each assessor scores modules 1–2 alone. |
| **11:00** | Move airside with the escort; allow 30 minutes for screening. |
| **11:30** | Modules 3–4 (airside), critical functions first: staff on duty (3.1), role-played assessment (3.4), equipment and PPE (4.1), the assessment space (4.2), then referral transport and the receiving facility (4.5, 4.6) and the other items. |
| **13:30** | Break. Each assessor scores modules 3–4 alone. |
| **14:15** | Module 5, starting with the notification test call (5.3): surveillance focal point, registers, returns and bulletins. |
| **15:15** | Module 6 and walk-through: arrival and departure flows, procedures at the point of use, information for travellers, a light sanitation check, and the timeline of the last real event or drill (6.4). Each assessor then scores modules 5–6 alone. |
| **16:15** | Reconciliation, calculation and the provisional scorecard. |
| **17:00** | Provisional readout to the competent authority, critical-function flags first. |
| **Within 5 working days** | Admissible late evidence received and checked; final scorecard and action list sent to the competent authority. |

If a block runs more than 15 minutes over time, move its remaining non-critical items to the end of the day or record them as ‘not assessed – team ran out of time’. Do not leave a critical function unchecked to keep to time: extend the day instead. At large or multi-terminal airports, plan a day and a half.

## What to record for each item

The methods used; the source, as a role or document title rather than a personal name; the date; what was seen or said; any restriction on the evidence; whether late evidence is expected; the score and the reason for it; and any disagreement between assessors and how it was settled. The field pack has a field for each.

# 06 Scoring, coverage and confidence

EXHIBIT 6.1

**The 0–2 scale**

## 2

### Demonstrated

In place, current and evidenced on the day.

TEST

Meets every element of the item's anchor for 2, with the evidence its type requires.

## 1

### Partial

Exists, but is incomplete, out of date, informal, untested, or unknown to the people who would use it.

TEST

Meets the item's anchor for 1.

## 0

### Absent

Not in place, or could not be shown by any method.

TEST

'We are buying one' scores 0 until it arrives.

Each item has its own anchors for 0, 1 and 2 in the field pack. The general meanings above summarise them; the item anchors decide. When the evidence sits between two scores, give the lower score and record why.

## Applicability is not the same as missing evidence

Each item has two separate fields:

- **Applies.** Yes by default. Mark 'No' only when the function genuinely does not apply at the airport. A 'No' needs a written reason and approval by a named reviewer role. Never mark an item as not applicable because evidence was hard to get.
- **Score, or the reason it was not scored.** An applicable item has either an agreed score or one of the four reasons below.

## When an item can be 'not assessed'

An applicable item may be left unscored only for a reason outside the airport's control:

| REASON | USE IT WHEN |
|---|---|
| **Not assessed – team ran out of time** | The assessment team did not reach the item. Because critical functions are checked first, this should affect only non-critical items. |
| **Not assessed – stopped by a real event or security incident** | A real event, a security alert or an operational emergency stopped the check. |

| REASON | USE IT WHEN |
|---|---|
| **Not assessed – access withheld by a third party** | An organisation outside the competent authority's control withheld access that had been agreed in writing. Record which organisation and the role that decided. If the same organisation would control access in a real event, score what the refusal shows instead. |
| **Assessor's record lost or illegible** | The evidence was seen, but the assessor's own record cannot be used. |

Everything else is scored. If the airport could not produce a document, a person, a room or a test that was requested or agreed in advance, score 0, or 1 where other evidence meets the anchor for 1. This includes a keyholder or focal point who is not on duty: in a real event on the same shift, they would also be absent.

## Three results, kept separate

### Capability

What the evidence shows is in place.

HOW IT IS MEASURED

Points awarded ÷ points possible, for applicable items that were scored.

### Evidence confidence

How strong the evidence behind the scores is.

HOW IT IS MEASURED

The number and share of scored items at each confidence level, by module and overall.

### Coverage

How much of the review was completed.

HOW IT IS MEASURED

Scored applicable items ÷ all applicable items.

Report the three together, with the floor. A high capability result with low coverage or weak evidence must stay visibly qualified.

