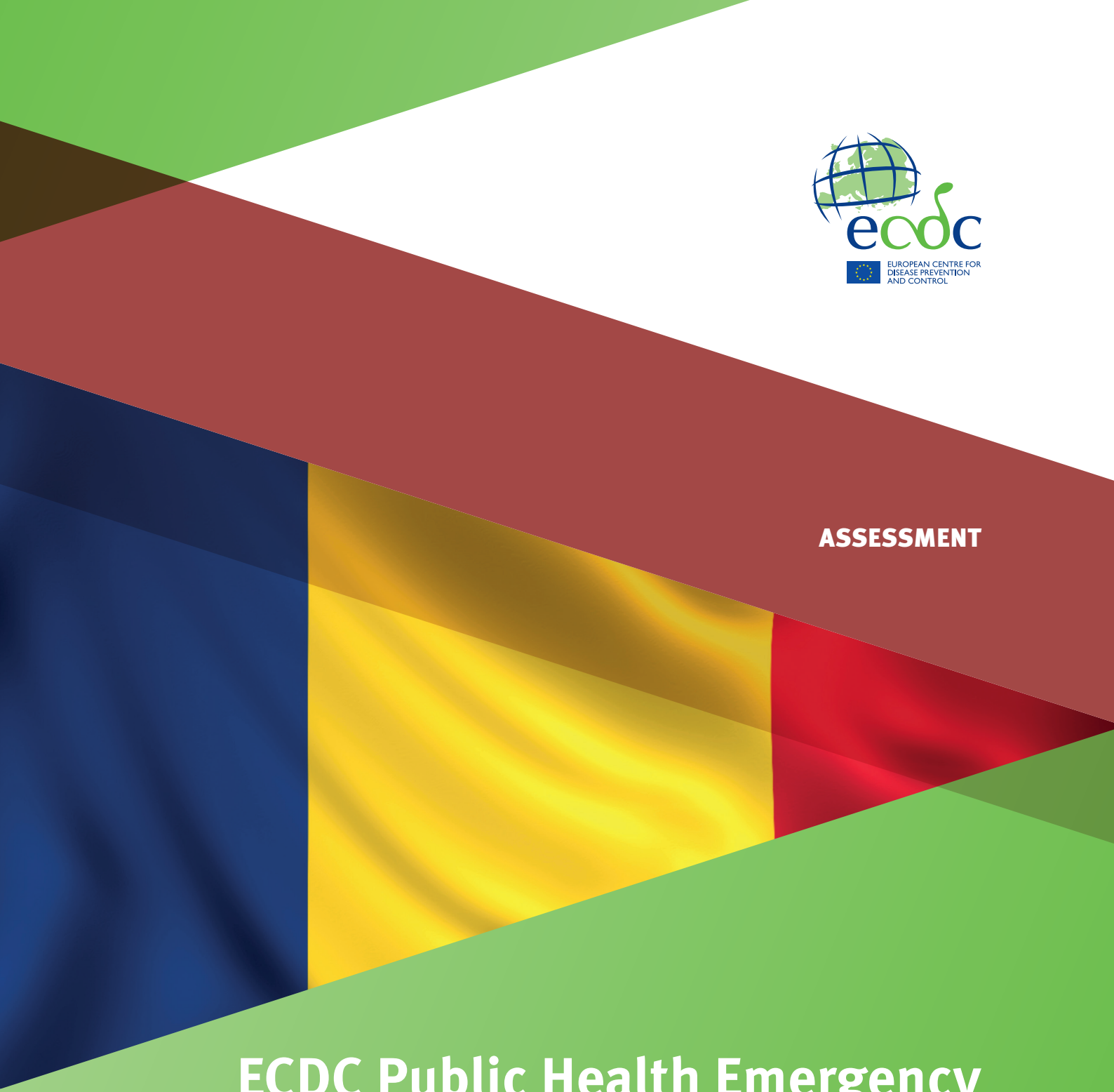


ASSESSMENT

ECDC Public Health Emergency Preparedness Assessment for Romania, 2026

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

ECDC ASSESSMENT

Country report: Public Health Emergency Preparedness Assessment for Romania, 2026

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



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Abbreviations

AMR	Antimicrobial resistance
ANRSPS	National Administration of State Reserves and Special Issues
ANSVSA	National Sanitary Veterinary and Food Safety Authority
ARI	Acute Respiratory Infection
BSL	Biosafety Laboratory
CBIT Babeș	Clinical Hospital of Infectious and Tropical Diseases 'Victor Babeș'
CBRN	Chemical, Biological, Radiological and Nuclear
CLP	Classification, Labelling and Packaging (Regulation)
CLSU	Local Emergency Situation Committees
CNAS	National Health Insurance House
CNCCI	National Intervention Coordination and Management Centre
CNMRMC	National Centre for Monitoring Risks in the Community Environment
CNSCBT	National Centre for Communicable Diseases Surveillance and Control
CRSP	Regional Public Health Centres
DG SANTE	(EU) Directorate-General for Health and Food Safety
DSP	County Public Health Directorate
DSU	Department for Emergency Situations
ECDC	European Centre for Disease Prevention and Control
ECHA	European Chemicals Agency
EEA	European Economic Area
EOC	Emergency Operations Centre
EQA	External Quality Assessment
ESIR	Electronic System for Inventory Reporting
EU	European Union
EU FAB	European Future-proofed Advanced manufacturing capacity
EU-HIP	EU Health Information Platform project
EU-WISH	EU Wastewater Integrated Surveillance for Public Health
EURL-PH	European Union Reference Laboratory for Public Health
EWRS	Early Warning and Response System
FNUASS	National Health Insurance Fund
GP	General Practitioner
HAI	Healthcare-associated infection
HERA	(EU) Health Emergency Preparedness and Response Authority
HSC	Health Security Committee
IDSA	Diagnosis and Animal Health Institute
IGSU	General Inspectorate for Emergency Situations
IHR	International Health Regulations
ILI	Influenza-like Illness
INBIMB	National Institute of Infectious Diseases 'Matei Balș'
INCDMM	National Institute for Medico-Military Research and Development 'Cantacuzino'
INSP	National Institute of Public Health
IPC	Infection Prevention and Control
IPMN	National Institute of Pulmonology 'Marius Nasta'
JADE	Joint Assessment and Detection of Events (WHO exercises)
LNSP	National Laboratory for Public Health
MCI	Mass Casualty Incident
NAAT	Nucleic Acid Amplification-based Test

NGS	Next Generation Sequencing
NPMTIS	National Poisoning Monitoring and Toxicological Information System
ONAC	National Office for Centralized Procurement
PCR	Polymerase Chain Reaction
PHEPA	Public Health Emergency Preparedness Assessment
RAMP UP	EU mechanism for scaling production of medical countermeasures
RENAR	Romanian Accreditation Association
ReSanMed	National Registry of Health Risks in Relation to Environmental Factors
ReTox	Toxicological registry system
RSV	Respiratory Syncytial Virus
RUBT	Single Register of Communicable Diseases
SARI	Severe Acute Respiratory Infection
SCBTH	Serious Cross-Border Threats to Health (EU Regulation)
SMURD	Mobile Emergency Service for Resuscitation and Extrication
SOP	Standard Operating Procedure
SPAR	State Party Self-Assessment Annual Report
UCPM	EU Civil Protection Mechanism
UN	United Nations
UPU/CPU	Emergency Reception Unit/Emergency Department
VEBIS	Vaccine Effectiveness, Burden and Impact Studies
WHO	World Health Organization
WNV	West Nile Virus
WWS	Wastewater surveillance

Executive summary

Introduction

The aim of the Public Health Emergency Preparedness Assessment, as mandated in Article 8 of the Regulation (EU) 2022/2371 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. 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 Romania. This involved a desk review of relevant documents, followed by a five-day country visit that took place between 20 April and 24 April 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 Chemical events (Capacity 11).

