



ASSESSMENT

ECDC Public Health Emergency Preparedness Assessment for the Czech Republic, 2026

Under Article 8 of the Regulation (EU) 2022/2371

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Country report: Public Health Emergency Preparedness Assessment for the Czech Republic, 2026

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Contents

Contents	iii
Abbreviations	iv
Executive summary	1
Introduction	1
Key findings	1
Main recommendations for each capacity assessed in depth	2
Conclusions	3
Introduction	4
Background and legal basis	4
Aim and objectives	4
Assessment process	5
Main findings and overarching recommendations	5
Recommendations	6
Findings and recommendations per capacity	7
Conclusions	23
Annex 1. List of capacities included in the assessment	24
Annex 2. Practical arrangements for the assessment process	25

Abbreviations

ADIS	EU Animal Disease Information System
AMC	Antimicrobial consumption
AMR	Antimicrobial resistance
AMS	Antimicrobial stewardship
API	Active pharmaceutical ingredients
ARHAI	Antimicrobial Resistance and Healthcare-Associated Infections
AWaRe	Access, Watch and Reserve
BSL	Biosafety Level
CAI	Czech Accreditation Institute
CEM	Centre for Epidemiology and Microbiology
CHMI	Czech Hydrometeorological Institute
CKS NAAP	Central Coordination Group of the NAAP
COVID-19	Coronavirus disease 2019
CPE	Carbapenemase-producing Enterobacterales
CZERIN	Czech Clinical Research Infrastructure Network
DG SANTE	Directorate-General for Health & Food Safety
DG HERA	Health Emergency Preparedness and Response Authority
EARS-Net	European Antimicrobial Resistance Surveillance Network
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EFSA	European Food Safety Authority
EHR	Electronic record-based
ERIC	European Research Infrastructure Consortium
ESAC-Net	European Surveillance of Antimicrobial Consumption Network
EU	European Union
EURGen-Net	European Antimicrobial Resistance Genes Surveillance Network
EURL	European Reference Laboratory
EQA	External Quality Assessment
HAI	Healthcare-associated Infections
HAI-Net	Healthcare-associated Infections Surveillance Network
IPC	Infection prevention and control
IHR	International Health Regulations
ILI/ARI	Influenza-like illness/Acute Respiratory infections
IRS	Integrated Rescue Service
ISIN	Infectious Diseases Information System
ISO	International Organization for Standardization
IVD	In vitro diagnostics
KHS	Regional Public Health Authorities
KRIT	Crisis Information Team
LIMS	Laboratory Information Management System
MCM	Medical counter measure
MDRO	Multidrug-resistant organisms
NAP	National Action Plan
NAAP	National Antibiotic Awareness Programme
NAAT	Nucleic Acid Amplification-based Test
NFP	National Focal Point
NGS	Next Generation Sequencing
NRC HAI	National Reference Centre for Healthcare-Associated Infections
NRHZS	National Register of Reimbursable Health Services
NRL	National Reference Laboratory
NRL ATB	National Reference Laboratory for Antibiotics

PHEPA	Public Health Emergency Preparedness Assessment
PHSM	Public health and social measures
PoE	Points of Entry
PPE	Personal protective equipment
PPS	Point prevalence survey
PPR	Prevention, preparedness and response
RVVI	Council for Research, Development and Innovation
SARI	Severe Acute Respiratory Infections
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SCBTH	Serious cross border threat to health
SOP	Standard Operating Procedures
SPAR	State Party Self-Assessment Annual Report
SÚJB	State Office for Nuclear Safety
SÚKL	State Institute for Drug Control
SVA	State Veterinary Administration
SZÚ	National Institute of Public Health
TB	Tuberculosis
ÚZIS	Institute of Health Information and Statistics
WGS	Whole Genome Sequencing
WHO	World Health Organization
WNV	West Nile Virus
ZÚ	Health Institute
WAHIS	World Animal Health Information System

Executive summary

Introduction

The aim of the Public Health Emergency Preparedness Assessment, as mandated in Article 8 of Regulation (EU) 2022/2371 on serious cross-border threats to health, is to improve prevention, preparedness and response planning in European Union/European Economic Area (EU/EEA) countries through the implementation of recommendations following individual country assessments. As specified in the Regulation, each EU/EEA country will undergo an assessment every three years, with the first cycle of these occurring between 2024 and 2026.

This report presents the findings and recommendations of the first assessment conducted in the Czech Republic. This involved a desk review of relevant documents, followed by a five-day country visit that took place during the period 16–20 February 2026. As per the assessment methodology, all of the 16 capacities included in Article 7 of the Implementing Regulation (EU) 2023/1808 self-assessment template were assessed, with five of them considered in-depth: Laboratory (Capacity 3); Surveillance (Capacity 4); Health Emergency Management (Capacity 6); Antimicrobial resistance (AMR) and healthcare-associated infections (Capacity 12) and Zoonotic diseases and threats of environmental origin (Capacity 10).

Key findings

The Czech Republic is administratively divided into 13 regions and the capital city of Prague, with the regions comprising 76 districts. The public health system in the Czech Republic is decentralised, with the Ministry of Health holding a central governing role at the national level, ensuring coordination across the regions and with the European Union level, and the National Institute of Public Health (SZÚ) having a technical advisory role. The Ministry of Health recently established an Emergency Operation Centre (EOC) within its organisational structure. The country has a decentralised system of 14 Regional Public Health Authorities (KHS) and two Health Institutes (ZÚ) with a degree of autonomy. National Reference Laboratories are located at the SZÚ and ZÚ, providing coordination and support for the public health laboratories in the country.

The provision of health services and a substantial part of the operational responsibility for preparedness and response to emergencies is placed at the regional level, with central coordination in certain cases. The Ministry of Interior and regional fire rescue services are the main coordination bodies for civilian crises. Outbreak investigation is conducted at regional and local level; the Ministry of Health only coordinates at national level during outbreaks affecting more than one region, or international outbreaks. The involvement of SZÚ in outbreak investigations depends on whether local public health authorities and clinical and public health laboratories have requested methodological and specialised support.

A key strength of the country is a comprehensive legislative framework that guides and governs surveillance and laboratory activities, as well as preparedness and response to emergencies. Two acts that constitute the backbone of public health emergency preparedness and response are the Protection of Public Health Act No. 258/2000 Coll. and the Crisis Management Act No. 240/2000 Coll., with additional legislative instruments complementing the overall framework. The country has many topic-specific plans at all administrative levels for preparedness and response to all-hazard emergencies with an impact on human health.

The public health system is evolving to address new needs and emerging risks. A revision of the national risk profiling is currently underway, reflecting a proactive approach to identifying and prioritising threats, including those to public health. However, risk assessment of public health threats is conducted on an ad-hoc basis and a risk assessment methodology at the national level is not in place. The country also plans to develop a generic, all-hazard prevention, preparedness and response plan (PPR), embedding the One Health approach.

Significant progress is also being made with digitalisation, and an integrated and automated surveillance system based on electronic health records is being rolled out.

Indicator-based surveillance of antimicrobial resistance (AMR) and healthcare-associated infections (HAIs) is established at the local and, for some indicators, national level, demonstrating efforts to address these critical public health challenges. However, further work is needed, including the strengthening of surveillance and approval, funding and implementation of the national action plan (NAP) on AMR.

Across all areas, resource limitations – both human and financial – were identified as critical constraints at both regional and national level. Recruitment and retention of technical staff were reported to be a significant challenge. These limitations inevitably hinder more ambitious public health prevention, preparedness and response goals. It is essential to address these resource gaps in order to maintain the country capacity to prevent and respond to health emergencies and to further implement the ongoing reforms of the public health system.

Main recommendations for each capacity assessed in depth

Health emergency management (Capacity 6)

- Finalise the generic prevention, preparedness and response (PPR) plan and link all existing plans with the aim of harmonising mechanisms for collaboration and reducing the planning burden.
- Regularly perform risk profiling and prioritisation of public health threats to prioritise resources and actions accordingly. Furthermore, update, possibly every three to four years, the national all-hazard risk profiling.
- Perform risk assessment of public health threats that arise at national level and define a standard operating procedure (SOP) on how to conduct the assessment.
- Formalise the procedure/mechanism for intersectoral and multi-level collaboration in case of a public health event that does not yet require a crisis declaration. For outbreaks and public health events that are at an initial stage and are not formally declared as a crisis by law, collaboration for early warning and monitoring between sectors and at the local, regional and national levels would help the response phase.
- Develop and implement a methodology to identify crisis relevant medical countermeasures (MCMs) (e.g. lists of essential MCMs across all categories such as medicinal products, medical devices/in vitro diagnostics (IVDs) and personal protective equipment (PPE)).
- Develop a methodology to map the production of critical MCMs across all categories, including raw materials/components/active pharmaceutical ingredients (APIs), and a mechanism to mitigate their supply chain vulnerabilities.

Laboratory (Capacity 3)

- Ensure a strategy for laboratory capacity scale up, including diagnostic testing and whole genome sequencing, is included in the generic PPR plan. Define roles and responsibilities of key actors and mechanisms for coordination of scaling up, including reimbursement.
- Conduct a mapping exercise of available high containment laboratory capacities in the country. Explore the potential needs of the public health sector to involve the high-containment laboratory capacity of other sectors (e.g. academia) to achieve adequate capacities for emergency response situations and formalise agreements and/or processes as necessary.
- Integrate clinical microbiological and genomic surveillance data with epidemiological surveillance data at national level to enhance their potential for surveillance, prevention and control activities, and ensure planning for maintenance as well as future development.
- Continue strengthening national capacity and capability for health laboratory services, including genomic typing and pathogen characterisation, primarily, but not exclusively, for respiratory pathogens.
- Ensure professional development opportunities for laboratory staff and bioinformaticians to continue building essential capacities and capabilities. As part of this work, maintain collaboration of the public health sector with other sectors (e.g. academia) as relevant – for example in the areas of high-containment laboratories, next generation sequencing (NGS), data analysis – in order to ensure that state-of-art methodologies are translated into the public health context.

Surveillance (Capacity 4)

- Complete and fully implement the automated and integrated Infectious Diseases Information System (ISIN), ensuring sustainable long-term funding, staffing and maintenance while keeping the current surveillance systems active until the ISIN is validated.
- Automate routine national outputs and data extracts within ISIN and further enhance data-visualisation functionalities to support timely analysis and decision-making.
- Clearly integrate ISIN functions into the generic PPR plan, defining data use and adaptations needed for enhanced information collection.
- Implement a nationwide dedicated tool for event-based surveillance to streamline validation, management, and communication of event-based signals.
- Provide opportunities for professional development, focusing on strengthening analytical capacity and promoting collaboration and exchange between regions.

Antimicrobial resistance and healthcare-associated infections (Capacity 12)

- Ensure approval, implementation and funding of the National Action Plan (NAP) on antimicrobial resistance (AMR), as this is currently not in place.
- Raise awareness on AMR among relevant stakeholders, including the general public. The aim for such efforts should be to improve implementation of surveillance, infection prevention and control (IPC) and antimicrobial stewardship (AMS) activities, and to increase understanding among all stakeholders of the need to take action against AMR.

- Set up timely indicator-based AMR and healthcare-associated infections (HAI) surveillance at national and regional level. Maintain WGS capacity to allow detection and response to multidrug resistant organism (MDRO) and HAI outbreaks.
- Ensure that an IPC programme and an antibiotic programme are set up in all healthcare facilities, including continuous professional development, funding and legislative support for the antibiotic programmes, with the aim of improving IPC and AMS monitoring and implementation at several levels.
- Ensure approval of a national strategic plan for HAI surveillance, and the setting up of a national IPC coordination and adequate funding.

Zoonotic diseases and threats of environmental origin, including those due to the climate (Capacity 10)

- Strengthen environmental integration in routine work and emergencies: bring environmental authorities (i.e. the Ministry of Environment and the Czech Hydrometeorological Institute (CHMI)), wildlife protection, land use, and others into relevant working groups (WGs) (climate and zoonoses, vector-borne diseases) with defined responsibilities (e.g. wildlife surveillance, carcass management, environmental drivers).
- Build an intersectoral digital data-sharing solution beyond whole genome sequencing data for zoonoses, with agreed minimum datasets and access rules, to share event signals, outbreak summaries, exposures, investigation status and control measures.
- Formalise and document the production of One Health Joint Risk Assessments and scientific guidance, through the development of written SOPs across the Ministry of Health/National Institute of Public Health (SZÚ), Ministry of Agriculture/State Veterinary Administration (SVA), and the Ministry of Environment that clarify triggers, roles, data inputs, timelines, approvals, and how risk assessment outputs translate into response actions. For climate sensitive zoonoses, forward-looking assessments could be produced.
- Invest in modelling and forecasting of the health impact of climate change and extreme weather events, in the National Action Plan for Adaptation to Climate Change.
- Embed the One Health approach into the generic prevention, preparedness and response (PPR) plan with regard to zoonotic diseases and the health impact of climate change/extreme weather events. Conversely, include cross-references to the generic PPR Plan in the NAP for Adaptation to Climate Change.

Conclusions

The Czech Republic has a well-established legislative framework that underpins its public health system and its preparedness and response to emergencies. The system itself is substantially decentralised, allowing regional and local authorities to implement response measures adapted to their specific contexts.