EXHIBIT 6.2

### How the numbers are calculated

| RESULT | FORMULA |
|---|---|
| **Module capability** | *Sum of agreed scores in the module ÷ (2 × scored applicable items in the module)* |
| **Overall capability** | *Sum of agreed scores across all modules ÷ (2 × all scored applicable items)*<br>Every item carries equal weight, so a module with more items carries more weight. The method does not average module percentages, which would be a different measure. |
| **Floor** | *Sum of agreed scores ÷ (2 × all applicable items)*<br>Unscored applicable items count as 0, so the floor is the lowest result the recorded evidence allows. It is always reported beside capability, so that the effect of unscored items is visible. |
| **Coverage** | *Scored applicable items ÷ all applicable items* |
| **Reporting rule** | A capability percentage is reported only when coverage is at least 80%. The rule is applied separately to each module and to the overall result. Below 80%, report the floor and the number of unscored items. In a four-item module, one unscored item takes coverage to 75%, so that module's percentage is not reported. |

## Evidence confidence

Every scored item, including items scored 0, gets a confidence level from the methods used to reach its score and from its type.

| LEVEL | RULE |
|---|---|
| **High** | Two or more methods that agree, including an observation or test (on-site item) or a dated document (record item). |
| **Moderate** | At least one method other than interview, but not High. For example, a document and an interview for an on-site item. |
| **Low** | Interview only, or the sources conflict. |
| **Not recorded** | No method marked. Correct the record before the final scorecard. |

For an item scored 0, record the methods used to establish the absence: a room looked for and not found is an observation; a document requested in advance and not produced counts as a document check; staff confirming that something does not exist is an interview.

Summarise confidence for each module and overall as the number and share of scored items at each level. Mark a capability result ‘weak evidence’ when Low and Not recorded items together make up 25% or more of the scored items in that module or overall. The 25% rule is a working convention, like the band thresholds.

EXHIBIT 6.3

### Bands




**RED**

**Below 40%**

Large gaps across the items scored.

**AMBER**

**40% to below 70%**

Partial capability; important gaps remain.

**GREEN**

**70% and above**

Points awarded are at least 70% of points possible. Gaps can remain, including critical functions scored 0 or 1; the critical-function flags shown above the result take precedence. Not certification, and not a finding of IHR compliance.

## Rounding and boundaries

Every test uses the unrounded ratio: the band, ‘near boundary’, the 80% coverage rule and the 25% weak-evidence rule. Displayed percentages (capability, coverage and floor) are rounded down to the whole number, so a displayed number never appears to be in a higher band than the result it shows.

- A capability of 69.6% is displayed as 69% and is Amber.

**80%**

**minimum coverage to report a capability percentage**

Applied separately to each module and to the overall result.

- ‘Near boundary’ means the unrounded result is less than 5 percentage points from 40% or 70%: above 35% and below 45%, or above 65% and below 75%. A result of 65.5% is displayed as 65% and is near boundary; exactly 65.0% and exactly 75.0% are not.
- Coverage of 24 of 31 items is 77.4% and does not meet the 80% rule; 25 of 31 is 80.6% and does.

Bands always carry their name; colour is never the only signal.

## Critical-function flags

Seven items test functions without which an ill traveller cannot be safely detected, assessed, isolated, referred or notified, or staff cannot be protected: 3.1, 3.4, 4.1, 4.2, 4.5, 4.6 and 5.3. These functions always apply at a designated airport, so they cannot be marked ‘does not apply’.

| FLAG | RAISED WHEN THE CRITICAL FUNCTION IS | PRIORITY |
|---|---|---|
| ▲ **Critical gap** | Scored 0. | **P1** |
| ▲ **Critical – not verified** | Applicable but not scored. | **P1** |
| ▲ **Critical – partial** | Scored 1. | **P2** |
| ▲ **Critical – weak evidence** | Scored 1 or 2 with Low confidence, or with no method recorded. Can appear with ‘partial’. | Check again before the final scorecard. A 2 on weak evidence is priority Verify. |

Flags appear above the scores and stay visible whatever the overall result. They are proposed escalation aids for operational use, not legal classifications, and remain under technical review in this pilot version.

## Independent scoring and reconciliation

Each assessor scores alone, from the evidence, before any discussion. Then compare. Where scores differ, return to the anchor and the evidence, agree a score and record the cause: an unclear anchor, different evidence seen, evidence misread, or new evidence. Keep both original scores. The field pack reports exact agreement and the number of one-point and two-point differences before reconciliation, for items scored by both assessors; items seen by only one assessor are left out.