Key findings

Romania's public health system is structured around a centrally coordinated but decentralised model, with the Ministry of Health providing strategic leadership and the National Institute of Public Health (INSP) ensuring technical and scientific coordination. Implementation, largely at sub-national level, is carried out through County Public Health Directorates (DSPs), supported by a well-established surveillance and laboratory network. The system benefits from a solid legal framework, clearly defined institutional roles, and established mechanisms for emergency response, particularly through strong cooperation with the Ministry of Internal Affairs.

Overall, the system demonstrates important strengths. It is supported by a comprehensive governance and legal framework, which provides mandates and responsibilities. A strong tradition in civil protection and emergency response enhances operational readiness, particularly in acute crisis situations. Committed and experienced staff, often supported by informal professional networks, contribute significantly to maintaining functionality across levels. Ongoing digitalisation initiatives provide a foundation for further modernisation, improved data management, and increased system efficiency, while the National Health Strategy 2023 to 2030 provides overall strategic direction.

At the same time, several cross-cutting challenges affect system performance. Limited financial and human resources continue to place strain on both routine public health functions and emergency preparedness capacities. Workforce shortages, particularly at sub-national level, and an uneven distribution of expertise across the country reduce the system's ability to respond consistently across regions. Coordination between institutions and sectors remains an area for improvement, with reliance on informal mechanisms often compensating for insufficiently formalised collaboration structures.

The system's strong reliance on legal acts and formal procedures, while providing structure, may also limit flexibility and timely adaptation during rapidly evolving health threats. Preventive capacities remain relatively weak, as illustrated by low vaccination coverage for routine immunisation and emergency campaigns, highlighting gaps in public trust and health communication. The private healthcare sector is not consistently integrated into preparedness and response planning, which may complicate mobilisation of the overall healthcare workforce and workforce coordination during crises.

Overall, while Romania has a solid and well-structured public health system with strong emergency response capabilities, addressing constraints in resources, coordination, flexibility, and prevention will be essential to enhance resilience and ensure a more balanced and effective preparedness approach.

Main recommendations for each capacity assessed in depth

Health emergency management (Capacity 6)

- Conduct a national prioritisation exercise for serious cross-border threats to health involving and/or including pathogens.
  - The final prioritised list of pathogens can be used to inform a range of emergency planning activities, such as formulating operational plans, the Concept of Biosecurity and identifying crisis-relevant medical countermeasures (MCMs) to be included in the stockpile.
- Develop/update operational plans (or SOPs) for priority pathogens which are needed to complement the framework for the management of epidemics.
  - The operational plans or SOPs should reflect the final prioritisation list of pathogens and should follow the same levels of escalation as those defined in the National Concept for Epidemics.
- Finalise and test the 'Concept of Biosecurity'.
- Establish a testing strategy focusing on desktop exercises, involving outbreak scenarios and engaging all relevant national actors, to test the coordination between all stakeholders including various aspects of the health system.
- Ensure that supply and demand is monitored across MCM categories, consolidating the stockpiling data and aligning with the Union-level reporting requirements under Council Regulation (EU)2022/2372.
- Integrate crisis-relevant MCM into emergency plans, consolidating provisions for stockpiling, manufacturing, supply chain management, and innovation, with a coherent description of how different MCM interventions complement one another.

Laboratory (Capacity 3)

- Officially designate and recognise National Reference Centres (National Reference Laboratories for Human Pathogens), including clear designation criteria, responsibilities and operational arrangements, to clarify and strengthen their central role in surveillance and during public health emergencies.
- Establish a competent body responsible for the authorisation and oversight of BSL-3 laboratories and the activities conducted within them, ensuring coordinated governance and regular verification of infrastructure, operational practices, staff training, waste management and standard operating procedures.
- Integrate laboratory data, including molecular typing and sequencing data, into existing and future electronic surveillance and reporting systems to ensure interoperability and avoid the development of parallel laboratory-specific reporting platforms.
- Define the accreditation standard and scope applicable to all medical analysis laboratories under the National Health Strategy 2023–2030 and assess progress towards the laboratory accreditation objectives established under the Strategy's monitoring framework and indicators.

Surveillance (Capacity 4)

- Automate data processes (e.g. cleaning and validation, and preparation of outputs).
- Improve respiratory surveillance data according to World Health Organization (WHO)/European Centre for Disease Prevention and Control (ECDC) guidance, including Severe Acute Respiratory Infection (SARI) year-round surveillance and tests/detections for all viruses.
- Assess the feasibility of participating in European mortality monitoring activities (EuroMOMO) and develop the technical and institutional arrangements required for routine mortality reporting.
- Formalise collaboration with academia to take advantage of skills and expertise not available to INSP.

Antimicrobial resistance and healthcare-associated infections (Capacity 12)

- Reactivate the National Committee for Limiting Antimicrobial Resistance and the National Committee for the Prevention and Limitation of Healthcare-Associated Infections to fulfil their mandates in supporting operationalisation of the 'National Strategy for preventing and limiting healthcare-associated infections and combatting antimicrobial resistance in Romania for 2023–2030'. Ensure that these committees facilitate the actions of responsible institutions, as outlined in the National Strategy.
- Accelerate the establishment of a dedicated national reference laboratory for AMR. Some necessary national reference laboratory functions include supporting quality AMR testing in laboratories across the country, cluster/outbreak detection and investigation, and conducting timely AMR surveillance with a reliable network of laboratories.
- Complete the ongoing digitalisation of antimicrobial resistance (AMR) and healthcare-associated infection (HAI) surveillance, shifting scarce human resources skilled in HAI and AMR control from data collection/reporting activities to prevention and control activities. Automation and digitalisation of surveillance allow further focus on data interpretation and use of these data to guide effective prevention and control activities.
- Implement a package of actions to address carbapenem-resistant organisms. Control of carbapenem-resistant organisms requires a coordinated effort between public health authorities, laboratories, and healthcare facilities for timely detection, epidemiological investigation, and infection control specifically for these organisms. Appropriate antimicrobial use is also critical for prevention and control of carbapenem resistance. These activities require a defined plan, budget, and timelines with implications for multiple stakeholders.

Chemical events (Capacity 11)

- Ensure that all relevant agencies participate in capacity building exercises, irrespective of who organises them (e.g. JADE exercises).
- Create a multi-sectoral, multi-layered coordination mechanism (or equivalent) that anchors collective capacity building ownership and sustained collaboration among the different ministerial actors in relation to health and public health.
- Collectively identify and prioritise health threats related to chemicals.

Conclusions

This assessment indicates that the country's public health emergency preparedness system is built on well-established structures whose effectiveness depends on how well they are mobilised and coordinated under pressure. Romania benefits from a strong institutional foundation and dedicated expertise, providing a solid basis for responding to acute crises. However, overall performance is shaped by how effectively these capacities work as a coherent, flexible, and integrated system. While coordination mechanisms exist, their effectiveness can vary, particularly in rapidly evolving situations, pointing to the need for stronger alignment and coordination the whole system.

The assessment also highlights the importance of strengthening prevention and preparedness functions, including risk communication and community engagement, to complement strong response capacities. In parallel, workforce sustainability and improved data use emerge as critical enablers of resilience.

Overall, the country possesses the potential to build upon its strengths, with future progress depending on greater integration, improved coordination, and a stronger focus on prevention across the system.

Introduction

The aim of the Public Health Emergency Preparedness Assessments, as mandated in Article 8 of the 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 Romania. 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 health[1].

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 Regulation[2], 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 to the Union prevention, preparedness and response plan are defined by the Commission Delegated Regulation (EU) 2024/1232, adopted in March 2024[4].