The country's ongoing efforts to revise the national risk profiling and to develop an overarching, generic PPR plan are acknowledged. By fully embedding the One Health and all-hazard approach, such a comprehensive and unified PPR framework would enhance coherence, coordination and overall readiness across sectors. Close cooperation and active involvement of all relevant stakeholders (including ministries, regional authorities, and other key actors) is essential for the successful development of the PPR framework.

Full operationalisation of the Infectious Diseases Information System (ISIN) should remain a priority. Once fully implemented, it is expected to improve the timeliness, completeness and analytical capacity of surveillance data, supporting evidence-based decision-making. This should also be conducive to the setting up of timely indicator-based AMR and HAI surveillance at national and regional level, as well as the detection and response to multidrug-resistant organisms (MDRO) and HAI outbreaks.

Ensuring sustained allocation of sufficient human and financial resources to core public health functions and activities is critical and the Czech Republic should consider implementing incentives for recruitment and retention of its skilled public health workforce. It is also essential to improve coordination between sectors, administrative levels, regions and intersectoral entities to ensure the most efficient use of available resources.

The open and committed approach of the Czech Republic demonstrated during this assessment, engaging many experts from multiple sectors and administrative levels, is noteworthy and it will continue to be a valuable asset when developing and implementing the action plan stemming from the findings and recommendations of this assessment.

Introduction

The aim of the Public Health Emergency Preparedness Assessments, as mandated in Article 8 of Regulation (EU) 2022/2371 on serious cross-border threats to health, is to improve prevention, preparedness and response planning in European Union/European Economic Area (EU/EEA) countries through the implementation of recommendations following individual country assessments. As specified in the Regulation, each EU/EEA country will undergo an assessment every three years, with the first cycle of these occurring between 2024 and 2026.

This report presents the findings and recommendations of the first assessment conducted in the Czech Republic. This process involved a desk review of relevant documents, followed by a five-day country visit.

Background and legal basis

During the COVID-19 pandemic it was recognised that the legal framework for combatting serious cross-border threats to health, provided for in Decision No 1082/2013/EU, needed to be broadened and enhanced to ensure a more effective response across the EU to deal with health-related emergencies. Hence, the European Commission developed and published on 23 November 2022 the Regulation (EU) 2022/2371 on serious cross-border threats to health¹.

Within this Regulation it is recognised that prevention, preparedness and response planning are essential elements for combatting serious cross-border threats to health. In addition to creating a Union prevention, preparedness and response plan (Article 5 of the Regulation), the Regulation also outlined the importance of updating and seeking coherence with Member States' prevention, preparedness and response plans (Article 6 of the Regulation).

To monitor the implementation of the plans, the Member States shall report to the European Commission regarding their prevention, preparedness and response planning at the national level every three years. For this purpose, a self-assessment template was developed under Article 7 of the Regulation², complementary to the International Health Regulations (IHR) State Party Self-Assessment Annual Report (SPAR)³.

In order to support the assessment of these plans, Article 8 of the Regulation indicates that ECDC has the responsibility – in coordination with relevant Union agencies and bodies – to conduct assessments of all 30 EU/EEA countries every three years. The procedures, standards and criteria for the assessments of the state of implementation of national prevention, preparedness and response plans and their relation with the Union prevention, preparedness and response plan are defined by the Commission Delegated Regulation (EU) 2024/1232, adopted in March 2024⁴.

ECDC has developed a methodology for Public Health Emergency Preparedness Assessment to implement Article 8 of the Regulation (EU) 2022/2371. The assessment process addresses the 16 capacities included in the Article 7 self-assessment template and is designed to maintain a consistent approach throughout the three-year cycle, taking into account national respective circumstances.

Aim and objectives

The aim of the ECDC Public Health Emergency Preparedness Assessment process, drawn from Article 8 of the Regulation on serious cross-border threats to health, is to improve prevention, preparedness and response planning in EU/EEA countries through the implementation of recommendations following individual country assessments. Countries are asked to provide an action plan addressing the proposed recommendations of the assessment within nine months of the receipt of the ECDC report.

¹ European Commission (EC). Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health and repealing Decision No 1082/2013/EU. Brussels: EC; 2022. Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32022R2371&from=EN>

² European Commission (EC). Commission Implementing Regulation (EU) 2023/1808 of 21 September 2023 setting out the template for the provision of information on prevention, preparedness and response planning in relation to serious cross-border threats to health in accordance with Regulation (EU) 2022/2371 of the European Parliament and of the Council. Brussels: EC; 2023. Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32023R1808>

³ World Health Organization (WHO). IHR (2005) States Parties self-assessment annual reporting tool, 2nd ed. Geneva: WHO; 2021. Available at: <https://www.who.int/publications/i/item/9789240040120>

⁴ European Commission (EC). Supplementing Regulation (EU) 2022/2371 of the European Parliament and of the Council as regards assessments of the state of implementation of national prevention, preparedness and response plans and their relation with the Union prevention, preparedness and response plan. Brussels: EC; 2024. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=OJ:L_202401232

The specific objectives of the assessment process are to:

- Collaborate with countries to identify good practice, challenges, bottlenecks, and gaps or areas for improvement in relation to the 16 capacities referred to in Article 7 (see the list of capacities in Annex 1).
- Encourage the inclusion of key elements for prevention, preparedness and response planning such as cross-sectoral and cross-border coordination, crisis management, response governance, communication, plan testing, evaluation and regular reviews, according to the lessons identified from the response to public health emergencies.
- Convene main stakeholders from all relevant administrative levels and sectors.
- Use the opportunity of a standardised approach to contribute to the improvement of EU/EEA prevention, preparedness and response capacities by promoting a common understanding of key elements and a coordinated approach and by creating a community or practice.
- Provide support to countries in enhancing their national prevention, preparedness, and response capacities through recommendations based on the PHEPA, and provide targeted assistance upon request.

Assessment process

An ECDC-led team composed of seven ECDC experts and three experts from the European Commission (DG SANTE and DG HERA) and WHO Regional Office for Europe was assembled to conduct the assessment, in collaboration with the country focal point and national experts from the Czech Republic. The assessment process consisted of a desk review phase and a country visit that took place during the period 16–20 February 2026.

As per the established process, the team reviewed the Czech Republic's responses to the Article 7 self-assessment questions, with five of them considered in depth: Laboratory (Capacity 3); Surveillance (Capacity 4); Health Emergency Management (Capacity 6); Antimicrobial resistance (AMR) and healthcare-associated infections (Capacity 12) and Zoonotic diseases and threats of environmental origin (Capacity 10).

The assessment mission was conducted with an open and transparent approach from the host country, including timely sharing of relevant documents and engaging in a productive discussion. The country's commitment was apparent from the active involvement of many experts, across various sectors and including high-level representatives, in the assessment process. The national coordinating team remained readily available throughout the entire preparatory and assessment phase, offering guidance, clarifications, and practical assistance whenever needed.

Further details regarding the practical aspects of the mission are available in Annex 2.

Main findings and overarching recommendations

The Czech Republic is an EU Member state bordering Austria, Germany, Poland and Slovakia. The country has a population of 10.9 million people. The capital and largest city is Prague. Administratively, the country is divided into 13 regions and the capital city of Prague, with the regions comprising 76 districts. Public health is coordinated at the national level by the Ministry of Health which is the executive body. The National Institute of Public Health (SZÚ) fulfils a technical advisory role and operates the infectious disease surveillance system, as well as national reference laboratories. In each of the regions and in Prague, there is a Regional Public Health Authority (KHS) with a degree of autonomy and two Health Institutes (ZÚ) in Ostrava and Ústí nad Labem, which operate state-funded public health and clinical national reference laboratories with supra-regional competence.

The public health system is highly decentralised and a substantial component of the responsibility for preparedness and response to emergencies is placed at the regional and municipal level. The fire rescue services also play a strong role, representing the operational core of local response structures as part of an all-hazards approach. Outbreak investigation is conducted at the regional and local level and the Ministry of Health only coordinates at national level or the SZÚ only gets involved if an outbreak affects more than one region, or if the outbreak is international.

The Czech Republic has a robust legal basis to ensure representation and engagement in EU structures for health emergency preparedness and response. The country has a strong legislative framework for most of its surveillance, laboratory activities, and crisis preparedness and response at all levels and in all sectors. Two acts that constitute the backbone of public health emergency preparedness and response are the Protection of Public Health Act No. 258/2000 Coll. and the Crisis Management Act No. 240/2000 Coll., with additional legislative instruments complementing the overall framework. However, the health security context/landscape remains somewhat fragmented, and would benefit from a more consolidated and coherent legal framework to strengthen national PPR capacities and the Ministry of Health's coordinating and collaborating role in this context.

An Emergency Operations Centre (EOC) within the Ministry of Health enables coordination at EU level and rapid threat detection, situational awareness and analysis to support timely decision-making. In the event of a legally declared crisis, coordination is facilitated through a Central Crisis Management Team, chaired by the Minister of the Interior or Minister of Defence depending on the type of crisis (civil or military). Crisis staff and teams are also identified at ministerial, regional and local level. The Central Epidemiological Commission, a permanent working body of the government chaired by the Minister of Health, co-chaired by the Chief Public Health Officer, and including representatives of ministries and central government agencies, provides scientific advice and recommendations in the event of a public health crisis.

The country has many topic-specific plans at all administrative levels concerning preparedness and response to all-hazard emergencies with an impact on human health – e.g. the pandemic influenza plan (2011) and the pandemic avian flu plan (2012). However, at present there is no overarching generic prevention, preparedness and response (PPR) plan in place to form a unified and comprehensive framework, with clear links to existing instruments and processes. There is an ongoing revision of risk profiling, including risks with an impact on public health. There is a long-standing culture of testing plans and crisis structures through national and international simulation exercises for most of the relevant aspects.

Surveillance of communicable diseases in the Czech Republic is a core public health function. The national Public Health Act No. 258/2000 (§62, paragraph 1) establishes the obligation to report illness or death from infectious diseases (including suspected cases), providing a strong legal basis for collecting infectious disease data. An integrated automated surveillance system based on electronic health records (EHR) is being rolled out over a number of years and, once all functionalities are in place, this will provide significant advantages. It was however noted that the system needs to be properly validated, and sustainable long-term funding needs to be ensured for its maintenance as at present it is externally funded through EU Direct Grants for surveillance (available until 2028).

Although AMR/HAI surveillance in the Czech Republic is conducted as indicator-based surveillance at local level, these results are only reported to the regional level using event-based surveillance (an event being an outbreak, severe damage to health or death of the patient) if it is deemed to be a HAI, or if it is a notifiable disease. At the regional level, results are routinely reported to the Ministry of Health on a monthly basis. In addition, there is limited national indicator-based surveillance on AMR/HAI, as well as some national AMR monitoring. The current surveillance structure may therefore miss outbreaks not identified at the local level, especially outbreaks that are spread across healthcare facilities and regions, as well as multidrug-resistant organism (MDRO) outbreaks. In addition, there is limited reporting of the AMR/HAI surveillance results at national level. However, it was noted that efforts are being made to create a dashboard to report some of the surveillance results.

The laboratory system benefits from a long-standing emphasis on quality and accreditation, and the national quality standards are implemented, including mandatory accreditation of all laboratories working with the health and public health sector. However, there is currently insufficient integration of clinical microbiological and genomic surveillance data with epidemiological surveillance data at national level, and work towards full electronic reporting by all relevant laboratories in the country, with seamless integration into the Laboratory Information Management System (LIMS) is ongoing. Scale-up of laboratory testing during the COVID-19 pandemic was achieved on an ad hoc basis, but a coordination mechanism to activate and involve relevant sectors and stakeholders still needs to be formalised.

With regard to prevention and management of zoonoses, multiple authorities are involved across sectors. Competencies for tackling zoonoses are legislatively defined in the Veterinary Act No. 166/1999 Coll., and in the Protection of Public Health Act No. 258/2000 Coll., which requires public health authorities and SVA to cooperate in preventing the spread of infectious diseases. However, technical procedures and communication flows among sectors and between national and regional authorities could be further formalised. The Czech Republic has developed a Strategy for Adaptation to Climate Change 2021–2030. An update of the associated National Action Plan is under preparation. To make this plan operational and sustainable, details on implementation and respective cost estimates per sector and activity should be incorporated.

For all capacities assessed, limitations in both human and financial resources were identified as critical constraints, affecting capacity at the national and regional level. While the country benefits from competent and dedicated public health teams, challenges related to the recruitment and retention of technical staff persist, reflecting broader structural workforce shortages and an absence of effective incentives to support retention and attract new personnel. Addressing these limitations will be critical to sustain and enhance public health capacities for routine and emergency activities, and ongoing reforms.

Recommendations

- Develop a generic national prevention, preparedness and response (PPR) plan with a One Health approach, covering all hazards.
- Strengthen the mandate and role of the Ministry of Health in coordinating and collaborating with other sectors with regard to prevention, preparedness and response to serious cross border health threats.
- Finalise the ongoing risk profiling analysis (National Threat Analysis led by the Ministry of Interior) and ensure this feeds into preparedness planning.
- Complete and fully implement the automated and integrated surveillance system, ensuring sustainable long-term funding and staffing.
- Set up timely indicator-based antimicrobial resistance and healthcare-associated infection surveillance at national and regional level.
- Ensure adequate resources (human and financial) across public health functions at all levels. Consider incentives for recruitment and retention of public health staff.

Findings and recommendations per capacity

A list of the capacities that were included in the assessment is available in Annex 1.