EXHIBIT 6.4 FICTIONAL

## Worked arithmetic for module 4 at an invented airport

| Item | 4.1 ▲ | 4.2 ▲ | 4.3 | 4.4 | 4.5 ▲ | 4.6 ▲ |
|---|---|---|---|---|---|---|
| TYPE | On site | On site | On site | Record | Record | Record |
| AGREED SCORE | **2** | **1** | **0** | **1** | **Not assessed: real event** | **2** |
| METHODS | O, T | O | O, I | D | — | D, I |
| EVIDENCE CONFIDENCE | High | Moderate | High | Moderate | — | High |
| FLAG | — | ▲ Critical – partial | — | — | ▲ Critical – not verified | — |
| SUGGESTED PRIORITY | — | **P2** | **P2** | **P3** | **P1** | — |

These are not data from any real site.

Applicable items 6; scored 5. Points awarded 2 + 1 + 0 + 1 + 2 = 6. Points possible 2 × 5 = 10.

Capability 6 ÷ 10 = 60% (Amber). Coverage 5 ÷ 6 = 83.3%, displayed as 83% (rounded down); it meets the 80% rule, so the percentage is reported. Floor 6 ÷ 12 = 50%, reported beside it.

Evidence confidence: 3 High and 2 Moderate of 5 scored items. Low and not recorded make up 0%, so the result is not marked ‘weak evidence’.

Item 4.5 was not scored because a real event paused the review, so the module carries a ‘critical – not verified’ flag whatever its 60%. Item 4.2 carries ‘critical – partial’.

REPORTED AS

**Module 4 — critical – not verified (4.5); critical – partial (4.2). Capability 60%, Amber. Floor 50%. Coverage 83% (5 of 6). Evidence: 3 high, 2 moderate.**

# 07 From gaps to owned actions

Record each priority gap as an action with an owner, a target date and a test that shows when it is closed. The field pack suggests a priority for each item from its score, whether it is a critical function and, for critical functions, the strength of the evidence.

EXHIBIT 7.1

### Priority rules

| PRIORITY | RULE | RESPONSE |
|---|---|---|
| **P1** | A critical function scored 0, or not verified. | Immediate containment or escalation within days, plus a longer-term fix. A critical function not verified is checked before the final scorecard or, if that is not possible, as the first action. |
| **P2** | A critical function scored 1, or any other item scored 0. | Action within the improvement cycle. If the critical function also carries ‘weak evidence’, check it again first. |
| **P3** | Any other item scored 1. | Planned improvement. |
| **Verify** | Any other applicable item not scored, or a critical function scored 2 on weak evidence. | Complete the missing check within the late-evidence window if a document can settle it; otherwise at the first follow-up. |

**4**

**priority labels**

P1, P2, P3 and Verify.

These four labels are used unchanged in this note, the workbook and the forms. The reason for a P1 (critical gap or not verified) is shown by the flag, not by the label.

Within each priority, order actions by consequence and feasibility, and agree the order with the competent authority. Keep immediate containment, such as clearing and equipping an assessment room this week, separate from system improvement, such as a written agreement with the receiving hospital.

IMMEDIATE CONTAINMENT

Clearing and equipping an assessment room this week.

SYSTEM IMPROVEMENT

A written agreement with the receiving hospital.

EXHIBIT 7.2

## The action record

| FIELD | WHAT TO WRITE |
|---|---|
| **Gap statement** | What the evidence shows, in one or two sentences, with the item number. |
| **Consequence** | What could happen if the gap remains. |
| **Action type** | Immediate containment, short-term fix or system improvement. |
| **Action and owner** | The change to be made, and the accountable role. Use roles, not names, in shared copies. |
| **Support and dependencies** | Other roles that must act; resources or decisions needed. |
| **Target date** | When the action should be complete. |
| **Closure test** | The evidence or test that will show the function works. |
| **Status and remaining risk** | Open, in progress, done and awaiting verification, verified closed, or risk accepted; any remaining risk and the role that accepts it. |

EXHIBIT 7.3 FICTIONAL

## Example of a completed action record

| | |
|---|---|
| GAP STATEMENT | The designated assessment room holds stored items and has no hand hygiene point (item 4.2, scored 1). |
| CONSEQUENCE | An ill traveller would wait in a public area while the room is cleared. |
| ACTION TYPE | Immediate containment, then system improvement. |
| ACTION AND OWNER | Clear and equip the room and post its checklist on the door; agree with the airport operator that the room is not used for storage. Owner: port health officer in charge. |
| SUPPORT AND DEPENDENCIES | Airport operations; facilities management. |
| TARGET DATE | Seven days. |
| CLOSURE TEST | Two unannounced checks, a week apart, find the room clear, equipped and ready. |