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 that some adaptations may need to be made based on national 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 receiving 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 instances of good practice, challenges, bottlenecks, gaps or areas for improvement concerning the 16 capacities referred to in Article 7 (a list of the capacities is available in Annex 1).
- Encourage the inclusion of key elements of 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 previous public health emergency responses.
- Convene the main stakeholders from all relevant administrative levels and sectors.
- Use the standardised assessment process as an opportunity to improve EU/EEA wide prevention, preparedness and response capacities by promoting a common understanding of key elements and a coordinated approach, as well as by creating a community of practice.
- Support countries' enhancement of their national prevention, preparedness, and response capacities by providing recommendations based on the assessment, and tailored assistance upon request.

Assessment process

An ECDC-led team composed of seven ECDC experts and five experts from the Directorate-General for Health and Food Safety (DG SANTE), the European Chemicals Agency (ECHA), the EU Health Emergency Preparedness and Response Authority (DG HERA), WHO and Spain was assembled to conduct the assessment, in collaboration with the country focal point and national experts from Romania. The assessment process consisted of a desk review phase and a country visit that took place between 20 April and 24 April 2026.

In accordance with the established process, the team reviewed Romania'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 Chemical events (Capacity 11).

The assessment mission benefited from a highly open and transparent collaboration with the host country. Key documentation supporting the evaluation of various capacities was provided in advance, allowing the assessment team to gain a solid understanding of existing structures and prepare effectively for the visit. During the coordination phase, a series of meetings were organised alongside the document review, where dedicated teams engaged in focused exchanges on the capacities under detailed assessment. Throughout the one-week country visit, the assessment team held constructive and collaborative discussions with a wide range of key stakeholders. The focal point team's experts demonstrated strong commitment by thoroughly planning and coordinating both the preparatory meetings and the Public Health Emergency Preparedness Assessment (PHEPA) country visit.

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

Main findings and overarching recommendations

Romania's public health system operates within a Bismarck type model, financed primarily through compulsory health insurance contributions and complemented by state funding for public health programmes. While healthcare services are mainly financed through the National Health Insurance House, public health functions such as prevention, surveillance, and health promotion are the responsibility of the Ministry of Health. The system combines strong central coordination with decentralised implementation at regional and county levels.

The Ministry of Health serves as the central authority, responsible for setting policies, developing strategies, financing national public health programmes, and coordinating responses to health threats and emergencies. It also represents the country in international health frameworks. Supporting the Ministry, the National Institute of Public Health (INSP) provides scientific and technical expertise and ensures methodological coordination across the system. Its work spans key areas including communicable and non-communicable diseases, environmental health, health promotion, public health statistics, and laboratory services.

INSP is organised into five specialised centres covering communicable disease surveillance and control, environmental health risks, non-communicable diseases, and health information systems, alongside a national laboratory component. A central role is played by the National Centre for Surveillance and Control of Communicable Diseases (CNSCBT), which leads activities related to disease surveillance, risk assessment, epidemic intelligence, preparedness, and outbreak response. The INSP also has seven Regional Public Health Centres (CRSPs).

Public health implementation is largely carried out at sub-national level through County Public Health Directorates. There are 42 of these directorates, and they act as the operational arms of the Ministry of Health. Their responsibilities include monitoring population health, conducting surveillance, investigating outbreaks, enforcing public health measures, and coordinating with local healthcare providers. Hospitals, laboratories, and primary care providers are required by law to report communicable diseases to these authorities, ensuring the functioning of the national surveillance system.

Romania has an established surveillance system that covers a wide range of communicable diseases and public health risks. Reporting obligations are clearly defined, with certain diseases requiring immediate notification. Data collected at the local level are transmitted to national databases, where they are analysed and used to guide decision-making. An early warning system is in place to detect unusual events and potential outbreaks, enabling timely public health responses.

The laboratory system has a multi-level structure to support surveillance and response activities. It includes the national public health laboratory, regional laboratories, and county-level laboratories. These are complemented by specialised institutions that provide reference diagnostic capacity. The laboratory network plays a critical role in confirming cases, monitoring trends, and supporting outbreak investigations.

Public health in Romania also involves collaboration across multiple sectors, with the Ministry of Internal Affairs, the Ministry of Defence, and the National Sanitary Veterinary and Food Safety Authority (ANSVSA) contributing to areas such as emergency management, zoonotic disease control and food safety.

Overall, the Romanian public health system is characterised by centralised policy direction and decentralised execution, supported by a structured surveillance and laboratory network. While the system has strong foundations in communicable disease control and emergency response, it is still evolving, and efforts are ongoing to strengthen coordination, digitalisation and integration across sectors.

Although there are a number of persistent challenges that affect its overall performance and resilience, Romania's public health system demonstrates several notable strengths. On the one hand, the country benefits from a well organised public health structure, supported by a generally robust governance and legal framework. This provides a clear institutional foundation for surveillance, preparedness, and response activities. The system is further strengthened by engaged and committed staff, who often rely on strong informal networks to facilitate communication and coordination across levels. Romania also has a long-standing tradition in civil protection and health emergency response, with the Ministries of Health and Interior playing central roles in managing crises. In addition, ongoing digitalisation processes offer promising opportunities to improve efficiency, data sharing, and decision making across the system. These efforts are complemented by the National Health Strategy 2023 to 2030, which sets out a strategic direction for further development and reform.

At the same time, several challenges continue to place the system under strain. Limited financial resources and workforce capacities constrain both routine public health functions and emergency response capabilities. One area for improvement is inter-institutional collaboration and coordination, particularly in a context where responsibilities are distributed across multiple actors. Although legal acts and formal orders provide structure, the strong reliance on these instruments can sometimes limit flexibility in rapidly evolving situations if not complemented by operational guidance and coordination mechanisms. There are also difficulties with the implementation of preventive efforts, as reflected in the relatively low vaccination coverage for both routine immunisation and emergency campaigns for measles, mumps, rubella and COVID-19. This indicates a need for sustained investment in prevention and public trust. Finally, the private healthcare sector is not fully or consistently integrated into public health planning and response, which may create operational and contractual challenges during crises, further complicating system-wide coordination.

Overall, while Romania's public health system is built on solid institutional and operational foundations, a concerted approach is required to accelerate the transition towards a focus on health resilience across the health sector. Addressing these structural and functional challenges will be the key to strengthening the resilience and effectiveness of the system.

Recommendations

- Strengthen and streamline inter-institutional collaboration by ensuring alignment and consistency across mandates, preparedness plans, and coordination mechanisms.
- Maximise the use of national and EU funding opportunities (including EU4Health, civil-military cooperation initiatives and other Union instruments) to strengthen health resilience, laboratory capacity, workforce sustainability and preparedness systems.
- Develop and implement a coordinated strategy to address misinformation and disinformation during routine operations and public health emergencies.
- Increase routine vaccination coverage and strengthen evidence-based interventions to reduce vaccine-preventable morbidity and mortality while improving trust in health authorities. Ensure interoperability and systematic use of surveillance, laboratory, AMR, HAI and emergency management information systems to support public health decision-making.
- Develop mechanisms to expand and sustain public health workforce capacity during peacetime and crises, including through engagement of academic institutions, medical students, private-sector expertise and surge-capacity arrangements.

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

Romania has an all-hazards national emergency management system, where epidemics are included as a specific risk.

A number of legal documents, along with the National Strategy for Health 2023–2030 and the National Concept for Response to Epidemics from the Ministry of Interior, and the relevant Ministry of Health Regulation on the management of emergencies generated by epidemics were provided, along with the description of the National Emergency Management System and the law describing the Management of Risks. The National Concept for Response to Epidemics, and the Regulation on the management of emergency situations generated by epidemics and the risks associated with them provide the operational framework for managing epidemics across institutions. These institutions include the Ministry of Health; the Department for Emergency Situations (DSU/Ministry of Internal Affairs); the National Institute of Public Health (INSP); County Public Health Directorates (DSPs) and Local Emergency Situation Committees (CLSU).