Capacities assessed in depth

Health emergency management (Capacity 6)

Management of health emergency response

The Czech Republic has a complex and structured legislative framework for crisis preparedness and response at all levels and in all sectors. The Crisis Management Act No. 240/2000 Coll. describes the authorities and bodies for crisis coordination, the required documentation and crisis plans to be developed, and the possible measures for risk management. A security council and crisis staff are established at national, regional and municipal level; they include representatives of the government, police, fire rescue service, public health authority, emergency medical service, and other sectors when needed according to the type of emergency.

The Law 374/2011 on the emergency medical services ensures that the procedures are in place for the management of patients in case of emergency. The country has skilled emergency medical teams and well-trained rescue services. Furthermore, cross-border agreements are in place with all neighbouring Member States for mutual-aid in the event of disasters and bilateral agreements have been established with Austria, Germany and Slovakia for the cooperation of emergency medical service providers.

The updated Directive of 11 January 2019 No 33, 34 and 35 ensures a uniform procedure and effective system for the preparedness and response in the event of an emergency subject to the International Health Regulations (2005) due to a highly contagious disease in an aircraft landing at an air transport entry point or in a healthcare facility.

The development of a generic, all-hazard prevention, preparedness and response (PPR) plan is ongoing. At present, the country has many topic-specific plans at all administrative levels for preparedness and response to all-hazard emergencies with an impact on human health. A crisis plan has been developed at national, regional and municipal level. Crisis plans are activated when an emergency escalates into a crisis. Furthermore, there are topic specific plans developed at national and regional level, such as the pandemic influenza plan (2011), the pandemic avian flu plan (2012) and the epidemic plan for all types of infectious diseases (2017, updated in 2020). Healthcare facilities also have a trauma plan for the operations of the emergency medical services in case of mass casualty events.

Through Act No. 240/2000 Coll., the Ministry of Health is entitled during emergencies to coordinate the activities of the public health authorities, to ensure the purchase and distribution of the necessary medicinal products, and to coordinate acute in-patient and medical rescue services across regions. In these situations the Ministry of Health establishes expert working groups to monitor the epidemiological situation, assess levels of risk, provide evidence for decision-making and propose measures to ensure public health protection and the provision of health services. One of these expert working groups is the Central Epidemiological Commission, a permanent working body of the government, chaired by the Minister of Health, co-chaired by the Chief Public Health Officer and including representatives of ministries and central government agencies, such as the Ministry of Interior, Ministry of Foreign Affairs, Ministry of Agriculture, Ministry of Education, Associations of the Regions, police, fire brigades, army, laboratories and a WHO representative, who may participate as needed. This Commission coordinates the work of the regional epidemiological commissions.

Other sectors also develop topic-specific plans, so called type plans, following the same methodology and structure defined by the Ministry of the Interior - General Directorate of the Fire Rescue Service, which is the authority that coordinates cross-sectoral planning and approves each plan after verifying its compliance with the methodology. A regular update, every four years, is recommended, although the pandemic plans are outdated. A type plan is required for each of the 22 priority threats, including pandemics, identified by the national all-hazard risk profiling, conducted in 2016. While this risk profiling is going to be updated, there is no routine health emergency risk profiling for serious cross-border threats to health. Some of the type plans, such as the one for radiation, ensure specific national coordination mechanisms for preparedness and response in the event of an intentional release scenario.

There is a long-standing culture of testing plans and crisis structures through national and international simulation exercises. These exercises are mainly driven by the rescue service under the Ministry of Interior, and include multisectoral simulations, contributing to a high level of operational familiarity among authorities and responders. Examples are the 2023 exercise relating to a suspected Ebola virus disease case at the Prague airport, the 2025 exercise for the transport of a patient with Ebola virus disease to the designated hospital, the Contagion exercise on animal health, which is organised on an annual basis, and the ZONE exercise covering nuclear events.

Risk assessment of public health threats is conducted on an ad-hoc basis and locally: there is no formal methodology in place on how to conduct a risk assessment at the national level. This may hinder a timely early warning to other local stakeholders regarding an ongoing health threat, especially during the early phase of an event.

An Emergency Operations Centre (EOC) has recently been established within the Ministry of Health, with the objective of enabling rapid threat detection, situational awareness and analysis to support timely decision-making. In the event of a crisis being legally declared, coordination is facilitated through a Central Crisis Management Team chaired by the Minister of the Interior.

Public health and social measures (PHSMs) are listed in the Act No. 258/2000 Coll. and in Act No. 240/2000 Coll. and both were widely used during the COVID-19 pandemic. They can be enforced by the relevant authorities.

There is a lack of a mechanism for the implementation of multi-sectoral workforce surge during a public health emergency.

Recommendations

- Finalise the generic prevention, preparedness and response plan and link all existing plans with the aim of harmonising mechanisms for collaboration and reducing the planning burden.
- Regularly perform risk profiling and prioritisation of public health threats to prioritise resources and actions accordingly. Furthermore, update, possibly every three to four years, the national all-hazard risk profiling.
- Perform a risk assessment of public health threats arising at national level and define a standard operating procedure (SOP) on how to conduct the assessment.
- Increase early warning and define the criteria for the flow of information regarding ongoing health threats in the country in order to provide timely information and alert public health stakeholders at all levels (regions and municipalities).
- Formalise the procedure/mechanism for intersectoral and multi-level collaboration in case of a public health event that does not yet require a crisis declaration. For outbreaks and public health events that are at an initial stage and have not formally been declared as a crisis by law, collaboration for early warning and monitoring between sectors and between local, regional and national levels would help the response phase.

Emergency logistic and supply chain management

The Czech Republic has developed and published a list of essential antimicrobials which is updated annually. In addition, several types of personal protective equipment (PPE), medical devices and medicinal products have been identified for stockpiling purposes only, but there is no exhaustive list of critical medical counter measures (MCMs) for preparedness and response to serious cross-border threats to health, nor is there a methodology or criteria for inclusion/exclusion of MCMs in this list. It is recommended that the methodology and the list of critical MCMs is developed in collaboration with the State Institute for Drug Control (SÚKL) and the public health authorities.

The State Institute for Drug Control (SÚKL) monitors notifications (by economic operator) of shortages, both for medicinal products and medical devices, and for all products under these categories, since this is a legal obligation. However, a more robust mechanism to estimate the demand and monitor the supply of critical MCMs (including other categories such as PPEs) is absent. National policies or plans are under consideration for these purposes.

Although the country has not completed an exhaustive mapping of the production of critical MCMs on its territory, there is an awareness of the limited manufacturing capacity, mainly consisting of a small number of pharmaceutical companies whose products are exported abroad. Nevertheless, during the COVID-19 pandemic, there was a satisfactory provision of MCMs, in general, and shortages were only acute for the same products as in other European countries (mainly facemasks, gloves and other PPEs). There have been exercises, conducted by the Ministry of Health, to map the supply chain for specific products and the pharmaceutical industry has been identified in the Czech Republic's Economic Strategy as a strategic industrial sector.

There is also an awareness of the fact that the country relies partially on joint procurement mechanisms to acquire the MCMs it needs internationally. The Czech Republic is also looking into stockpiling at the EU level as a solution to the lack of access to/availability of some MCMs, with participation in the Joint Action 'Stockpile – Comprehensive and Sustainable Strategic Stockpiles of Medical Countermeasures Used in Crisis' and in rescEU.

An economic mobilisation framework exists that can be activated in the event of a public health emergency. There is also an awareness of the need for more comprehensive and strategic policy/plans to ensure availability of critical MCMs, taking into account other dimensions, such as the identification and mitigation of supply chain vulnerabilities or scale-up manufacturing.

The country has a legal framework establishing a national strategic reserve of essential goods for emergencies, mainly medicinal products, medical devices and PPEs (it does not include vaccines or diagnostic tests). This reserve is managed centrally by a central independent authority (State Material Reserves Administration), which receives the stockpiling request from regional/local authorities and decides on its inclusion in the Reserve after approval by the Ministry of Health. At the moment, there is no standardised procedure for the deployment process when needed.

The strategic stockpiles are decentralised in some of the regions and complemented by stockpiles of MCMs, also at hospital level.

Recommendations

- Develop and implement a methodology to identify crisis relevant MCMs (e.g. lists of essential MCM across all categories – medicinal products, medical devices/IVDs, PPEs, etc.).
- Develop the existing tools to ensure monitoring of supply and estimating demand of critical MCMs, taking into account the reporting requirements that should be applicable in case of a public health emergency. The relevant tools should allow the collection of information across all categories (including PPE).
- Develop a methodology to map the production of critical MCMs across all categories, including raw materials/components/active pharmaceutical ingredients (APIs), and a mechanism to mitigate supply chain vulnerabilities.
- Continue developing the current stockpile strategy at central and regional level ensuring effective coordination and developing a procedure and criteria for MCM deployment.

Laboratory (Capacity 3)

The laboratory system in the Czech Republic has a clear legal basis through the Protection of Public Health Act No. 258/2000 Coll. and benefits from long-standing emphasis on quality and accreditation. A prevention, preparedness, and response plan (PPR) is being prepared, and different aspects of the laboratory capacity need to be included in the preparedness considerations.

National quality standards have been implemented, including mandatory accreditation of all laboratories working with the health and public health sector. All state-funded medical laboratories (all National Reference Laboratories (NRL) in the SZÚ and both Health Institutes (ZÚ Ostrava, ZÚ Ústí nad Labem)) have a quality system in accordance with the standard ČSN EN ISO 15189:2023 for medical laboratories. Similarly, all NRLs established under the Ministry of Agriculture within the veterinary administration are accredited to ČSN EN ISO/IEC 17025:2018 for testing laboratories. Accreditation certificates are not monitored by SZÚ but the Czech Accreditation Institute (CAI), the country's single accreditation body⁵, which maintains a list of accredited laboratories⁶. Higher reimbursement by insurance companies is an additional incentive to achieving and maintaining accreditation.

Biosafety and biosecurity guidelines and/or regulations are implemented by all accredited laboratories. Guidelines and/or regulations are evaluated and updated in line with revisions of the applicable ISO standards (as above). Government regulations were updated in 2019 and 2025. A system for oversight of the regulations is in place through the State Office for Nuclear Safety (SÚJB), with controls by the Regional Public Health Authorities (KHS). ISO/IEC 17025:2018 does not contain a dedicated biosecurity clause, but laboratories must meet several requirements that collectively form a strong biosecurity framework. ISO 15189:2023 embeds biosecurity through specific requirements. Specific SOPs on implementation of quality management, biosecurity and biosafety processes were not reviewed during the PHEPA assessment, but an overview of BSL-3 activities at SZÚ with some aspects of biosafety and biosecurity was provided.

A system for referral and transport of specimens is in place for all priority diseases and all specimens. Both category A and B specimens can be transported inside and outside the country. The system of transport for specimens is based on legislation – Law 258/2000, Decree 306/2012, resolutions of the Government of the Czech Republic No. 33 & 34 & 35/2019 and relevant ISO standards (as above). Obligations are translated into SOPs. The Laboratory Manual for Sampling at the Laboratories of the Centre for Epidemiology and Microbiology (CEM Laboratories – i.e. all NRLs) of the SZÚ was reviewed during the assessment visit. The routines and processes for specimen and patient transport are used on a daily basis. The processes for IHR-related events are rehearsed regularly and involve the Integrated Rescue Service (IRS), KHS and the Ministry of Health, and these processes show that actors meet the stipulated timeline requirements. For international transport, the SZÚ has contracted a service that follows international standards for the safe and secure transport. In addition, the SZÚ may request and receive timely assistance from the army of the Czech Republic for specimen or patient transport in the case of IHR-related events within and outside the national territory.

There are several BSL-3 capacities in the country: in addition to one BSL-3 laboratory at the SZÚ and another at the ZÚ Ostrava, three more BSL-3 laboratories at state institutions are available to the public health system in the Czech Republic. The level of access to high containment laboratories during the COVID-19 pandemic was assessed as insufficient and three of the above-mentioned five BSL-3 laboratories were added after the pandemic. Today, the capacities are considered sufficient. The Ministry of Health and the Chief Public Health officer ensure prioritisation of BSL-3 access by means of a central committee. Further BSL-3 laboratories exist in research institutions in the country, but an exact overview is not available. A project among academic BSL-3 laboratories aims to harmonise and align SOPs to make involvement of these laboratories in public health activities more feasible.

Contractual agreements are in place with the Robert Koch Institute in Berlin for the diagnosis of high-risk pathogens under BSL-4 conditions. A Ministry of Defence BSL-4 laboratory is under construction in Těchonín which is planned to become operational in 2027. The Ministry of Defence operates mobile laboratories with different levels of equipment and a container laboratory capable of operating at BSL-4 standards. They are primarily intended for use outside of the Czech Republic but could be deployed in the country if needed.

⁵ https://single-market-economy.ec.europa.eu/single-market/goods/building-blocks/accreditation-conformity-assessment-bodies_en#:~:text=1%20accreditation%20body%20per%20EU,FA's%20tasks%20include

⁶ https://www.cai.cz/?subject_category=test_laboratories

The laboratory system can perform clinical microbiological analyses to identify all endemic and prioritised diseases in line with IHR. The laboratory networks are headed by NRLs at the SZÚ and the ZÚ Ostrava. NRLs work with all relevant laboratories (approximately 180 laboratories distributed across all 14 regions) within their remit. The SZÚ is host to 24 NRLs, is accredited for provision of proficiency testing (ISO/IEC 17043:2023) and provides external quality assessments (EQA) to laboratories in the country. NRLs are part of the networks served by specific European Reference Laboratories (EURLs) and can thereby access EURL services to resolve methodological issues and request reference service diagnostics, EQAs, training courses, etc.