# 08 Verification and the preparedness sprint

## Closing an action

Close an action only when its closure test is met. A purchased item, a signed plan or a completed training course is a step towards readiness, not proof of it. Readiness needs evidence that fits the function: a test call that reaches the right person, a room found ready on an unannounced check, a drill in which the traveller reaches the receiving facility within the planned time. Record any remaining risk and the role that accepts it.

## When to verify

WHEN

### At each P1 target date

WHAT IS CHECKED

The P1 action’s closure test, for example an unannounced room check.

WHEN

### At the end of a sprint (four to six weeks)

WHAT IS CHECKED

Every item the sprint worked on, re-scored against the same anchors.

WHEN

### 90 and 180 days after the diagnostic

WHAT IS CHECKED

All critical functions and all open actions, to check that changes have held.

## How follow-up results are recorded

A follow-up check re-scores only the items it covers, with the same anchors and evidence rules, and is recorded as a new dated entry (the Follow-up checks sheet in the workbook, or form F7). Keep the baseline record unchanged.

A follow-up check updates each re-checked item’s current score, its critical-function flag and the status of its actions. It does not produce a new module or overall capability percentage: items that were not re-checked may have changed since the baseline, and carrying their old scores forward would overstate what is known. Report a follow-up as item-level change, for example ‘four of five re-checked items improved; the critical gap on 4.2 is closed’.

A new capability percentage needs a repeat diagnostic that re-scores at least 80% of applicable items within one visit. Record it as a new baseline.

## Handing over to a preparedness sprint

**3–5**

**priority gaps in a sprint**

Worked through to verified closure within a fixed period.

A sprint takes a small number of priority gaps, often three to five, and works them through to verified closure within a fixed period. The diagnostic supplies the baseline evidence and the action records. If the sprint starts from other evidence (section 3), score the selected items against the field pack anchors at the start; that record is the sprint baseline. The sprint charter states the problem and the functions selected; the baseline evidence; the owner and the scope; the approvals and resources needed; and how and when closure will be verified.

**Find the bottleneck before choosing the fix.** For each selected gap, use the timeline of the last event or drill (item 6.4) to name the step that failed or caused delay, and its cause, as an early action review does [E12]. Record the time from detection to notification and compare it with the national timeline and with the 7-1-7 target of notification within one day of detection [E13].

**Test changed functions with an exercise.** Start with a tabletop exercise and add a bounded functional test where it is safe and authorised. Review each exercise, record what failed and retest it. WHO exercise and after-action review guidance describes how to do this [E8–E10]. Reviews held during a response, such as intra-action reviews at points of entry, serve the same purpose [E14].

# 09 Limitations

**A screen, not a full assessment.**

Thirty-one items in one day cannot cover every Annex 1B capacity. The diagnostic does not examine inspection of conveyances (Annex 1B, 1(c)), treatment of baggage, cargo and conveyances (2(e)) or the quarantine of suspect travellers (part of 2(d)), and checks sanitation and vector control only lightly (1(d), 1(e)).

**Not an aviation audit.**

The diagnostic does not assess compliance with ICAO standards or the aerodrome emergency plan as a whole. It checks only whether the public health plan is linked to that plan (item 2.1).

**Airports only.**

Ports and ground crossings differ in governance, traffic and referral routes. Adapted versions need their own development and testing.

**Limited testing so far.**

Agreement between independent assessors has not yet been measured across sites. Version 1.0 changes several rules (section 11), so results from version 0.9 are not directly comparable.

**Working conventions.**

The band thresholds, the 80% coverage rule, the 25% weak-evidence rule, the item types and the critical-function list are working conventions, not calibrated values.

**Judgement remains.**

Anchors reduce, but do not remove, differences between assessors. Calibration and independent scoring help.

**One point in time.**

Results reflect the evidence available on the day. Staffing, supplies and leadership can change them quickly.

**Not for ranking.**

The diagnostic helps one airport improve. It is not designed to compare or rank airports. Do not publish site-level results without the competent authority's agreement.