The levels of response are from 0 to Level 2, where Levels 0 and 1 are managed locally and Level 2 nationally. The organisation of the National Committee of Emergency Situations is also described. This body is defined as the main decision-making committee in major emergency situations, led by the Prime Minister, and including the Minister of Health.

Romania has a strong emergency response system, led by the Department of Emergency Situations (DSU) in the Ministry of Internal Affairs. This civil-protection-led response focuses on first-response operations and is well-equipped in terms of detection, response vehicles and staff trained in emergency medicine who are able to respond to various types of disasters (earthquakes, flooding, traffic accidents, chemical accidents, etc.). DSU has an Emergency Operations Centre (EOC) which operates on a daily basis for the management of emergency care (ambulance service and emergency departments). A special facility for responding to large events is available with higher-level equipment. The Ministry of Health has its own Emergency Operations Centre (EOC) which also operates 24/7, requiring continued coordination arrangements to ensure interoperability and rapid joint action between the two ministries during emergencies.

The Department of Emergency Situations has a strong culture of assisting other countries in the EU/EEA (e.g. during the COVID-19 pandemic or assisting in the management of large forest fires, earthquakes, etc.). They are an active contributor to the rescEU mechanism of the European Civil Protection and Humanitarian Aid Operations (DG-ECHO) and use the Union Civil Protection Mechanism (UCPM) frequently. At the same time, they have a strong culture of conducting annual simulation exercises (field and tabletop) which maintain their operational readiness for response to disasters and other events (e.g. Mass Casualty Incidents (MCIs)).

The framework for the response to disasters, which includes scenarios involving epidemics and epizootics, is well structured. It describes responsibilities at the various levels of administration, however it is hampered by the existence of multiple legal documents. We examined and discussed a small number of operational plans (e.g. pandemic influenza from 2010, avian influenza) and stressed the need for flexibility of response. A good example of an integrated operational plan was presented by the department of blood safety for the response to the annual circulation of West Nile Virus (WNV) in the country. Although a list of high-risk diseases is mentioned in some documents, this information was not validated during the discussion and, if it exists, it is probably outdated.

According to the plans and the administrative structure of Romania, staff at the local level (42 county-level departments) are required to handle their own crises, including outbreaks, which are usually managed in collaboration with the Regional Public Health Centres (seven) and the INSP, as needed. The capabilities at sub-national levels vary (e.g. epidemiology expertise or laboratory capacity may be reduced or lacking). Each county has a predefined emergency threshold. Once this is exceeded, national coordination centres are informed, and support from neighbouring counties or national resources is mobilised. For specific high-risk scenarios (e.g. earthquakes), predefined automatic deployment rules exist to address likely communication failures. Early coordination at the prefect level, involving all key actors to avoid loss of response time, was identified as a need during discussions.

Each hospital is also required to have its own Incident Management Plan ('White Plan') based on severity levels. These are tailored to hospital type (emergency versus chronic care) and hospitals are required to update their plans periodically (particularly after incidents) and test them through exercises.

Risk assessment for an incident involving an outbreak depends on the regional public health and/or INSP experts who give their assessment to the DSU and/or the National Committee of Emergency Situations. No specific methodology is available; ECDC risk assessments are used as needed.

With regard to the implementation of public health and social measures during the COVID-19 pandemic, the proposal for each measure was developed by the Ministry of Health, with limited technical collaboration from the sectors involved, and discussed by the National Committee on Emergencies. However, many outbreak control measures are sector-dependent, and responsibility lies with the mayor or prefect at the local level (e.g. school closure). The decentralised system can cause delays in the actual implementation of measures.

Both the DSU (Department for Emergency Situations) and COSU-MS (Ministry of Health's Operational Centre for Emergencies) operate under their specific mandates (tactical-operational and clinical-epidemiological, respectively). While both centres receive multiple field reports, the capacity to generate a common operational picture is constrained by the lack of a single technical platform for data interoperability, highlighting the need to digitalise and automate workflows between the medical and civil protection sectors.

Response to a chemical or biological incident is organised by DSU, including the fire department, police and intelligence services. Different actors are involved, depending on the suspected agent and the level of suspected threat. For chemical incidents, the lead actor is the General Inspectorate for Emergency Situations (IGSU) under the DSU, a civil protection structure with military personnel status and strong operational capabilities. For radiological/nuclear incidents, response is coordinated with the Romanian Atomic Energy Committee. Detection equipment for chemical agents is available for field operations. DSU is also planning to procure field detectors for biological agents. Laboratory testing (according to an older list of pathogens) in these cases is performed by the Cantacuzino Institute, which is part of the Ministry of Defence. Current preparedness is stronger for natural public health events than for intentional biological attacks. A 'Concept of Biosecurity' (national biosecurity strategy) has been under development for some time, with collaboration of the various sectors including the INSP, and this will address the intentional release of biological agents.

Recommendations

- Conduct a national prioritisation exercise for serious cross-border threats to health involving and/or including pathogens.
  - The final prioritised list of pathogens can be used to inform a range of emergency planning activities, such as formulating operational plans, the Concept of Biosecurity and identifying crisis-relevant MCMs to be included in the stockpile.
- Develop/update operational plans (or SOPs) for priority pathogens, which are needed to complement the framework for the management of epidemics.
  - The operational plans or SOPs should reflect the final prioritisation list of pathogens and should follow the same levels of escalation as those defined in the National Concept for Epidemics.
- Finalise and test the 'Concept of Biosecurity'.
- Establish a testing strategy focusing on desktop exercises involving outbreak scenarios and engaging all relevant national actors to test the coordination among all stakeholders, including various aspects of the health system.

Emergency logistic and supply chain management

Romania has developed a comprehensive and operationally mature system in the area of MCMs, supported by a combination of legislative provisions, institutional arrangements, and EU-level cooperation mechanisms. At the same time, there are opportunities to further strengthen the integration and strategic coherence of existing capacities.

Romania has established processes to identify MCMs relevant for preparedness and response to serious cross-border health threats. A dedicated list of MCMs exists which has been developed by both the Ministry of Health and the Ministry of Internal Affairs, and this list is currently being updated. However, a formalised and systematic methodology for identifying crisis-relevant MCMs across all categories, anchored in national risk profiling and aligned with Union-level definitions, has not been yet developed.

Romania has put in place multiple mechanisms to monitor supply and estimate demand for crisis-relevant MCMs. A legal and operational basis is provided by Order No. 269/2017, which establishes continuous stock monitoring through the Electronic System for Inventory Reporting (ESIR). This system enables daily reporting from distributors, manufacturers, importers, and pharmacies to the Ministry of Health. In parallel, the INSP publishes vaccine stock data at county level, while the Department for Emergency Situations and the General Inspectorate for Emergency Situations monitor operational resources and contribute to broader situational awareness. However, the existing systems currently lack interoperability, and the data – particularly with regard to stockpiles – are not consolidated, limiting the availability of a comprehensive and real-time overview of existing capacities.

Romania has put in place a range of legal and operational measures to mitigate supply chain vulnerabilities. These include minimum stock requirements, daily monitoring through ESIR, shortage alert mechanisms, and the possibility to introduce temporary export restrictions for critical products. These measures are complemented by strategic stockpiling arrangements and active participation in EU-level mechanisms, including joint procurement and rescEU reserves. Romania also reported that arrangements are in place, or under development, to scale up the manufacturing of crisis-relevant MCMs. These include access to EU-level instruments, such as EU FAB and RAMP UP, and ongoing national and private-sector investments to increase production capacity, which include the area of critical medicines.