The Ministry of Health and the Chief Public Health Officer can coordinate NRL activities, including preparedness aspects, ensuring access to a network of accredited state-funded laboratories as the core of scale-up capacities in public health emergency situations. A memorandum is in place to recruit further capacity from the health sector and academia. The IRS and the Ministry of Defence have further laboratory capacities. During the COVID-19 pandemic, inter-departmental collaboration was essential to the ad-hoc scaling up of laboratory capacities and capacities were monitored in real-time to allow their coordination. However, there is no formal framework or mechanism to scale up for the public sector. This will be addressed in the PPR plan and similar interaction required with the private sector will be addressed. After the pandemic, the inter-departmental cooperation improved the ability and willingness to cooperate and undertake shared projects. During the COVID-19 pandemic, reserve funds from the Ministry of Health and the government were used to finance early scale-up activities. However, funding for a fast laboratory response is challenging and will probably continue to depend on the reserve funds because the state budget and the budget of the relevant institutions have no specific amount set aside for this type of preparedness and response activity.

A new nucleic acid amplification-based test (NAAT) can be implemented at an NRL within one to three months, including the adaptation of laboratory systems. A bottleneck for implementation of a new NAAT is the availability of positive control material. EURLs may take a leading role to support countries in such situations. As laboratory EQA provider, the SZÚ ensured proficiency of all diagnostic laboratories during the COVID-19 pandemic and achieved a NAAT testing capacity that reached at least 1% of the population. Capacities and capabilities for next generation sequencing (NGS) to perform whole genome sequencing (WGS) exist in different institutions, including the SZÚ, the ZÚ Ostrava and Ústí nad Labem, as well as in the health sector and academia. Sequence data of influenza, SARS-CoV-2 and TB are shared via international databases. The sharing of sequence data for zoonotic events is required. A sequencing centre is being built at the SZÚ. At present, it is mainly the research laboratories dealing with medical research that have equipment and procedures for de novo sequencing. While equipment and operators for NGS are available, partly due to HERA1 and HERA2 grants, there is insufficient financing to run the operations, especially bioinformatic analyses. Therefore, free online software solutions are mostly used to analyse and interpret sequence data. Expertise is higher in the academic sector than in the public health sector. Participation in ECDC's GenEpi BioTrain programme has proven helpful, but attracting and retaining a highly specialised and skilled workforce remains challenging. There is no coordination mechanism to ensure the optimal use of NGS capacities during the response to acute events in the Czech Republic.

The electronic reporting system, ISIN, has a module for electronic reporting of laboratory testing results for COVID-19. The system administration lies with the Ministry of Health, and the Institute of Health Information and Statistics (ÚZIS) operates the system. A revised version, enabling the transmission of laboratory data with national reach, is currently being built under an EU-financed project (SCOPE IS). The new system will be scalable and new pathogens/diseases can be added within days. It will allow seamless integration into the existing Laboratory Information Management Systems to collect clinical microbiological data from all relevant laboratories. The system will include data from primary care, in-patient care and laboratories. It will start with 11 diseases and gradually expand. Additional data available at the ÚZIS will be integrated into the system (e.g. vaccination coverage, number of healthcare workers, health services and their capacity). No challenge to operationalisation was mentioned during the assessment.

Recommendations

- Ensure a strategy for laboratory capacity scale-up, including diagnostic testing and WGS, is included in the PPR plan. Define roles and responsibilities for key actors and mechanisms for coordination of scale-up, including reimbursement.
- Conduct a mapping exercise of available high-containment laboratory capacities in the country. Explore potential needs of the public health sector to involve high-containment laboratory capacity from other sectors (e.g. academia) to achieve adequate capacity in emergency response situations and formalise agreements and/or processes to this end as necessary.
- Integrate clinical microbiological and genomic surveillance data with epidemiological surveillance data at national level to enhance the potential for surveillance, prevention and control activities and ensure planning for maintenance as well as future development.
- Continue strengthening national capacity and capability for health laboratory services, including genomic typing and pathogen characterisation, primarily, but not exclusively, for respiratory pathogens.
- Ensure professional development opportunities for laboratory staff and bioinformaticians to continue building essential capacities and capabilities. As a part of this work, maintain collaboration of the public health sector with other sectors, (e.g. academia) as relevant, for example in the areas of high-containment laboratories, NGS and data analysis to ensure that state-of-art methodologies are translated into the public health context.

Surveillance (Capacity 4)

Surveillance of communicable diseases in the Czech Republic is a core public health function. The national Public Health Act No. 258/2000 (§62, paragraph 1) establishes the obligation to report illness or death from infectious diseases (including suspected cases), providing a strong legal basis for collecting infectious disease data. The legislation does not restrict data format or patient demographics. Additional laws and implementing decrees further define reporting requirements for infectious diseases and vaccination data, including a list of 65 diseases specified in Decree 389/2023 and its annexes.

The country currently operates a comprehensive influenza-like illness/acute respiratory infections (ILI/ARI) surveillance system. ARI surveillance is based on ICD-10 codes; and since 2004, ILI reporting has been added, relying on clinical diagnosis in accordance with the EU case definition to complement ARI data. Since 2025, both ARI and ILI reporting into the Infectious Diseases Information System (ISIN) have been automated through general practitioner (GP) clinical records (GP records also support insurance billing). Clinical data are complemented by sentinel virological surveillance of ARI patients, conducted seasonally (weeks 40–20), with a target of 70–100 samples per week across participating sites. From 2026 onward, year-round virological surveillance is planned. In addition, non-sentinel laboratory-based data is reported, although these data cannot currently be linked to clinical surveillance (e.g. ILI/ARI).

Laboratory-confirmed influenza cases from intensive care units (ICUs) are reported comprehensively from over 150 ICUs. During the COVID-19 pandemic, a separate system was developed to monitor hospitalised SARS-CoV-2 cases. Plans are under way to introduce a comprehensive electronic health record (EHR)-based SARI system collecting case-based hospital, ICU, and mortality data using ICD-10 codes. The Czech Republic participates in ECDC-funded projects and has a protocol for EHR-based reporting. A pilot is currently being conducted at one hospital, with expansion planned for the next season.

In recent years, the country has invested in the modernisation of surveillance systems, expanding the use of EHRs and automated reporting into ISIN. These developments are externally funded through EU direct grants for surveillance, available until 2028. Virological data collection has been integrated into this unified electronic reporting system, and a vaccination registry has been launched for data collection beginning in 2025 (prospective, no historic data available). There are plans to include laboratory data for all notifiable pathogens in the system, after an initial pilot with a selected number of pathogens. Although data linkage is not yet operational, it will be essential for maximising the value of the system. A unique national identifier, generated by the Ministry of Health, should facilitate linkage in the future. However, validation of data linkage, the data entry and the overall system will be required. The automated reporting system is intended to replace current severe influenza and COVID-19 reporting, as well as sentinel virological surveillance in primary care. A fully automated, comprehensive and linkable system that follows infectious disease cases across the full care pathway would dramatically strengthen the national surveillance capacity. To remain sustainable, such a system will need long-term funding for maintenance and further refinement beyond short-term project grants.

A respiratory virus bulletin is published weekly on the National Institute of Public Health (SZÚ) website. These outputs, and the weekly data submissions to ECDC are curated manually. This operation requires extensive resources on a weekly basis. Automatic generation of outputs in the ISIN is planned. Regional public health agencies will also be able to navigate the data and compare outputs by region. This capability already exists for some data streams (e.g. ILI/ARI and vaccination registry data), and filtering by demographics and region has been identified as useful.

The Ministry of Health maintains a national system separately from the ISIN, providing up-to-date information on in-patient care capacity (hospital and ICU beds) and this is being expanded to cover all relevant healthcare providers. Hospitals report occupancy and availability of specialised equipment. This tool is used mainly for monitoring as individual healthcare facilities determine appropriate control measures for routine seasonal respiratory epidemics (e.g. visitor restrictions, mask use). Nationwide measures are applied only during more severe public health events. Testing capacity was monitored during the COVID-19 pandemic, using a simple tool that can be reactivated as necessary.

The national pandemic plan, drafted after the 2009 influenza pandemic, outlines the responsibilities of different stakeholders (e.g. Ministry of Health, crisis management bodies) during a respiratory pandemic but contains limited technical detail on surveillance, responsibilities in the SZÚ and KHS, and reporting mechanisms. It is essential that the pandemic plan describes how the ISIN will be used and adapted for enhanced data collection during emerging threats (e.g. additional variables, increased data volumes). The capabilities of the ISIN system should be regularly tested and staff appropriately trained.

During the COVID-19 pandemic, the Czech Republic implemented a model for analysis and was actively conducting important analysis with research partners to assess the pandemic threat (e.g. severity, transmissibility, etc). At present, there are no dedicated human or financial resources to maintain advanced analytical work or to participate in projects such as ECDC VEBIS. Limited training budgets further constrain the development of staff competencies in modern analytical methods. The existing training allocation is also insufficient to support the organisation of network meetings for regional public health authorities or to facilitate attendance at international scientific

conferences, which are essential for scientific exchange and capacity building. The Czech Republic is currently involved, and plans to continue participating in the European Programme for Intervention Epidemiology Training (EPIET) Member State track and remains open to support from ECDC, participating in relevant networks and projects where possible.

The Czech Republic has wastewater monitoring established for poliovirus (24 collection points with monthly monitoring, as well as monitoring special sites, such as refugee centres) and SARS-CoV-2 (five sites including Prague airport and the main bus terminal). SARS-CoV-2 wastewater surveillance covers 70% of the population, with samples taken at central collection points, preventing regional interpretation. The Czech Republic is a partner of European Union's Wastewater Integrated Surveillance for Public Health (EU-WISH) and HERA supersite activities. Current SARS-CoV-2 wastewater data are not used for respiratory virus situational assessment due to insufficient sampling frequency (monthly) and spatial resolution. Although there is interest in expanding wastewater surveillance to additional pathogens, no systematic prioritisation has been carried out to define which pathogens should be monitored and for what purpose. Moreover, it would need to be determined what public health action could be taken if a signal were detected. Wastewater surveillance should be guided by public health and health security and integrated into the overall surveillance frameworks. From a preparedness perspective, implementation of Article 17(1) and (2) of the recast Urban Wastewater Treatment Directive (EU 2024/3019) will facilitate the use of WBS in public health emergency or pandemic situations, especially the setting up of a national system for cooperation and coordination between the entities involved.

The 14 regional health authorities are autonomous, each having its own protocols for event detection and management. The ISIN, which currently collects ILI/ARI data and other infectious diseases data, contains a module for cluster reporting and information may also be reported through other channels (e.g. telephone calls). KHS investigate clusters and outbreaks within the respective region and informs the relevant stakeholders as necessary. Cases that form a cluster only when their data are combined across different regions run the risk of being undetected. Event investigation can place a strain on regional authorities, especially when larger clusters need to be followed (e.g. operate 24/7 epidemiological duty with limited personnel, contact tracing without a proper system). There is currently no dedicated tool to facilitate the validation, management and communication of event-based surveillance data. During the COVID-19 pandemic, an externally purchased software system was used which is no longer available. While SOPs and procedures are in place at the regional level, a system for event management would greatly facilitate and streamline responses to events and exchange between stakeholders.

Recommendations

- Ensure full implementation of the automated, comprehensive Infectious Diseases Information System (ISIN), covering ILI/ARI, SARI and other relevant infectious diseases. Secure sustainable long-term funding and human resource capacity for its operation, maintenance and future development beyond the current project-funded period. Maintain all existing surveillance systems until the new system is fully implemented and validated.
- Establish and validate data linkage between clinical, laboratory and other relevant datasets (e.g. vaccination registry) within the ISIN, using the national unique identifier to enable high-quality, integrated case-based surveillance.
- Automate national and supranational reporting outputs, ensuring that routine outputs and data extracts are generated reliably, with minimal manual workload. Further enhance data-visualisation functionalities to support timely analysis and decision-making.
- Clearly outline the ISIN functions into the planned prevention, preparedness and response plan, including how surveillance data will be used and what adaptations may be required to collect enhanced information (e.g. severity indicators, healthcare utilisation, early signals, the addition of a novel pathogen/syndrome). Test the ISIN using possible pandemic scenarios to assess system performance, identify potential weaknesses and ensure operational readiness. Ensure staff at all levels receive adequate training to use the system, including its outputs, effectively during routine operations and crises.
- Provide opportunities for professional development of national and regional staff, focusing on strengthening analytical capacity and promoting collaboration and exchange between regions. Maintain essential collaboration with research partners to support high-quality analysis during routine monitoring and public health emergencies.
- Implement a nationwide dedicated tool for event-based surveillance, enabling efficient validation, management and communication of event-based signals at regional and national level.