# 10 The 31 items at a glance

Full item statements, evidence prompts and anchors are in the field pack. ▲ marks a critical function. The type sets the evidence a score of 2 needs (section 5).

| ID | ITEM | TYPE | STEP |
|---|---|---|---|
| M1 | **Coordination and authority** | | |
| **1.1** | Competent authority and coordinator | Record | Supporting |
| **1.2** | Multi-agency coordination that meets | Record | Supporting |
| **1.3** | 24-hour contacts and escalation chain | On site | Notify |
| **1.4** | Public health roles known to partners | Record | Supporting |
| M2 | **Contingency plan: review, testing and use** | | |
| **2.1** | Contingency plan exists and is approved | Record | Supporting |
| **2.2** | Plan reviewed within cycle and after events | Record | Supporting |
| **2.3** | Plan tested in the past 24 months | Record | Supporting |
| **2.4** | Plan known and usable by staff on duty | On site | Supporting |
| **2.5** | Holding area and referral route found on site | On site | Isolate |
| **2.6** | Resource annex mapped and current | On site | Supporting |
| M3 | **Staff capacity for detection, assessment and referral** | | |
| **3.1** ▲ | Trained staff across operating hours | On site | Detect |
| **3.2** | Training in surveillance, case definitions and PPE | Record | Assess |
| **3.3** | Roster covers arrivals and departures | Record | Detect |
| **3.4** ▲ | Initial assessment of an ill traveller | On site | Assess |
| **3.5** | Referral focal point and procedure | Record | Refer |

| ID | ITEM | TYPE | STEP |
|---|---|---|---|
| M4 | **Equipment and facilities** | | |
| **4.1** ▲ | Screening equipment and in-date PPE | On site | Detect |
| **4.2** ▲ | Assessment and isolation space | On site | Isolate |
| **4.3** | Hand hygiene and infectious waste | On site | Assess |
| **4.4** | Specimen collection and transport pathway | Record | Refer |
| **4.5** ▲ | Referral transport | Record | Refer |
| **4.6** ▲ | Designated receiving facility | Record | Refer |
| M5 | **Links to the national surveillance system** | | |
| **5.1** | Reporting into national surveillance | Record | Notify |
| **5.2** | Events entered in the national event system | Record | Notify |
| **5.3** ▲ | Immediate notification pathway | On site | Notify |
| **5.4** | Feedback from national and subnational levels | Record | Supporting |
| **5.5** | Traveller information linked to surveillance | Record | Detect |
| **5.6** | Ill-traveller register shared | Record | Notify |
| M6 | **Readiness enablers** | | |
| **6.1** | Procedures at the point of use | On site | Supporting |
| **6.2** | Information for travellers | On site | Supporting |
| **6.3** | Sanitation, water and vectors (light check) | On site | Supporting |
| **6.4** | Last real event or drill | Record | Supporting |

# 11 References and resource information

## References

**E1** World Health Organization. International Health Regulations (2005), as amended in 2014, 2022 and 2024: consolidated text. Geneva: WHO; 2026. apps.who.int/gb/bd/pdf_files/IHR_2014-2022-2024-en.pdf

**E2** World Health Organization. International Health Regulations (2005): assessment tool for core capacity requirements at designated airports, ports and ground crossings. WHO/HSE/IHR/LYO/2009.9. Geneva: WHO; 2009. who.int/publications/i/item/WHO-HSE-IHR-LYO-2009.9

**E3** World Health Organization. International Health Regulations (2005): a guide for public health emergency contingency planning at designated points of entry. Geneva: WHO; 2012. who.int/publications/i/item/9789290615668

**E4** World Health Organization. Handbook for the management of public health events in air transport. Geneva: WHO; 2016. who.int/publications/i/item/9789241510165

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**E7** World Health Organization. WHO benchmarks for strengthening health emergency capacities: benchmark 17, points of entry and border health. Geneva: WHO; 2024. ihrbenchmark.who.int/document/17-points-of-entry-and-border-health

**E8** World Health Organization. WHO simulation exercise manual. WHO/WHE/CPI/2017.10. Geneva: WHO; 2017. who.int/publications/i/item/WHO-WHE-CPI-2017.10

**E9** World Health Organization. National health simulation exercise programme: implementation guidance to strengthen emergency preparedness, readiness and response. Geneva: WHO; 2025. who.int/publications/i/item/9789240119208