Romania maintains a multi-layered framework of strategic stockpiles, combining national reserves, rescEU-hosted capacities, commercial stocks, and military medical resources, and encompassing both physical and virtual stocks. National stockpiles, are managed by the Ministry of Health and the Ministry of Internal Affairs, with coordination ensured through established governance structures. Romania also hosts rescEU stockpiles, contributing to EU-level preparedness and response capacity. This diversified and flexible stockpile architecture represents a key strength and the system is further supported by ongoing investments under the National Recovery and Resilience Plan, including the development of logistics bases, regional warehouses, and digital inventory systems, as well as enhancements in transport and deployment capacity.

Overall, Romania demonstrates strong operational capacity in the field of medical countermeasures, underpinned by robust stockpiling systems, advanced monitoring arrangements, and active participation in EU mechanisms. The main opportunity for further development lies in consolidating this broad range of activities within a single document/preparedness plan, and in integrating data related to MCMs into a unified system, thereby enhancing strategic coherence and enabling a comprehensive overview of existing capacities.

Recommendations

- Ensure that supply and demand is monitored across MCM categories, consolidating the stockpiling data and aligning with the Union-level reporting requirements under Council Regulation (EU)2022/2372;
- Integrate crisis-relevant MCMs into emergency plans, consolidating provisions for stockpiling, manufacturing, supply chain management, and innovation, with a coherent description of how different MCM interventions complement one another.

Laboratory (Capacity 3)

Romania has a well-defined, tier-based laboratory system in place, covering the country's various regions and counties and including nearly 5 000 public and private medical laboratories according to the National Institute of Statistics. However, not all of these laboratories perform microbiological testing.

In terms of public health, the system is centred on the National Institute of Public Health (INSP) under the Ministry of Health. The INSP has the overall responsibility for the coordination of the surveillance of infectious diseases and operates a laboratory network composed of the National Laboratory for Public Health (LNSP) and three laboratories in Regional Public Health Centres (in Cluj, Iasi, Timisoara). It also provides methodological guidance to 41 district/county public health laboratories (DSPs). Reference functions for several human pathogens under surveillance are also covered by other public institutions: the National Institute for Medico-Military Research and Development 'Cantacuzino' (INCDMM) under the Ministry of Defence that hosts 11 specialised laboratories and three World Health Organization (WHO)-recognised laboratories (Poliovirus, Measles and Rubella, Influenza); the National Institute of Infectious Diseases 'Matei Balș' (INBIMB) under the Ministry of Health for HIV; the National Institute of Pulmonology 'Marius Nasta' (IPMN) for tuberculosis; the Clinical Hospital of Infectious and Tropical Diseases 'Victor Babeș' (CBIT Babes) and the National Institute of Blood Transfusion 'C.T. Nicolau' for blood-borne diseases. In addition, the Institute of Virology 'Stefan S. Nicolau' of the Romanian Academy and the network of National Reference Laboratories for animal health of the Institute for Diagnosis and Animal Health (IDSA) under the National Sanitary Veterinary and Food Safety Authority (ANSVSA) are also involved in public health activities. This rich and varied network provides all the skills and competencies needed to respond efficiently to a public health emergency.

The roles for network coordination and testing strategy implementation are described in several guidance documents and regulations. The reference functions are also mentioned in the documents, but these activities are not specifically funded and seem to be covered by the institutes' own budgets. There is no official designation of National Reference Centres/Laboratories for human pathogens that would give these laboratories a clear role in coordinating the laboratory response during a public health emergency and visibility at national and international levels (e.g. with the European Union Reference Laboratories for Public Health (EURL-PH)). Since the COVID-19 pandemic, Romania has revised several legislative documents to increase preparedness. In particular, the National Health Strategy for the period 2023–2030 aims to modernise the laboratory infrastructure, including that of the LNSP, at national level. As part of this modernisation, the establishment of a national public health reference laboratory for communicable disease surveillance at INSP Bucharest was envisaged under the Health Programme, in line with the objectives of the Strategy. However, the launch of the corresponding call for projects is still pending. In addition to this general National Health Strategy, several disease-specific national strategies have also been updated. The priority diseases of public health concern in Romania include tuberculosis, HIV, hepatitis and AMR. The INSP provides 'methodologies' (documents describing surveillance objectives and modalities) for all the 66 communicable diseases under surveillance.

In the event of a novel pathogen, Romania has the ability to implement new Nucleic Acid Amplification-based Tests (NAATs) in one or more laboratories within three months. During the COVID-19 pandemic, detection of SARS-CoV-2 by RT-qPCR was implemented by the Cantacuzino and Matei Balș institutes as early as week 5 of 2020 and gradually implemented at 93 public laboratories over the next four months. Genomic characterisation of pathogens is well established in Romania for all priority diseases and diseases under surveillance, and Next Generation Sequencing (NGS) was further developed during the COVID-19 pandemic. NGS facilities are now available in many public institutions, including the LNSP, which implemented protocols for the sequencing of several pathogens of public health importance within a two-year period. During the COVID-19 pandemic, sequencing capacities were reinforced with academic and private partners through specific legislation, but these were not formally integrated into the national surveillance system, meaning that data were not reported to the INSP. Trained bioinformaticians are working at the three main public health institutes (INSP, INBIMB and INCDMM Cantacuzino) and sequences of the different pathogens are made available through international databases.

Each medical analysis laboratory in Romania must be officially licenced, meaning that it must obtain a Sanitary Operating Authorisation confirming that it complies with Order 1301/2007, amended by Order 396/2026. Implementation of quality and competence requirements according to ISO norms for laboratories is included in the order. Accreditation by the Romanian Accreditation Association (RENAR) in accordance with ISO 15189 is currently mandatory only for laboratories financed by the National Health Insurance House (CNAS). However, the National Health Strategy for 2023–2030 sets a target for 100% of the medical analysis laboratories to be accredited through participation in external comparability quality control (EQAs). Nevertheless, the text of the National Health Strategy is not clear about the type of accreditation: ISO certification granted by RENAR, accreditation by the National Authority for Quality Management in Health (ANMCS) or another type. Information on progress towards this target for 2030 was not available during the assessment, as the National Health Strategy is monitored directly by the Ministry of Health and not by institutions that are part of the working group.

There is currently limited centralised infrastructure for the collection of public health data through an electronic reporting system, and this is restricted to SARS-CoV-2 testing. Although Romania implemented such a system (Coronaforms) during the COVID-19 pandemic, it is limited to COVID-19. Romania is, however, participating in an EU-funded project to develop a centralised system for the collection of epidemiological, laboratory and interventional data related to public health communicable diseases.

The legislation defines the biosafety and biosecurity requirements, based on international standards. Specificities are highlighted in the 'methodologies' provided by INSP for each disease under surveillance and the specific national guidelines for the priority diseases. In addition, biosafety is covered in the specific legislation on the protection of workers. Biosafety Laboratories level 3 (BSL-3) for human pathogens are available at Cantacuzino and the Institute of Virology 'Stefan S. Nicolau'. While biosafety requirements are regulated through several legislative instruments, no dedicated intersectoral mechanism currently exists for the authorisation and oversight of activities involving human pathogens at BSL-3 facilities. One BSL-3 laboratory for animal pathogens is available at the National Reference Laboratories of IDAH. There is currently no BSL-4 laboratory available in Romania and no formal agreement in place with another EU/EEA country to ensure access to such a laboratory.

Transportation of samples, specimens or isolates for surveillance of priority communicable diseases from local to regional or national referral laboratories within Romania is organised by the DSPs. The rules for each pathogen are summarised in the 'methodologies' provided by INSP for each disease under surveillance and in the specific national guidelines for the priority diseases. Transportation follows the EU/international regulations for the transport of biological and infectious material/samples (UN classification, labelling, packaging).