Antimicrobial resistance and healthcare-associated infections (Capacity 12)

The Czech Republic has developed a draft national strategy on antimicrobial resistance (AMR) with a One Health approach and estimated budget for implementation. Moreover, in the preparatory work towards the third National Action Plan (NAP) on AMR there are targets to measure progress on AMR/HAI and AMC in line with the Council Recommendation from 2023⁷ and, unlike the previous NAPs, this NAP has a plan for ear-marked funding. However, after having had two NAPs on AMR (2011–2013 and 2019–2022), the country currently does not have an approved NAP on AMR in place.

There is a National Antibiotic Awareness Programme (NAAP), coordinated by the Central Coordination Group of the NAAP (CKS NAAP). According to legislation, it acts as an external inter-departmental and intersectoral advisory body to the Minister of Health. The main activity of the NAAP is the drafting and coordination of the long-term NAAP strategy and its action plan as well as the related monitoring of AMR/AMC and implementation of Antimicrobial Stewardship (AMS), IPC and education.

AMR activities at the local level are mainly carried out by the local clinical microbiological laboratories, the healthcare facilities and their IPC teams and, when available, using antibiotic programmes focusing on AMS. The IPC teams report to the regional public health authorities who include events (defined as an outbreak, severe damage to health or the death of a patient, if they are deemed to be an HAI or involve a notifiable disease) in their monthly overviews submitted to the Ministry of Health and to the Chief Public Health Officer. In addition, the local clinical microbiological laboratories report data to the SZÚ, specifically the National Reference Laboratory for Antibiotics (NRL ATB) which conducts whole genome sequencing (WGS). The NRL ATB reports WGS data to the European level (EURGen-Net), and on an annual basis reports data on cerebrospinal fluid and blood isolates covering approximately 70% of the population at the European level (EARS-Net). In addition, in collaboration with healthcare IPC teams, the National Reference Centre for Healthcare-Associated Infections (NRC HAI) at the SZÚ provides data at the European level (HAI-Net). In the Czech Republic, there is a mandatory national electronic system collecting data on prescriptions, and AMC data are available through the State Institute for Drug Control (SÚKL), as well as the National Register of Reimbursable Health Services (NRHZS). Data on AMC are reported at European level (ESAC-Net). Moreover, evaluations of the antibiotic prescriptions of individual doctors against the WHO AWaRe classification are available on a web portal for quality indicators.

However, although AMR/HAI surveillance in the Czech Republic is indicator-based at local level, these results are only reported on to the regional level using event-based surveillance (an event being an outbreak, severe damage to health or death of the patient) if deemed to be an HAI or involving a notifiable disease. From the regional level results are routinely reported to the Ministry of Health on a monthly basis. In addition, there is some national indicator-based surveillance of AMR/HAI, including MDROs (carbapenemase-producing Enterobacterales (CPE) and *Candida auris*), as well as some national AMR monitoring. The current surveillance structure may therefore miss outbreaks not identified at the local level, especially outbreaks that are spread across healthcare facilities and regions, as well as MDRO outbreaks. The ongoing implementation of an electronic surveillance at SZÚ and the Institute of Health Information and Statistics could be an opportunity to address this aspect. In addition, at national level, there is no official report analysing the surveillance data. However, results from the national surveillance are accessible on the SZÚ web pages and are shared during seminars and conferences of professional societies. Reporting of surveillance results to the regional and local levels involves providing laboratories that participate in surveillance with ECDC reports (the results from EARS-Net and the point prevalence survey (PPS) of HAI). However, it was noted that efforts are being made to create a dashboard for the reporting of CPE surveillance results.

Each entity/stakeholder dealing with ARHAI receives separate funding and is meant to budget adequate funding for its activities. However, limited funding and staff resources at local and national level were reported as a challenge. For example, there is no dedicated budget for genomic surveillance of MDROs.

Various aspects of the ARHAI work have a legal basis. This includes the establishment of an NAAP, national reference laboratories, a list of essential anti-infectives, routines to control imported cases of colonisation and/or infection with CPE, a mandatory IPC programme in acute in-patient care hospitals, and the reporting of HAI 'in the event of an outbreak, severe damage to health or death of the patient', as well as recommendations on *Candida auris*. However, AMR surveillance is not mandatory unless it comes under one of the MDROs covered by legislation or fulfils the trigger for HAI event reporting. In addition, antibiotic programmes focusing on AMS do not have the same legal basis as the IPC programmes.

There are guidelines for antimicrobial treatment. However, antimicrobial consumption surveillance has shown that in the Czech Republic the proportion of the total consumption of antibiotics for systemic use belonging to the WHO AWaRe 'Access' group decreased in 2024 compared to 2019. WHO AWaRe Access antimicrobials are mostly first- and second-line therapies that offer the best therapeutic value, while minimising the potential for AMR. In the Czech Republic, which had the highest use of antimicrobials for systemic use in hospitals in 2024 in the EU/EEA, there was an increasing trend in the proportion of broad-spectrum antibiotics. It was reported that, although a shortage in narrow-spectrum antibiotics was noted during the COVID-19 pandemic, this had led to resources now being available to prevent this.

⁷ [Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach](#)

There is a draft national strategic plan on HAI surveillance which has not been approved at ministerial level. Moreover, although an IPC programme has been mandatory in acute care hospitals since 2013, a survey from 2023 showed that IPC staff were only present in 83% of hospitals. In addition, there is no national coordination of IPC efforts.

Another concern was that awareness of the concept of AMR was limited among the various stakeholders, including the general public. Since 2023, when a project supported by the EEA with funds from Norway came to an end, awareness-raising activities have been limited.

Recommendations

- Ensure approval, implementation and funding of the NAP on AMR, as this is currently not in place.
- Raise awareness of AMR among relevant stakeholders, including the general public. The aim for such efforts should be to assist in improving implementation of surveillance, IPC and AMS activities, as well as to increase understanding among all stakeholders of the need to take action against AMR.
- Set up timely indicator-based AMR and HAI surveillance at national and regional level, including the production of regular surveillance reports. Maintain WGS capacity to allow detection and response to MDRO and HAI outbreaks. Maintaining participation in EURGen-Net and EARS-Net and building on the experience gathered through this work when strengthening AMR and HAI surveillance may prove helpful. Strengthening of the surveillance should allow nationally coordinated, generated and revised guidelines on antibiotic use, as well as detection of outbreaks across healthcare facilities and regions.
- Ensure an IPC programme and an antibiotic programme is established at all healthcare facilities, including continuous professional development, funding and legislative support for the antibiotic programmes. This should improve IPC and AMS monitoring and implementation at several levels.
- Ensure approval of a national strategic plan for HAI surveillance, the setting up of a national IPC coordination and adequate funding. This should allow improved IPC implementation in all healthcare facilities, monitoring of the screening of patients transferred from abroad, dissemination of national targets to measure progress on AMR/HAI/AMC and their achievement, provision of further national IPC guidance to hospitals, work towards addressing hospital infrastructure limitations, and awareness raising on AMR (e.g. among hospital management).

Zoonotic diseases and threats of environmental origin, including those due to the climate (Capacity 10)

In the Czech Republic, the prevention and management of zoonoses involves multiple authorities across sectors. The State Veterinary Administration (SVA) operates under the Ministry of Agriculture and is responsible for animal health, veterinary surveillance and the implementation of animal disease control measures in accordance with the Veterinary Act No. 166/1999 Coll. The National Institute of Public Health (SZÚ) operates under the Ministry of Health and provides national expertise in epidemiology, laboratory reference function and public health surveillance. The Czech Agriculture and Food Inspection Authority (SZPI) under the Ministry of Agriculture supervises food safety in areas falling outside the competence of veterinary authorities. The Regional Public Health Authorities (KHS) are responsible for surveillance and response to communicable diseases at regional level in accordance with the Protection of Public Health Act No. 258/2000 Coll. Other public authorities and entities are often involved in early warning (e.g. Ministry of Environment for Wildlife and hunters' associations) or in the implementation of control measures in outbreaks involving highly pathogenic avian influenza, or response to extreme weather events (e.g. Integrated Rescue Service under the Ministry of Interior).

Competencies in tackling zoonoses are defined in the Veterinary Act No. 166/1999 Coll. and in the Protection of Public Health Act No. 258/2000 Coll. which requires public health authorities and SVA to cooperate to prevent the spread of infectious diseases. Building on their previous agreement (2009), a Memorandum of Understanding between the Ministry of Health and the Ministry of Agriculture is currently being developed. This cooperation between national animal health, food safety and public health authorities can be further formalised by defining technical procedures and communication flows among sectors and between national and regional authorities.

Since 2004, the Inter-Agency Working Group on Zoonoses has been composed of the Ministry of Health, Ministry of Agriculture, SZÚ, ZÚ, SVA, SZPI, State Veterinary Institutes, and Veterinary Research Institute. Occasionally they extend the invitation to private, hospital, national reference and public health laboratories. The Inter-Agency Working Group meets twice a year. Two groups were established in November 2025: a working group for updating the joint methodology on information sharing regarding the occurrence of foodborne zoonoses and causative agents and a working group for investigation of foodborne outbreaks, to collect and share data for the rapid detection of a national food epidemic, and help identify the food involved and contributing factors. The composition and rules for these working groups are under development. Data are uploaded to the EFSA/ECDC 'One Health' WGS system. The Working Group on Avian Influenza, established in 2006, reports to the Ministry of Health and has SVA, PHA and Ministry of Health representatives, to share global situation updates and to coordinate the methodological approach to addressing EC/ECDC requirements. The Central Animal Health Committee of the Czech Republic is an intersectoral advisory board for the Ministry of Agriculture. Intersectoral commissions and working groups are mostly in place for risk management and methods. At this stage, the environmental sector is mainly absent from agreements and committees.

Nationwide contingency plans exist for certain zoonoses. The SVA participates in the EU Animal Disease Information System (ADIS) and the World Animal Health Information System (WAHIS), for the reporting of outbreaks and communicating risks with other members of the networks. The SZÚ does not have a mandate for outbreak investigation unless it is an outbreak affecting more than one region, or an international outbreak. If a zoonotic disease outbreak is suspected, there are mechanisms for mobilising multidisciplinary teams at regional level between the KHS and the regional SVA. The SVA has established strong collaboration with other governmental authorities, both at national and regional level. These include the Integrated Rescue System, the Fire Rescue Service, the police, the army, the prison service, KHS and the Administration of State Material Reserves.

Monitoring of zoonoses and zoonotic agents is guided by Decree No 356/2004 Coll. and covers both livestock and wild animals, in accordance with the Methodology for Animal Health Control and Mandatory Vaccination, issued by the Ministry of Agriculture for the relevant year. The list of zoonotic diseases under surveillance responds to the Zoonosis Directive 2003/99/EC and the Animal Health Law. The interdepartmental group on zoonoses has not conducted a risk-based prioritisation. The SVA coordinates the production of annual zoonoses reports for zoonoses and zoonotic agents in food of animal origin, following the requirements of Commission Implementing Decision (EU) 2020/1729 for different animal species.

SVA established monitoring of West Nile Virus (WNV) infection in dead birds, with PCR testing and WGS, from 2026 onwards. All horses showing neurological symptoms are tested. With the exception of the reporting to the EFSA-ECDC One Health WGS of food, animal and human isolates, there is no national intersectoral on-line data sharing or common databases.

SZÚ at the national level conducts surveillance, trend analysis, risk assessment of zoonoses in humans, prevention and communication, and operates NRLs for human samples involving zoonotic pathogens.

A citizen science programme for reporting ticks has been implemented, and a mobile application is available as a result of good cooperation with academia/research bodies. However, discontinued funding may jeopardise a project on vector monitoring at the SZÚ among others. The One Health International Conference (last edition held in Brno in November 2025) is an event organised by the Ministry of Agriculture together and other key institutions, with input from the Slovak Republic, which targets a multidisciplinary audience. Technical sessions on zoonotic diseases are regularly offered as continuous professional development.

While the SVA does not have general guidelines for the public on handling dead or sick wild animals, information is disseminated through the media, press releases, or leaflets and the local municipalities are involved. Guidelines are produced as part of the emergency veterinary measures during specific outbreaks. Professional organisations (e.g. the Czech Society for Ornithology) and the Czech Hunters' Association also contribute to public awareness (e.g. reporting of more than five dead birds to the SVA).

Wastewater surveillance, predictive models for tick and mosquito activity and weather forecasting have been established through collaboration with the Ministry of Environment. In addition, the Czech Hydrometeorological Institute (CHMI), and the wildlife conservation authorities have demonstrated interest in strengthening their cooperation with the public health and animal health authorities.

In the last few years, the Czech Republic has experienced multiple floods (the last one in September 2024). Lessons have been drawn, learned and shared from this and mechanisms for early warning, crisis communication and crisis management are now well established. Crisis response is well coordinated in the event of floods, droughts, and other types of extreme weather. CHMI issues warnings disseminated through the Integrated Rescue System and public channels.

The national coordinator for adaptation to climate change is the Ministry of Environment. In line with the EU Adaptation Strategy and international commitments, the Czech Republic has developed a Strategy for Adaptation to Climate Change 2021–2030. An update of the National Action Plan (NAP) for Adaptation to Climate Change is being prepared for the period 2026–2030, based on two recent evaluations: one regarding its implementation during the period 2021–2025, and one regarding climate change and adaptation needs. The approach involves cross-sectoral coordination to address climate change impact in a holistic manner. Important activities outlined in the draft update include strengthening diagnosis and prevention of climate-sensitive infectious diseases, strengthening integrated surveillance and research, monitoring vectors and pathogens, warning systems and continuous risk assessment for communicable diseases, and educating health professionals and emergency responders on the health impact of climate change. Considerations related to implementation arrangements and cost estimates per sector and activity will be essential in order to make the plan operational and sustainable.