**E10** World Health Organization. Guidance for after action review (AAR). WHO/WHE/CPI/2019.4. Geneva: WHO; 2019. who.int/publications/i/item/WHO-WHE-CPI-2019.4

**E11** World Health Organization. Coordination of public health surveillance between points of entry and the national public health surveillance system: advising principles, 2nd ed. WHO/WHE/CPI/LSS/2018.41. Geneva: WHO; 2018. who.int/publications/i/item/coordination-of-public-health-surveillance-between-points-of-entry-and-the-national-public-health-surveillance-system

**E12** World Health Organization. Guidance and tools for conducting an early action review (EAR): rapid performance improvement for outbreak detection and response. WHO/WPE/HSP/CER/2023.1. Geneva: WHO; 2023. who.int/publications/i/item/WHO-WPE-HSP-CER-2023.1

**E13** Frieden TR, Lee CT, Bochner AF, Buissonnière M, McClelland A. 7-1-7: an organising principle, target, and accountability metric to make the world safer from pandemics. Lancet. 2021;398(10300):638–40. doi.org/10.1016/S0140-6736(21)01250-2

**E14** de Rooij D, van de Watering M, van Dijk R, Veenstra T, Appels R, Swaan C, Timen A. Evaluating intra-action reviews at points of entry: ongoing learning opportunities during the COVID-19 pandemic. BMC Public Health. 2023;23(1):36. doi.org/10.1186/s12889-022-14706-4

**E15** International Civil Aviation Organization. Annex 9 to the Convention on International Civil Aviation: Facilitation, Chapter 8 (national aviation plan for communicable disease outbreaks). Montréal: ICAO; current edition.

**E16** International Civil Aviation Organization. Annex 14 to the Convention on International Civil Aviation: Aerodromes, Volume I, Aerodrome design and operations, section 9.1 (aerodrome emergency planning). Montréal: ICAO; current edition.

**E17** International Civil Aviation Organization. Airport services manual (Doc 9137), Part 7: Airport emergency planning. Montréal: ICAO.

**E18** International Civil Aviation Organization. Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA). Montréal: ICAO. icao.int/collaborative-arrangement-prevention-and-management-public-health-events-civil-aviation-capsca

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EXHIBIT 11.1

## Changes from version 0.9

| AREA | CHANGE |
|---|---|
| **Layout** | Tables rebuilt so that they read correctly when exported or read aloud; section titles match the contents list; module header rows no longer use merged cells. |
| **Alignment (section 2)** | Added ICAO Annex 9 and Annex 14, aerodrome emergency planning and CAPSCA; WHO advising principles on surveillance coordination at points of entry; early action review, the 7-1-7 target and intra-action reviews. |
| **Pathways (section 3)** | Decision guide reordered, with a route for partial evidence and a baseline rule for sprints that start without a diagnostic. |
| **Preparation (section 4)** | Airside passes, escorts, keyholders and agreed tests; document list extended and mapped to items; both assessors attend every session and score module by module; calibration settled across all teams before the first visit. |
| **Evidence (section 5)** | Item types (on site, record); a score of 2 needs two methods including the one the type requires; late evidence limited to documents that existed on the visit day; provisional and final scores; revised schedule with transit time and a pacing rule. |
| **Scoring (section 6)** | A closed list of reasons for ‘not assessed’, without ‘respondent unavailable’; evidence confidence defined for every scored item and summarised by module and overall, with a 25% weak-evidence rule; rounding stated for every test; two new critical-function flags (partial, weak evidence); floor always reported. |
| **Actions and verification (sections 7–8)** | Priority labels standardised (P1, P2, P3, Verify); verification at P1 dates, at sprint end and at 90 and 180 days; follow-up checks update items, not capability percentages. |
| **Resource information (section 11)** | Provenance and licence finalised; E1 dated; references E11–E18 added. |

WORKING WITH PRESENT LAB

You can use the diagnostic without outside support. Where a competent authority or its partners want help, Present Lab can facilitate a rapid diagnostic; run a preparedness sprint; during an outbreak, run a short remote-first readiness check that tests the handoff from screening to isolation, referral and notification in a tabletop exercise; and carry out follow-up verification checks.

All support works at the competent authority’s direction, and support during an outbreak works under the national incident structure. Present Lab does not certify airports or replace response teams. Contact: **olaoluwa@presentlab.org**

POINTS OF ENTRY RESOURCES
FROM ANNEX 1B TO OPERATIONAL READINESS

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PRESENT LAB