Since the COVID-19 pandemic, Romania has developed a strategy to enhance laboratory capacity to improve preparedness in the event of a public health emergency. The country has important capacities in terms of laboratory facilities and a skilled and competent workforce. A few important gaps remain in the laboratory system, and addressing them is essential for Romania to accurately detect and respond to infectious disease threats.

Recommendations

- Officially designate and recognise National Reference Centres (National Reference Laboratories for human pathogens), including clear designation criteria, responsibilities and operational arrangements, to clarify and strengthen their central role in surveillance and during public health emergencies.
- Establish a competent body responsible for the authorisation and oversight of BSL-3 laboratories and the activities conducted within them, ensuring coordinated governance and regular verification of infrastructure, operational practices, staff training, waste management and standard operating procedures.
- Integrate laboratory data, including molecular typing and sequencing data, into existing and future electronic surveillance and reporting systems to ensure interoperability and avoid the development of parallel laboratory-specific reporting platforms.
- Define the accreditation standard and scope applicable to all medical analysis laboratories under the National Health Strategy 2023–2030 and assess progress towards achieving the laboratory accreditation objectives established under the Strategy's monitoring framework and indicators.

Surveillance (Capacity 4)

The INSP's National Centre for Communicable Diseases Surveillance and Control (CNSCBT) conducts infectious disease surveillance under a comprehensive legal framework. Published on 19 May 2022, the Government Decision 657/2022 defines both the content and methodology of data collection and reporting for the surveillance of communicable diseases in the National Register of Communicable Diseases (RUBT). It is worth noting that it refers to Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health, which was repealed by Regulation (EU) 2022/2371 on 23 November 2022. Ministry of Health Order 1738/2022 provides more details on data sources and information flows. There are special legal provisions for HIV/AIDS and TB surveillance, as surveillance for these is not coordinated by INSP. All healthcare providers – public and private – must report 66 notifiable infectious diseases to one of the 42 County Public health Directorates (DSPs). With the exception of COVID-19 cases, DSPs receive case reporting forms by email and then enter the information into the RUBT database, which is accessible by INSP and its five regional centres (CRSP) with epidemiology departments. There are 26 diseases which require immediate notification by phone. Surveillance data are analysed at both national and regional level by the CNSCBT and CRSPs, respectively. They prepare weekly, quarterly, and yearly reports, that are shared with the Ministry of Health, all DSPs and other relevant stakeholders, including a subset which are publicly available on the INSP website. The analyses are mostly descriptive but epidemic thresholds are set for some indicators.

In addition to data collection, most of the surveillance data processes are performed manually, including data cleaning and preparation of outputs, using Microsoft Excel and Epi Info – a statistical software developed by the US Centers for Disease Prevention and Control (US CDC) and retired in 2025. During the COVID-19 pandemic, a digital platform was developed to collect COVID-19 related data. Under the EU4Health project EU-HIP, INSP is expanding the COVID-19 digital platform to all diseases, which should facilitate data entry. As a next step of this project, the platform should be able to connect to IT systems used by healthcare providers to allow (semi)-automated data extraction.

For all diseases covered by the National Surveillance Programme, all costs (e.g. testing and/or shipping) are covered by the Ministry of Health. However, under-ascertainment and/or reporting is likely for several reasons. First, there are areas with few GPs, and some population may not seek care for mild conditions. Second, some physicians prescribe antimicrobials without testing for diseases, such as gonorrhoea. Third, some vulnerable groups such as the Roma population, may not be fully captured by the surveillance system.

Respiratory virus surveillance relies on a sentinel network of 181 GPs in 15 counties covering approximately 2% of the total population. Both acute respiratory infection (ARI) and influenza-like illness (ILI) are reported and a sample tested using RT-PCR for influenza, respiratory syncytial virus (RSV), and SARS-CoV-2. This scheme is complemented by a network of 15 hospitals representing 15% of the population and reporting SARI cases, which are systematically tested. Surveillance is operated year-round in primary care but only from week 46 to week 20 of the following year in secondary care. Funding permitting, SARI surveillance should cover the whole year from 2027. In primary care, both tests and detections are available for SARS-CoV-2, whereas only detections are available for influenza and RSV. The extension of the previously mentioned electronic platform should address this gap. Virus characterisation (e.g. genotyping for influenza viruses) is performed by the INCDMM Cantacuzino. It was possible to scale up surveillance to some extent during the COVID-19 pandemic but, given the heavy reliance on manual processes, this substantially increased the workload and affected data timeliness and quality over time. It is worth noting that SARI surveillance collapsed during the first wave of the pandemic, with the reorganisation of hospitals. Data on Influenza and SARS-CoV-2-related deaths are collected through sentinel and non-sentinel surveillance. Romania has not been able to participate in the European mortality monitoring project (EuroMOMO) as mortality data are managed by the National Institute of Statistics and may not be timely enough for the purpose of EuroMOMO analyses.

Romania has a system to monitor some indicators for hospital capacity (e.g. ICU or emergency rooms occupancy). While some indicators related to COVID-19 are reported in the COVID-19 electronic reporting systems, most are reported in a platform – alerte.ms – run jointly by the Ministry of Health and the Department for Emergency Situations (DSU) of the Ministry of Internal Affairs. This platform is used for national emergency coordination (e.g. dispatch of ambulances and distribution of severe patients across hospitals). These data are not fully integrated into public health surveillance workflows and INSP has limited access.

Although there is some capacity for advanced epidemiological analyses and other research studies, there is no formal mechanism for pandemic threat assessment or collaboration with external partners, such as universities. Romania has been participating in ECDC-funded Vaccine Effectiveness, Burden and Impact Studies (VEBIS) for years for both primary care and hospitals. During the COVID-19 pandemic, several seroprevalence studies were conducted in Romania, with findings reported in peer-reviewed publications. This was made possible with ad hoc funding and/or leftover funds from other projects.

Since 2015, Romania has been carrying out wastewater surveillance (WWS) for enteroviruses (polio and non-polio viruses) in 15 bordering districts. There are currently no concrete plans to initiate WWS of respiratory viruses, but it would probably involve using different sites, more representative of the population distribution. Romania is a beneficiary of the EU-Wastewater Integrated Surveillance for Public Health (EU-WISH) programme.

There is an interministerial order (Ministry of Health and Ministry of Internal Affairs) providing a framework for the management of crisis situations caused by epidemics, including the procedures for epidemiological alert and response, and coordination between health and emergency management authorities and operational responsibilities during outbreaks and epidemics. In practice, communication is primarily vertical from local (DSPs) to regional (CRSPs) and national level (CNSCBT) for detection and early warning. Verification, investigation and analysis are carried out at regional or national levels depending on the context. There is no specific platform for sharing information.

Recommendations

- Automate data processes (e.g. cleaning and validation, and preparation of outputs).
- Improve respiratory surveillance data in accordance with WHO/ECDC guidance, including SARI year-round surveillance and tests/detections for all viruses.
- Assess the feasibility of participating in European mortality monitoring activities (EuroMOMO) and develop the technical and institutional arrangements required for routine mortality reporting.
- Formalise collaboration with academia to take advantage of skills and expertise not available to INSP.

Antimicrobial resistance and healthcare-associated infections (Capacity 12)

The legal framework for prevention and control of antimicrobial resistance (AMR) and healthcare-associated infections (HAIs) is robust, owing to a comprehensive 'National Strategy for preventing and limiting healthcare-associated infections and combatting antimicrobial resistance in Romania for 2023–2030' and accompanying action plan, government decisions establishing national committees for HAIs and AMR, and Ministry of Health orders establishing requirements for national surveillance of HAIs and AMR. Representation of the human health, animal health, and environmental sectors in the national committee for AMR reflects a One Health approach, as does the inclusion of both the animal and human health sectors in the National Strategy for HAIs and AMR. However, actions remain separated by sector and joint activities on AMR are rare. It was noted that the Ministry of Health is responsible for convening the committees, and that committee activity lapsed following changes in leadership. One role of the committees is to analyse monitoring reports produced by the INSP and formulate recommendations; while monitoring and surveillance data are available, follow-up actions have been limited.