Recommendations

- Strengthen the integration of the environmental sector into routine work and emergencies: bring environmental authorities (i.e. the Ministry of Environment, the Czech Hydrometeorological Institute (CHMI), wildlife protection, land use bodies, and others) into relevant working groups (climate and zoonoses, vector-borne diseases) with defined responsibilities (e.g. wildlife surveillance, carcass management, environmental drivers).
- Build an intersectoral digital data-sharing solution beyond whole genome sequencing for zoonoses, with agreed minimum datasets and access rules, to share event signals, outbreak summaries, exposures, investigation status and control measures.
- Formalise and document the production of One Health Joint Risk Assessment and scientific guidance, through the development of written SOPs across the Ministry of Health/National Institute of Public Health (SZÚ), Ministry of Agriculture/State Veterinary Administration (SVA), and the Ministry of Environment. These SOPs should clarify triggers, roles, data input, timelines, approvals, and how risk assessment outputs translate into response actions. For climate sensitive zoonoses, forward-looking assessments could be produced.
- Invest in modelling and forecasting of the health impact of climate change and extreme weather events for the National Action Plan for Adaptation to Climate Change.
- Embed the One Health Approach into the generic PPR Plan, taking into consideration zoonotic diseases and the health impact of climate change/extreme weather events. Include cross-references to the generic PPR Plan in the NAP for Adaptation to climate change.

Policy, legal and normative instruments to implement the International Health Regulations 2005 (Capacity 1)

The Czech Republic has a robust legal and institutional framework for emergency preparedness and crisis management, supported by comprehensive legislation, sectoral plans, and clearly established crisis-management arrangements at national, regional and local levels. Legal instruments incorporate coordination across administrative levels, and, when a crisis is declared, decision-making processes are well defined and generally function effectively. However, some key plans (e.g. IHR Action Plan, Pandemic Plan) need to be reviewed and updated.

Crisis structures are regularly exercised through national and international exercises, including multisectoral simulations, contributing to a high level of operational familiarity among authorities and responders. These mechanisms have also been used regularly in the response to real events (e.g. floods). The integrated rescue system is well established and widely understood, and expert advisory bodies play a central role in informing risk assessment and response decisions. The responsibility for assessment and response to most acute public health events is at the regional level, unless multiple regions are involved or there is a need for additional resources to respond effectively.

The National IHR Focal Point (NFP) is designated as a permanent centre with 24/7 availability and maintains timely communication with WHO and relevant national stakeholders. Information exchange across sectors and authorities has improved substantially since the COVID-19 pandemic, supported by strengthened coordination mechanisms, expert commissions, and routine information sharing within the Ministry of Health and external partners. In practice, communication around IHR-related events functions well, and this includes communication with sectors such as animal health, food safety, nuclear safety and emergency services. However, the mandate, authority and institutional positioning of the IHR NFP are not sufficiently articulated in legislation or formal procedures, particularly as regards its role within the Ministry of Health and its interaction with crisis-management structures. This lack of formal clarity is most evident in the early phase of an event, before a situation escalates into a formally declared crisis, and contributes to a degree of fragmentation and uncertainty around roles and responsibilities.

The recently established Emergency Operations Centre (EOC) within the Ministry of Health represents a significant strengthening of national capacities for situational awareness, information consolidation and decision support. The EOC was initiated following long-standing planning efforts and accelerated by lessons from the COVID-19 pandemic, with the objective of enabling more rapid threat detection and analysis in order to support timely decision-making. The EOC is very proactive in collecting and sharing information on public health events in the Czech Republic and globally with relevant stakeholders in the Ministry of Health, other sectors and the general public. While the EOC and the Crisis Department of the Ministry of Health collaborate, the specific activities, responsibilities and interfaces between these two entities are not yet fully clarified, particularly across preparedness, assessment and response functions. Further clarification would help ensure coherence and avoid duplication within the Ministry's internal structures.

Overall, while the Czech Republic demonstrates strong crisis-management capabilities and well-functioning operational practices, greater legal and institutional clarity would strengthen IHR implementation, enhance assessment and response across phases of an event, and further consolidate coordination across sectors and administrative levels.

Recommendations

- Strengthen and clarify the legal and institutional framework for IHR implementation, with particular emphasis on clearly defining the mandate, authority, and positioning of the National IHR Focal Point and its relationship with crisis-management structures in the Ministry of Health and across sectors and administrative levels.
- Clarify the activities and responsibilities of staff of the recently established EOC in the Ministry of Health and the relationship with the Crisis Department.

Financing (Capacity 2)

Guided by the State Budget Act, the state budget annually assigns separate funding to municipal, regional and national entities dealing with public health emergencies. In line with the national legislation, the respective entity budgets should include a sum for funding in emergencies. However, there is no overview of the proportion of the overall budget that is assigned to IHR or health security-related activities, as entities include these tasks in their routine activities. The public health system is decentralised and budgets for regional and national entities are handled by different departments within the Ministry of Finance. The regional entities have significant autonomy over their respective budget distribution and do not routinely coordinate their budgets.

There is contingency funding in place to respond to unexpected health threats not covered by the respective entity budget. The contingency funding is achieved by budget transfer within the respective ministry chapter of the state budget, between ministry chapters of the state budget, or from the government budget reserve. Alternatively, contingency funding is achieved by an amendment to the state budget.

Contingency funding can be secured promptly in case of an emergency. The example was given of how the government budget reserve was accessed to approve a grant for the procurement of mechanical ventilators during the COVID-19 pandemic.

There are mechanisms in place to access emergency funding, although they reportedly work less well in the case of chemical events, and timeliness could potentially be improved. These mechanisms are not being tested but have been applied during real emergencies, such as floods and the COVID-19 pandemic.

In the event of a public health emergency, policies and activities are coordinated mainly in the form of regular meetings of the Central Crisis Management Team and the team may set up a crisis financing task force to facilitate the financing of all measures designed to avert and mitigate an event. During a declared state of crisis, procurement procedures allow for a faster procurement process.

Large variations in the respective entity budgets over time have not been noted at the Ministry of Finance level, including during the COVID-19 pandemic as state reserves were then mobilised for funding. However, at some levels in the Ministry of Health funding requests have increased. It was unclear whether this was reflected in the final budget requested from the Ministry of Health.

In several of the public health emergency preparedness capacities assessed it was reported that the funding and staffing of the capacities is challenging.

Recommendations

- Ensure sufficient and sustainable financing of preparedness in annual national and regional budgets, as well as the appropriate timely actions required to respond to a public health emergency, including adequate funding for human resources.
- Conduct regular exercises to test the financial mechanisms for accessing contingency funding and address issues identified during the testing.

Human resources (Capacity 5)

A mechanism to ensure surge capacity in the event of a public health emergency is in place. This facilitates the response to all types of emergencies, including infectious disease outbreaks that are small-scale or limited in terms of time. The country has skilled emergency medical teams able to face emergencies of any type such as floods, mass casualties, chemical, radiological or nuclear incidents. However, the capacity to handle larger emergencies and crises is limited. The surge capacity mechanism is structured and tested in hospitals, but not for the provision of other health services such as laboratory activities, outbreak investigation, contact tracing, etc. Furthermore, hospitals and healthcare facilities have agreements for receiving and exchanging human resource support when necessary, but these agreements are established on bilateral basis and an overview of the staff redeployed and exchanged on an ad-hoc basis at national level is missing.

Although the crisis law enforces the exchange of human resources between the regions, during small emergencies this exchange is not supported and encouraged by the different facilities. While the legislation during emergencies to facilitate the employment of trainees and enforce longer working hours and shifts is in place, its implementation is cumbersome and it is often quicker to employ students from medical schools and non-medical health professions faculties through local agreements.

Health workforce challenges include persisting shortages of healthcare professionals and public health specialists, as well as shortages of workforce in other sectors (e.g. animal health). Such workforce gaps are unevenly distributed across regions. Moreover, mechanisms for the retention of professionals in remote locations have not been successful and the remuneration of public health jobs is not perceived as attractive.

Recommendations

- Invest in recruitment and retention of personnel tasked with public health responsibilities at all levels (national, regional, municipal).

Health service provision (Capacity 7)

In the Czech Republic, health services are managed at the local and regional levels, with the municipalities and regions responsible for ensuring the availability of in-patient and out-patient care. Research and university hospitals are under the remit of the Ministry of Health. Health services and the conditions for their provision are specified in Law 372/2011. The Ministry of Health gets an overview of all available health services through the national registry of healthcare providers and of reimbursed health services. An online interactive map is accessible to the public, indicating the location and service details of all healthcare facilities in the country, but not their real-time availability.

Interdisciplinary crisis management coordination between all actors of the health care system, especially hospital and rescue services, is ensured through the legislation including Act No 374/2011 Coll. on the emergency medical service, Act No 239/2000 Coll. on the integrated rescue system and the Crisis Management Act No. 240/2000 Coll., which ensures the application of the crisis documentation and procedures at all levels. Hospitals and healthcare facilities are, under certain circumstances, required to implement the regional crisis plans, the national pandemic plan and the epidemic plan, and the crisis plan of the Ministry of Health. Emergency medical services are provided at the regional level, and the responsible facilities and hospitals are obliged to develop their own trauma plan which sets out the measures and procedures applied in the event of mass casualties.

While hospitals have a dedicated operational plan for continuity of healthcare service during emergencies and crises, laboratory, outpatient care and other services do not have such a plan. A package of essential health services is not defined and there are no plans or guidelines for continuity of essential health services during an emergency. According to WHO, essential health services are defined as critical, life-saving services (e.g. child and maternal care, immunisations, and treatment for communicable and non-communicable diseases) that should be reorganised and safely maintained in an emergency context. For example, this could be done by identifying routine and elective services that can be suspended or relocated to less affected areas, creating a roadmap for progressive reduction and restoration of services as pressure on the health system surges and recedes⁸.

The potential impact of a health emergency on continuity of healthcare services is only assessed at facility level, where the continuity of the services is constantly monitored even if not communicated to the national level. No mechanism has been set up for monitoring the continuity of health services in other health system facilities (outpatient services, laboratory, etc.).

National clinical case management guidelines for priority health events are implemented at all levels and these are exercised, reviewed, evaluated and updated on regular basis.

The country has international bilateral agreements with all neighbouring countries on mutual assistance in the event of disasters and bilateral agreements with Austria, Germany and Slovakia for the cooperation of emergency medical service providers.

Recommendations

- Develop a country-specific list of essential health services to be prioritised during emergencies with the aim of reorganising and safely maintaining access to high-quality, essential health services during an emergency.
- Ensure the availability of a real-time monitoring system of essential health services at national level.

Risk communication and community engagement (Capacity 8)

Risk communication, community engagement and infodemic management (RCCE-IM) constitutes a strategic component of the Czech public health system, which is supported by the Protection of Public Health Act No. 258/2000 Coll. and the Government Council for Public Health, established in 2024. The legal basis for crisis communication lies in the Crisis Management Act (Law 240/2000 Coll.). At the national level, the Ministry of Health is responsible for health-related RCCE-IM and coordinates its efforts with the Regional Public Health Authorities (KHS) and other national authorities (e.g. the Ministry of the Interior or the Directorate General of the Fire Rescue Service) who, when necessary, can dispatch warnings to the general population (e.g. via sirens, text messages and national/regional media). Infodemic management is managed by the Crisis Information Team (KRIT) of the Ministry of Interior.

⁸ https://www.who.int/publications/i/item/WHO-2019-nCoV-essential_health_services-2020.2

A comprehensive national crisis communication strategy has been established by the Ministry of the Interior and a crisis communication strategy by the Ministry of Health (incorporated into the Ministry of Health Crisis Plan) and these are followed during emergencies. As responsibility for security is shared among several sectors, intersectoral coordination and collaboration on communication outputs during crises is firmly established and was tested during a recent exercise 'Zóna 2025'. During the COVID-19 pandemic, the Ministry of Health established a central management team which functioned as the main public health coordination and advisory body, including for matters related to RCCE-IM. There is routine coordination between the national level (Ministry of Health, SZÚ) and the regional levels (KHS) – e.g. through regular bi-weekly meetings and the implementation of a unified methodology for communication through social media. However, at present there is no comprehensive and overarching health risk communication plan, with clear links, or fully embedded into general PPR planning, outlining standard operating procedures, roles and responsibilities of existing structures, and providing instructions for all Ministry of Health staff.

Both national and regional level public health actors recognise the importance of community engagement to understand the general sentiment among the population and data are often obtained by polling rather than social listening activities. The importance of delivering messages effectively through NGOs or known trusted individuals in communities is also recognised. A recent example of community engagement has been the ongoing hepatitis A outbreak, during which NGOs supported the public health authorities in risk communication efforts to the affected communities. SZÚ has carried out two large projects focusing on health disparities and health communication needs for disadvantaged communities, with specific information material produced in various languages and forms to improve accessibility. A socio-behavioural approach to RCCE-IM was implemented during the COVID-19 pandemic (Smart Quarantine, COVID-19 vaccination campaign), but dedicated socio-behavioural capacities are less attainable for routine RCCE-IM activities, due to resource limitations.