The National Strategy for HAIs and AMR, linked closely to Romania's National Health Strategy 2023–2030, astutely identifies necessary actions for Romania to develop sustainable systems for the prevention, detection, and response to AMR and HAI threats. The 2024 monitoring report on the National Strategy for HAIs and AMR summarises multiple accomplishments, including new legal frameworks for HAI, AMR, and antibiotic prescription surveillance; a mandate for 1% of the budgets of medical service providers to be dedicated to HAI detection, prevention, and control; updated national antibiotic prescribing guidance, and new training courses in surveillance and control of HAIs and AMR for nurses. In the same report, key barriers to full implementation of the action plan were also identified, including sub-optimal inter-institutional coordination, data gaps, uneven data quality, and limited technical capacity for reporting. Recommended actions in the monitoring report are necessary next steps and should be prioritised for action to address the high AMR prevalence and antibiotic overuse, workforce limitations, infrastructure and digitalisation needs, and laboratory capacity needs in Romania.

Surveillance activities for AMR and antimicrobial consumption (AMC) are developed in both the human and animal sectors, contributing to EU surveillance systems. While a new system for pharmacies to report dispensing data on s daily basis is semi-automated, most other AMC and AMR surveillance involves manual data entry and email-based reporting. Digitalisation and automation of these surveillance systems are critical for maintaining sustainable and effective action in controlling AMR. While digitalisation efforts are underway for public health surveillance, simple interim improvements can be considered, such as the use of online reporting forms instead of emailing files.

Romania's laboratory capacity to detect and respond to AMR threats would benefit from further standardisation and harmonisation across institutions. It is recognised that clinical laboratory capabilities and methodologies differ, limiting comparability of data. Only 22 laboratories in the country are included in the European Antimicrobial Resistance Surveillance Network (EARS-Net), representing 10–12% of the country. In some hospitals, laboratory services have been outsourced to private laboratories which are not included in the national surveillance programme. There is no designated national reference laboratory for AMR and there is no systemic mechanism for referral of isolates to other laboratories for advanced characterisation. These issues are recognised in the national strategy, but have not yet been resolved. Meanwhile, isolates from major regions (Bucharest, Transylvania and Moldova) show carbapenem resistance rates approaching 40–50%.

While AMR data from the 22 EARS-Net laboratories show worrying rates of carbapenem resistance, they are not representative of the entire country. Most of the participating laboratories are located at emergency and infectious diseases hospitals (university centres) in the main cities across Romania, where the most severe invasive infections are seen. The patients with these carbapenem-resistant bacteria infections could have been referred from smaller hospitals, where the resistant bacteria could also be spreading. The complete AMR situation in Romania is therefore difficult to understand clearly with the data currently available.

Romania has one of the highest antibiotic consumption rates in the EU, which is driving the development of AMR. However, some progress has been made in recent years, particularly with the removal of macrolides from the list of antibiotics available for emergency (48-hour supply) purchase without a prescription. More in-depth evaluation of pharmacy dispensing data may help guide further steps towards ending the dispensing of emergency antibiotics

without a prescription. Oversight of antibiotic use is needed in Romanian hospitals, however antimicrobial stewardship programmes to limit excessive antibiotic use and promote appropriate prescribing practices in the community sector are challenging to implement. Participation in the conferences, workshops, and online training courses organised by the general practitioner association (representing approximate 11 000 GPs – nearly 20% of all physicians in Romania) remains limited. Short, practical prescribing guidelines covering common outpatient syndromes have been developed for distribution.

Multiple mandates for reporting HAIs from health units are intended to provide a complete view of nosocomial infections and outbreaks, however this has not been possible due to underreporting. While fear of retribution is recognised as a potential cause of underreporting, one must also consider the need for technical expertise in HAI case finding and the manual nature of HAI reporting. There is a need to evaluate current HAI surveillance activities and potentially make changes to align surveillance capacities with needs. For example, while periodic point prevalence surveys are needed to investigate factors contributing to the development of HAIs, the mandate for annual surveys, particularly among other HAI surveillance activities, appears to impose an excessive burden, with little added benefit to those conducted every 3–5 years. Availability of professionals in infection prevention and control (IPC) is limited; data they collect must be used, and time they spend on surveillance must be balanced with time spent on necessary IPC actions.

The CARMIAAM-ROM (report on antimicrobial consumption, AMR, and HAIs in Romania) published by INSP provides useful analyses of available data and insights to inform priority public health actions. However, the most recent report is from 2023 and, while these reports are shared with hospital leadership and IPC professionals, it is not clear how the data and analyses translate into IPC actions in healthcare facilities. It was noted that when increases in AMR threats are identified, informational materials (e.g. on *C. difficile*, *Candida auris* and carbapenemase-producing *Klebsiella*) are developed and disseminated via the INSP website and through the authorities for onward distribution to hospitals. However, it was not always known whether these materials reach the intended recipients at local level.

With respect to outbreaks of multidrug-resistant organisms (MDROs), Romanian public health authorities are aware of several difficult-to-treat infections circulating in hospitals, including carbapenem-resistant organisms. Reporting thresholds for MDROs and HAI clusters are defined (e.g. one XDR case, two MDR cases, or three cases involving the same pathogen), although the specific timeframe of these detections is not clearly defined. Reports are submitted to county health authorities on a weekly basis and must include location information (for example wards). These data are analysed at national level, and summary reports with key findings and recommendations are sent back to hospitals. Outbreak reports include both infection and colonisation cases, but detailed characterisation (e.g. carbapenemase identification) is often limited due to laboratory capacity constraints. The ability of public health authorities to work closely with hospitals to control outbreaks varies, depending on the expertise of local health authorities. However, it is noted that the expertise required to control outbreaks of carbapenem-resistant organisms is limited.

IPC programmes are mandatory in all hospitals, and a nationwide study of hospital IPC programme capacities was completed in 2025 by INSP using the WHO Infection Prevention and Control Assessment Framework (IPCAF). Recommended actions from the findings in this study indicated the need to support IPC training and infrastructure in hospitals. Nurses have been identified as key actors for IPC implementation as they play a central role in hygiene, equipment management and daily clinical practice. Recently, IPC training for nurses has been initiated in major universities, resulting in the first cohort of nurses trained specifically in infection control. Furthermore, recent legislative changes require all ICU nurses to complete IPC training, and competency frameworks for stewardship activities are being developed. Practical IPC guidance and training materials, including simulation-based videos, are being developed through new projects. At national level, components for a national IPC programme are largely in place with HAI surveillance, training programmes, and national IPC policies. However, formalisation of a national IPC programme with designated leadership and focal points; use of monitoring, audit, and feedback to accompany legal frameworks; and multimodal approaches (see WHO's multimodal improvement strategies) is still needed.

In summary, legislative advances have recently been made for the surveillance and control of AMR and HAIs. However, the sustainability of prevention and control programmes is not guaranteed as resources are limited in the areas of governance, financing, skilled professionals and operational systems for surveillance, prevention and control. Reliance on manual surveillance processes is particularly unsustainable. Carbapenem resistance is a major AMR threat that is not well controlled, causing hospital outbreaks and leading to untreatable infections. The necessary actions are already identified in national strategies and monitoring reports.