A critical capacity gap lies in shortage of dedicated and trained RCCE-IM staff (including staff with socio-behavioural expertise) and sustainable financial resources for routine and emergency RCCE-IM activities at both national and regional levels.

Recommendations

- Ensure sufficient resources (human and financial) and trained RCCE-IM capacities at both national (Ministry of Health, SZÚ) and regional level (KHS). Establish formal functions for RCCE-IM (e.g. institutional focal points). Ensure and formalise coordination across already established communications functions.
- Develop and incorporate a RCCE-IM plan into the generic PPR plan, with clearly defined roles and responsibilities, including SOPs to guide RCCE-IM in both routine and emergency contexts.

Points of Entry and border health (Capacity 9)

In the Czech Republic, Václav Havel Airport in Prague is the only Point of Entry (PoE) for air transport officially designated in accordance with the IHR standards. There is an emergency medical unit nearby, available 24/7. This clinic belongs to the Bulovka University Hospital and functions as the National Centre for Highly Contagious Diseases. The airport adheres to the emergency preparedness and response plan that is regularly updated and tested.

The Czech Republic has 13 land crossings with neighbouring countries, which are all open crossings without systematic border controls and therefore not officially designated as PoEs in accordance with the IHR. However, if needed, a system is in place to trigger border controls at land crossings. The controls would be carried out by the police, supported by the regional public health office. This was successfully implemented during the COVID-19 pandemic. Similar controls can be triggered for river transport by the State Navigation Administration in cooperation with the police.

The Czech Republic has a robust system for control at the PoE for air transport. At the land crossings which can serve as PoEs if necessary, law enforcement can step up operations, in collaboration with the public health authorities and the bodies of the integrated rescue system.

Recommendations

- Organise regular smaller scale, table-top exercises to bring together all relevant stakeholders and update participants on new procedures.

Chemical events (Capacity 11)

The Czech Republic demonstrates a well-developed legal and operational framework for preparedness and response to chemical incidents. Responsibilities for managing chemical events are clearly defined in legislation and operational plans, with the Fire Rescue Service of the Czech Republic acting as the lead authority for response coordination. Chemical threats are integrated into the broader civil protection and emergency management system, ensuring a multi-hazard approach and strong intersectoral cooperation.

Preparedness planning is established at multiple levels, including central, regional and facility levels. Major hazard sites are identified and considered within preparedness and response planning, and standard operating procedures are in place to support coordinated action during chemical incidents. These arrangements enable cooperation between civil protection, health authorities, environmental services, laboratories and other relevant sectors.

Operational readiness is further supported through established communication channels and clearly defined roles and responsibilities during emergencies.

The country benefits from strong expert capacity, including toxicological expertise and well-established laboratory services, capable of supporting the detection and analysis of chemical hazards. A national poison service operating on a 24/7 basis provides continuous access to expert advice and supports the clinical management of chemical exposures. Surveillance and early warning mechanisms relevant to chemical events are embedded within existing systems and contribute to situational awareness and decision-making during incidents.

International and cross-border cooperation mechanisms are actively used, reflecting the Czech Republic's integration within European and international chemical safety and civil protection frameworks. These arrangements support information exchange, mutual assistance and coordinated responses to chemical events with potential cross-border implications.

Despite these strengths, a key gap identified during the assessment relates to health risk assessment in the context of chemical incidents. While expertise is available, there is no standardised, nationally agreed procedure for conducting health risk assessments during chemical events and a lack of standards against which to perform the assessments. In addition, there is limited guidance addressing the medium- and longer-term follow-up of populations affected by chemical incidents. While acute response and immediate clinical management are well covered, structured approaches for longer-term health monitoring, follow-up of exposed individuals and assessment of potential chronic health impacts are not clearly articulated within existing plans.

Recommendations

- Develop a procedure for standardised health risk assessment in response to chemical events.
- Develop guidance for medium- and longer-term monitoring of the health of the exposed population following chemical events.

Union level coordination and support functions (Capacity 13)

The Czech Republic has a robust legal basis for ensuring representation and engagement in the EU structures for health emergency preparedness and response. There are designated contact points for collaboration and communication with relevant EU bodies, including the Health Security Committee, the Board of HERA, ECDC and other EU agencies. The Chief Public Health Officer has a central role in EU-level coordination, supported by the newly established Emergency Operations Centre (at the Ministry of Health since 2025) and the European and International Coordination Department of the Ministry of Health.

The Ministry of Health and its Public Health Protection Department serve as the national competent authority for the purposes of the Early Warning and Response System.

The opinions of the Health Security Committee and ECDC advice and outputs (e.g. ECDC Risk Assessments) are factored in and used (e.g. in the production of national risk assessments) and there is a national system in place for further dissemination of opinions, advice and outputs to other sectors and relevant authorities which is used on a routine basis.

Recommendations

- Make more use of existing EU resources and networks to strengthen national capacities.
- Enhance participation in EU activities in the area of epidemic intelligence, threat detection and RCCE-IM (such as training courses, ECDC round-table with Member States, etc.).

Research development and evaluations to inform and accelerate emergency preparedness (Capacity 14)

The Czech Republic has a set of expert institutions and networks capable of conducting research during emergency, clinical trials and observational studies. Public funding of research activities is provided through ministries. The Council for Research, Development and Innovation (RVVI) sets national research priorities and facilitates intersectoral coordination of research activities between major stakeholders at the national level, ensuring coherence across sectors. These stakeholders include the Ministry of Health; the Ministry of Education, Youth and Sports, which contributes to the development of human resources relevant for public health preparedness, including higher level and doctoral education; the Ministry of Interior; the Ministry of Defence, and the State Institute for Drug Control. It is important to note that national research infrastructures, such as those of the EXCELES programme and universities, contribute to the development of capacities for preparedness and response. At international level, the Czech Republic is part of several European Research Infrastructure Consortia (ERIC), such as the Czech Clinical Research Infrastructure Network (CZECRIN), an independent network that provides coordinated support for academic and contractual clinical research across the country in the biomedical clinical area. In addition, the Czech Republic is a member of the EU-funded project BE READY PLUS, a hub for coordination of research and innovation introduced in 2026 following the goals of the Strategic Research and Innovation Agenda on Pandemic Preparedness.

National research priorities are set out in concepts which are translated into strategies and programmes to support implementation. The Healthcare Research Concept for 2030⁹ includes public health as a priority for the first time, with sub-chapters addressing health economy, digitalisation of health, demographic change and global health. The Concept also considers RCCE-IM. The aim of adding public health as a priority is to build an institutional foundation that supports new interdisciplinary cooperation between medical and behavioural science. It also considers needs for developing workforces in the field and innovation in the public health system where necessary.

During the COVID-19 pandemic, research activities started quickly due to research institutions being able to pivot and re-allocate resources towards COVID-19-related topics. However, it took until September 2021 to mobilise reserve budgets from the Ministry of Health into a newly added sub-programme for grant-based research funded by the state. New research, development and innovation legislation was introduced in 2025 (Act No 328/2025 Coll.¹⁰) and this will be fully implemented by 2027, allowing shortened timelines for the establishment of grant programmes for public health emergency research.

The pandemic plan for influenza does not refer to strategies for research. Inclusion of research concepts in the PPR that is under development was not considered since such concepts are usually for a specific time period in the Czech Republic. However, a coordination mechanism that also outlines the key actors and their roles and responsibilities with respect to research during an emergency has not been formalised. Addressing this may also offer an opportunity to close the gap between public health information needs and academic research endeavours.

The country is an attractive site for clinical trials of medical products, but this has declined in recent years, similar to the situation in most European countries. The State Institute for Drug Control assesses applications for authorisation/announcement of clinical trials, supervises the course of clinical trials and also supports institutions by providing advice, regulatory workshops and related training courses and linking up partners and organisations. Clinical trials will be further supported by the National Strategy for Clinical Trials of Medicinal Products, which is currently being finalised in a participatory and transparent process, including all relevant stakeholders. Moreover, mechanisms exist to ensure rapid ethical clearance and regulatory authorisation of clinical trials in the event of a public health emergency.

The research sector is not formally embedded in crisis governance and coordination during emergencies relies partly on ad-hoc arrangements. Translation of research into public health decision-making or action was experienced as sub-optimal during the COVID-19 pandemic and a better connection between these two sectors would enable findings to be applied more effectively.

Research is currently facing funding cuts and there is also a need to invest in research to inform and strengthen risk communication, community engagement and infodemic management (e.g. socio-behavioural research).

Recommendations

- Enable research and innovation during emergencies and define a cooperation mechanism, possibly in the PPR, between the research and public health sectors during crises to ensure that the research outputs support the desired public health outcome.
- Include support for projects targeting emergency preparedness and response in the National Strategy for Clinical Trials of Medicinal Products which is currently under development.

Recovery elements (Capacity 15)

The Czech Republic has legal and institutional mechanisms that support recovery following crises, primarily embedded within the broader crisis management and public health legislation. Recovery-related activities are coordinated through governmental crisis and recovery mechanisms, involving key ministries and regional and local authorities, with decision-making taken at government level. Processes are in place to formally terminate crisis situations and return to a standard operational regime, including initial post-crisis assessments of impact and costs.

Recovery activities are implemented following major events such as floods, infrastructure disruptions or the COVID-19 pandemic. In these contexts, assessments of damage and functionality have been conducted, and reports have been produced to inform remedial measures, including subsidy programmes for material damage and targeted corrective actions. After-action reviews or similar evaluative processes have been undertaken in practice by different sectors, regions and institutions, including hospitals, although these are not governed by a single standardised methodology.

Overall, recovery is managed in a largely ad hoc manner and depends on the nature of the event and the stakeholders involved. There is no dedicated, comprehensive national recovery plan in the public health context that systematically links recovery, after-action reviews and the embedding of lessons learned into a structured national action plan. Monitoring recovery implementation across sectors and administrative levels remains a challenge.

⁹ <https://mzd.gov.cz/wp-content/uploads/2022/12/Health-Research-Concept-to-2030.pdf>

¹⁰ <https://www.zakonyprolidi.cz/cs/2025-328>

Amendments to the crisis management framework are under preparation, and there is a plan to better integrate recovery planning into crisis and preparedness plans. Although this presents an opportunity to establish a more systematic approach, there needs to be a focus on the public health aspects of recovery following crises and public health events. The planned PPR is also another opportunity to include the public health aspect of recovery and link recovery, evaluation and future preparedness efforts.

Recommendations

- Include a recovery element in the planned PPR plan and existing crisis plans which includes a public health aspect. This should include a recommendation to conduct lessons learned activities after each crisis using a standardised methodology (e.g. ECDC or WHO) and to develop an action plan to implement the findings.

Actions taken to improve gaps found in the implementation of prevention, preparedness, and response plans (Capacity 16)

The Czech Republic uses multiple mechanisms to identify gaps in prevention, preparedness and response, including lessons emerging from emergencies (in-action and after-action reviews), simulation exercises, sector-specific reviews and assessments coordinated across ministries. Findings from these activities have informed improvements in selected areas, and the country intends to use the results of the PHEPA assessment to further support this process.

However, there is currently no comprehensive national action plan for health security that consolidates recommendations from different reviews, assessments and exercises into a single, structured framework. Action planning remains fragmented across thematic plans (e.g. pandemic preparedness), sector-specific legislation and individual strategies, rather than being guided by a unified, whole-of-government and One Health approach.

The authorities reported that the development of a comprehensive action plan is not currently a national priority, although there is recognition of the added value of a more integrated approach. Plans are underway to conduct a national risk profiling exercise, aligned with the EU Serious Cross Border Threats to Health Regulation, covering multiple hazards and involving interdepartmental cooperation, including civil protection and the Fire Rescue Service.

The intention is that this risk profiling exercise will inform the future development of a more structured action plan, potentially integrating One Health principles and addressing preparedness for both acute events and longer-term risks. At present, however, there is no single national action plan aligned with the National Action Planning for Health Security (NAPHS) model that is costed, implemented and monitored across sectors and administrative levels.

Recommendations

- Allocate sufficient resources to the national risk profiling exercise.
- Develop a NAPHS-type document to integrate the findings from PHEPA and lessons-learned exercises.

Conclusions

The assessment highlights some of the country's strengths, such as the comprehensive legal framework for preparedness and response to crises, the presence of several preparedness and response plans and the establishment of an EOC in the Ministry of Health for national and international coordination. However, it also shows the critical importance of adopting a comprehensive and overarching generic prevention, preparedness and response (PPR) plan with a One Health approach, a streamlined governance structure, defined roles and responsibilities, and standard operating procedures to facilitate coordinated and timely action. There is also a need to reinforce the role of the Ministry of Health in the coordination of preparedness and response to public health emergencies across governmental levels and sectors.

It is recommended that a methodology is developed for the risk assessment of public health threats and the ongoing risk profiling analysis is finalised and regularly updated, so that it can feed into overall preparedness planning. A standard methodology for national risk assessment would improve timely early warnings to relevant stakeholders of ongoing health threats, especially in the early phase of an event, and facilitate a rapid and effective response. Regular risk profiling will aid the national authorities in prioritising the most significant and emerging risks, including directing resources where they are most needed, and ensuring that the PPR planning remains aligned with a changing threat landscape.

The national laboratory system should sustain its emphasis on quality and accreditation and the implementation of national quality standards, as this is crucial for accurate and reliable diagnostics. Clinical microbiological and genomic surveillance data should be integrated with epidemiological surveillance data at national level, along with a strategy for laboratory capacity scale-up, including diagnostic testing and WGS. All this should be incorporated or linked to the generic PPR plan to ensure alignment with wider preparedness and response framework.

Completing and fully operationalising the automated, integrated surveillance system is another key priority. Ensuring its long-term sustainability through secure funding, adequate and trained staffing, and enhanced analytical expertise of the workforce will further improve the surveillance outputs and support evidence-based decision-making. For antimicrobial resistance and healthcare-associated infection surveillance, a timely indicator-based surveillance should be set up at both national and regional levels and the approval, implementation and funding for the National Action Plan on AMR should be ensured.

To fully implement the One Health approach, a broader integration of environmental aspects into public health emergency preparedness and response is essential. Responsibilities for the prevention and control of zoonoses and threats of environmental origin should be further defined and operationalised, with mechanisms for joint risk assessment and cross-sectoral evidence-based guidance developed across sectors and institutions.

Finally, ensuring sufficient and sustainable staffing and financial resources across all public health functions is fundamental for sustained prevention, preparedness and response to public health emergencies. With recruitment and retention of skilled professionals being consistently reported as a limitation across several areas, incentives to attract and retain public health workforce should be strongly considered to ensure and strengthen the operational capability of public health institutions, and the system as a whole, in both routine and emergency contexts.

Annex 1. List of capacities included in the assessment

Table 1A. List of capacities included in the assessment

Capacity no.	Capacity name
Capacity 1.	International Health Regulation (IHR) implementation and coordination
Capacity 2.	Financing
Capacity 3.	Laboratory
Capacity 4.	Surveillance
Capacity 5.	Human resources
Capacity 6.	Health emergency management
Capacity 7.	Health service provision
Capacity 8.	Risk communications and community engagement (RCCE)
Capacity 9.	Points of Entry (PoEs) and border health
Capacity 10.	Zoonotic diseases and threats of environmental origin, including those due to the climate
Capacity 11.	Chemical events
Capacity 12.	Antimicrobial resistance (AMR) and healthcare-associated infections
Capacity 13.	Union level coordination and support functions
Capacity 14.	Research development and evaluations to inform and accelerate emergency preparedness
Capacity 15.	Recovery elements
Capacity 16.	Actions taken to improve gaps found in the implementation of prevention, preparedness and response plans

Annex 2. Practical arrangements for the assessment process

Assessment team and national experts

Assessment team

The experts involved in this assessment are detailed in the table below.

Members of the assessment team			
Name	Institution	Role in the team	Capacities assessed
Gianfranco Spiteri	ECDC	PHEPA Team Lead and capacity lead	1, 4, 11, 15, 16
Barbora Kinross	ECDC	PHEPA coordinator and capacity lead	1, 2, 8, 10, 11, 13
Stefania De Angelis	ECDC	Capacity lead	5, 6, 7, 14
Carmen Varela Santos	ECDC	Capacity lead	7, 9, 10, 12, 14
Hanna Merk	ECDC	Capacity lead	2, 3, 4, 5, 12
Luisa Hallmaier-Wacker	ECDC	Capacity lead	4
Maximilian Riess	ECDC	Capacity lead	3, 8, 12, 14,
Martina Karzel	DG SANTE B2	Expert	1, 6, 9, 13, 15, 16
Maria Del Carmen Sanz-Urdin	DG HERA	Expert	6
Peter Sousa Hoejskov	WHO Europe	Expert	1, 6, 10

National experts supporting the document sharing

This section indicates the national focal points that coordinated the implementation of the PHEPA at country level and acted as ECDC contact points. In addition, the table includes information about the national experts that have access to the SharePoint site set up by ECDC and support the document collection and sharing with the assessment team for phase 1: the desk review.

Country focal point(s) and experts involved in the document sharing process			
Name	Email address	Organization	Role (focal point/document sharing)
Tomáš Kotěšovec	tomas.kotesovec@mzcr.cz	Ministry of Health	Focal point and document sharing
Tomáš Tóth	tomas.toth@mzd.gov.cz	Ministry of Health	Focal point and document sharing
Tomáš Čermák	tomas.cermak@mzcr.cz	Ministry of Health	Focal point and document sharing

National experts participating in the assessment process

National experts participating in the assessment process			
Name	National institution	Role in assessment	Main capacity to assess
Lucie Bareková	National Institute of Public Health	Expert	12
Ivana Bejdová	Ministry of Agriculture	Expert	6, 10
Miloslav Beneš	Faculty Hospital Plzeň	Expert	6
Jana Benová	Czech Association of Pharmaceutical Companies	Expert	6
Tomáš Boráň	State Institute for Drug Control	Expert	6, 14
Iva Brejzová	The General Directorate of Fire Rescue Service of CR	Expert	9
Pavel Březovský	National Institute of Public Health	Expert	4
Daniel Cihlár	Ministry of Defence	Expert	10
Tomáš Čermák	Ministry of Health	Coordinator	9
Jan Daňhelka	Czech Hydrometeorological Institute	Expert	10
Jozef Dlhý	Ministry of Health	Expert	
Kristýna Dražanová	State Office for Nuclear Safety	Expert	6
Lenka Duchajová	Ministry of Health	Expert	
Tereza Magdaléna Dvořáčková	Ministry of Agriculture	Expert	
Kateřina Fabiánová	National Institute of Public Health	Expert	4
Dagmar Felklová	Ministry of Health	Expert	13
Matyáš Fošum	Ministry of Health	Expert	1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16
Markéta Galiová	Ministry of Health	Coordinator	6
Roman Gřegoř	Society for Emergency and Disaster Medicine	Expert	7
Jakub Haas	Ministry of Finance	Coordinator	2
Marián Hajdúch	Research, Development and Innovation Council	Expert	14
Dana Hedlová	National Institute of Public Health	Expert	12
Jaroslava Hejdová	Ministry of Health	Expert	2, 15
Barbora Honzejková	The General Directorate of Fire Rescue Service of CR	Expert	11
Jakub Horecký	Ministry of Environment	Expert	10
Vladislav Jakubů	National Institute of Public Health	Expert	
Tomáš Jarosil	State Veterinary Administration	Expert	
Sabína Jelinková	Ministry of Environment	Expert	11
Eduard Ježo	Public Health Institute	Expert	3
Blanka Kavková	Ministry of Health	Coordinator	7
Eliška Kazdová	Ministry of Health	Coordinator	8
Helena Kazmarová	National Institute of Public Health	Expert	10
Marie Klečková	RPHA South Bohemia	Expert	2, 5, 6, 9, 10, 12
Tomáš Kotěšovec	Ministry of Health	Coordinator	15
Antonín Koukal	Faculty Hospital Brno	Expert	6
Vratislav Kozák	Ministry of Education, Youth and Sports	Coordinator	14
Jana Kozáková	National Institute of Public Health	Coordinator	10
Milan Kozelka	Ministry of Defence	Expert	10
Lenka Krafková	Ministry of Health	Coordinator	14
Klára Kroupa Němcová	State Navigation Administration	Expert	9
Jakub Kubát	Institute of Health Information and Statistics	Expert	4

National experts participating in the assessment process			
Name	National institution	Role in assessment	Main capacity to assess
Kateřina Kybicová	National Institute of Public Health	Expert	10
Jan Kynčl	National Institute of Public Health	Coordinator	4
Zdeněk Kyselý	Ministry of Health	Coordinator	1,5,13,16
Olga Laaksonen	Ministry of Health	Expert	5, 14
Radomíra Limberková	National Institute of Public Health	Expert	4
Barbora Macková	Ministry of Health	Expert	1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16
Jan Mach	Ministry of Finance	Expert	2
Andrea Mančíková	National Institute of Public Health	Expert	10
Martina Marešová	RPHA Prague	Expert	3, 4
Daniel Maršálek	Prague Airport	Expert	9
Jan Michálek	Ministry of Health	Expert	5
Marek Michna	Ministry of Health	Expert	
Martin Novák	Czech Hydrometeorological Institute	Expert	10
Hana Orliková	National Institute of Public Health	Expert	10, 13
Petr Pajer	Ministry of Defence	Expert	3
Bohdan Pavelka	State Material Reserves Administration	Expert	6
Aneta Pierzynová	State Veterinary Administration	Expert	9
Miroslav Pokorný	Customs Administration	Expert	9
Silvie Přibyllová	State Veterinary Administration	Expert	
Hana Roháčková	Faculty Hospital Bulovka	Expert	4
Marek Slabý	AZZS ČR	Expert	6
Daniela Slavičková	Ministry of Environment	Coordinator	10
Pavel Slezák	National Institute of Public Health	Expert	4
Jitka Sosnovcová	National Institute of Public Health	Coordinator	3
Petr Svoboda	AZZS ČR	Expert	6
Jiří Sýkora	RPHA Prague	Expert	3, 5, 9, 10, 12
Dana Šalamunová	RPHA Central Bohemia	Expert	8
Petr Šatrán	State Veterinary Administration	Expert	
Ondřej Šedivka	Society for Emergency and Disaster Medicine	Expert	7
Michaela Špačková	National Institute of Public Health	Expert	10
Jakub Švehla	Police of the Czech Republic	Expert	9
Ruth Tachezy	BIOCEV	Expert	3
Martin Tilcer	The General Directorate of Fire Rescue Service of CR	Coordinator	11
Tomáš Tóth	Ministry of Health	Expert	
Tomáš Troch	Ministry of Health	Expert	2
Jaroslav Valůch	Ministry of Interior	Expert	8
Jan Váňa	State Veterinary Administration	Coordinator	10
Stanislav Verosta	Ministry of Health	Expert	6
Michael Vít	National Institute of Public Health	Expert	11
Veronika Vlasáková	State Veterinary Administration	Coordinator	10
Libuše Vlasáková	Ministry of Environment	Expert	
Ondřej Vosátka	Customs Administration	Expert	9
Hana Zákoucká	National Institute of Public Health	Expert	3
Helena Žemličková	National Institute of Public Health	Coordinator	12
Klára Žižková	Ministry of Health	Expert	4

Agenda for the in-country visit

Monday 16.2.		Tuesday 17.2.		Wednesday 18.2.	Thursday 19.2.	Friday 20.2.	
Welcome & Registration 08:30-09:00		Registration 08:30-09:00		Registration 08:30-09:00	Registration 08:30-09:00	Internal assessment team meeting 08:30-10:00	
Opening Remarks (country) 09:00-09:15		Breakout room 1 C.3 Laboratory (Assessment of in-depth capacities) 09:00-10:30	Breakout room 2 C.6 Health Emergency Management - planning, IMS, risk profiling, PHSM (Assessment of in-depth capacities) 09:00-10:30	C.5 Human Resources 09:00-09:45			C.13 Union level coordination 09:00-10:00
Overview and key aspects of the assessment process (ECDC and DG SANTE F2) 09:15-09:45				C.7 Health Service Provision 09:45-10:30			
Overview of the country public health structure, prep and resp mechanisms and generic and specific plans available relevant to the assessment (country) 09:45-10:30							
Coffee Break 10:30-11:00		Coffee Break 10:30-11:00		Coffee Break 10:30-11:00	C.9 PoE 10:00-11:00	Main findings, conclusions, recommendations and next steps (ECDC presentation and discussion with Country) 10:00-11:30	
Assessment of Cross-Cutting Aspects – Scenario based discussion 11:00-12:30		Breakout room 1 C.3 Laboratory (Assessment of in-depth capacities) 11:00-12:30	Breakout room 2 C.6 Health Emergency Management - planning, IMS, risk profiling, PHSM (Assessment of in-depth capacities) 11:00-12:30	C.2 Financing 11:00-11:45	Coffee Break 11:00-11:30		
				C.11 Chemical events 11:45-12:30	C.15 Recovery and C.16 Action plan (together in the same session) 11:30-12:30		
Lunch 12:30-13:30		Lunch 12:30-13:30		Lunch 12:30-13:30	Lunch 12:30-13:30	Summary (findings, conclusions, recommendations and next steps) with high-level representatives 11:30-12:00	
Breakout room 1 Capacity 10. Zoonotic diseases and threats of environmental origin, including those due to the climate (Assessment of in-depth capacity) (ECDC and DG SANTE F2 joint) 13:30-15:00		Breakout room 1 C.12 AMR/HAls (Assessment of in-depth capacities) 13:30-15:00	Breakout room 2 C.6 Health Emergency Management - Medical Counter Measures (Assessment of in-depth capacities) 13:30-15:00	C.14 Research 13:30-15:00	Buffer for further in-depth discussion Wrap-up session 13:30-15:00	Concluding remarks (country) 12:00-12:30	
Coffee Break 15:00-15:30						Coffee Break 15:00-15:30	
Breakout room 1 Capacity 10. Zoonotic diseases and threats of environmental origin, including those due to the climate (Assessment of in-depth capacity) (ECDC and F2 joint) 15:30-17:00		Breakout room 3 C.4 Surveillance (Assessment of in-depth capacities) 15:30-17:00	Breakout room 1 C.12 (Assessment of in-depth capacities) 15:30-17:00	Breakout room 2 C.6 Health Emergency Management - Medical Counter Measures (Assessment of in-depth capacities) 15:30-17:00	C.1 IHR 15:30-16:15 / RCCE-IM?	Internal assessment team meeting 15:00-17:00	
Coffee Break 15:00-15:30							
Wrap-up Day 1 (ECDC and F2 together with country) 17:00-17:30							

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