Recommendations

- Reactivate the National Committee for Limiting Antimicrobial Resistance and the National Committee for the Prevention and Limitation of Healthcare-Associated Infections to fulfil their mandates in supporting operationalisation of the 'National strategy for preventing and limiting healthcare-associated infections and combatting antimicrobial resistance in Romania for 2023–2030'. Ensure that these committees facilitate the actions of responsible institutions, as outlined in the National Strategy.
- Accelerate establishment of a dedicated national reference laboratory for AMR. Some necessary national reference laboratory functions include supporting quality AMR testing in laboratories across the country, cluster/outbreak detection and investigation, and conducting timely AMR surveillance with a reliable network of laboratories.
- Complete the ongoing digitalisation of AMR and HAI surveillance, shifting scarce human resources skilled in HAI and AMR prevention and control from data collection/reporting activities. Automation and digitalisation of surveillance allow further focus on data interpretation and use of these data to guide effective prevention and control activities.
- Implement a package of actions to address carbapenem-resistant organisms. Control of carbapenem-resistant organisms requires a coordinated effort between public health authorities, laboratories, and healthcare facilities for timely detection, epidemiological investigation, and infection control specifically for these organisms. Appropriate antimicrobial use is also critical for prevention and control of carbapenem resistance. These activities require a defined plan, budget, and timelines with implications for multiple stakeholders.

Chemical events (Capacity 11)

The legal and regulatory context in Romania is defined by a comprehensive framework of national laws and government decisions governing the management of dangerous chemical substances, risk management, and emergency preparedness. This framework includes the implementation of the Seveso Directive, which requires hazardous industrial sites to establish both internal and external emergency plans. Effective implementation relies on mandatory coordination among multiple ministries and other relevant authorities, ensuring an integrated and consistent approach to chemical safety and emergency response. The framework is further complemented by legislation on chemical safety, civil protection, emergency medical assistance, and the National Emergency Management System.

A key pillar of the system is Government Decision No. 557/2016, underpinned by Law No. 360/2003, which establishes a comprehensive governance structure for risk prevention, preparedness, response, recovery, and coordination across a wide range of risks, including those with a chemical dimension. Chemical-related scenarios are not addressed as a single stand-alone risk category, but are embedded across a variety of areas such as industrial accidents, hazardous substances transport, environmental pollution, and chemical, biological, radiological and nuclear (CBRN) incidents. The Decision clearly defines responsibilities, timing, and authority, and applies a uniform command and control logic across all scenarios. Emergency command is clearly assigned to the Ministry of Internal Affairs; however, health-sector leadership for defining exposure thresholds, acceptable risk, and long-term health measures is not explicitly specified. In addition, the framework is predominantly designed for acute emergencies, while chronic exposure, bioaccumulation, and delayed health effects are not systematically addressed.

If CBRN incidents are suspected criminal offences/illegal actions, the first response will be coordinated by the CBRN team of the Romanian Police (SIIAS/IGPR/Ministry of Internal Affairs); if a CBRN incident is classified as an 'act of terrorism' (either by the prosecutor or by a judge), the first response will be coordinated by the CBRN unit of the Antiterrorist Brigade of the Romanian Intelligence Service – AB/SRI and SRI will also coordinate the overall incident management (according to Law no. 535/2004 regarding the prevention of terrorism).

Chemical surveillance and health-related monitoring are regulated by Government Decision No. 83/2019, which established the National Registry of Health Risks in Relation to Environmental Factors (ReSanMed). In parallel, dedicated mechanisms exist for the surveillance, real-time notification, and analysis of chemical and environmental events, including the ReTox system. These systems use standardised reporting forms and defined information flows between public health authorities and the INSP, enabling timely health impact assessment and intersectoral communication, while recognising the need for continued optimisation and integration of existing data flows.

Multiple stakeholders operate within this framework, including toxicological information centres, public health authorities, healthcare units, and emergency services. It is noteworthy that the system includes regional antitoxic centres dedicated specifically to children, representing a unique and specialised structure that recognises the distinct clinical, toxicological, and care needs of paediatric poisoning cases. In addition, the operation of the ReTox registry for hazardous mixtures and acute poisoning cases, and technical guidance for medical personnel on standardised recording and reporting are defined under Ministry of Health Order No. 1808/2007. The Ministry of Internal Affairs plays a central role in emergency preparedness and response through the Department for Emergency Situations (DSU), which coordinates key operational structures, such as the General Inspectorate for Emergency Situations (IGSU) which also includes SMURD, emergency aviation and ambulance services, and hospital-based emergency care units (UPU and CPU). DSU also coordinates the National Intervention Coordination and Management Centre (CNCCI), an inter-institutional crisis coordination body activated during major emergencies.

The Ministry of Health's role is primarily focused on medical care, monitoring, and post-event activities. A key technical body is the INSP, which provides scientific, surveillance, and risk-assessment functions at national level. Within INSP, the National Centre for Monitoring Risks in the Community Environment (CNMRMC) focuses on environmental and chemical risks, including toxicological information systems, and contributes to chemical and radiological preparedness and response. Health system financing and service coverage are ensured through the National Health Insurance House (CNAS), which manages the National Health Insurance Fund (FNUASS). In addition, the Ministry of Finance, supports preparedness and response through the National Office for Centralized Procurement (ONAC), by acting as the central purchasing body for goods and services relevant to health emergencies.

Responsibilities related to hazardous mixtures under Article 45 of the CLP Regulation are assigned to the Ministry of Health and toxicological information centres. According to the Government Decision No. 1008/2022, the ReTox is established to register data on industrial chemical mixtures and cases of acute poisoning or deaths related to these mixtures. Medical and toxicology response is coordinated nationally by the National Toxicology Center, which provides 24/7 toxicological consultation services. Together with the Critical Care Toxicology Unit and the Toxicological Laboratory Unit, it operates at the Bucharest Emergency Hospital as an integrated structure, offering approximately 25 dedicated beds, advanced detoxification capabilities (including haemodialysis and plasmapheresis), antidote distribution, and laboratory toxicological analysis. The system is based on the National Poisoning Monitoring and Toxicological Information System (NPMTIS) and coordinated by INSP. Collaboration is established with the Ministry of Defence and academic institutions for diagnostics, training, and research. A key gap identified is the limited availability of certain antidotes, although efforts are underway to strengthen national stockpiles.

Major accident risks are addressed through the Seveso framework, including external emergency plans and standard operating procedures covering detection, decontamination, population protection, evacuation, and environmental protection. These actions are coordinated by territorial emergency inspectorates and supported by internal intervention procedures, 'white plans' for hospitals and RED intervention plans for pre-hospital structures designed to be applied for mass-casualty events, and classified coordination arrangements for CBRN incidents.

National procedures and standardisation ensure that emergency response is applied consistently across all counties. Centrally issued templates, protocols, and guidance are used nationwide and aligned with national legislation and EU-level requirements. Counties adapt their plans to local risk profiles (e.g. transport corridors or industrial activities), but all plans are reviewed and approved by IGSU. Counties have access to detection devices and mini-laboratories at regional and local levels, and local emergency services are usually the first responders, followed by national and environmental authorities, as required.

Prevention and inspection of chemical threats are a major priority within the system. Inspection activities are organised according to four priority levels, with frequencies ranging from once or twice per year to once every three years. Environmental and chemical inspections focus primarily on preventive measures rather than post-accident response. Public communication and warning systems are managed through a dedicated communication unit. Emergency alerts can be sent directly to citizens' mobile phones via automated systems, with backup channels such as sirens, radio, and television. For nuclear and radiological incidents, a joint communication centre is activated, involving emergency services and the Ministry of Environment and Nuclear Regulatory Body. Clear, timely, and accurate public communication is considered critical to protect health.

While pilot projects (e.g. poison enforcement and hospital notification systems) have shown positive results, data sharing remains partly constrained by confidentiality requirements. In practice, ministries operate within their own mandates and inter-ministerial coordination mechanisms, but there is not always a unified, overarching ownership framework for chemical events at the national level.

Regular exercises are conducted to test preparedness, including annual tabletop exercises, full-scale exercises every few years, and yearly site-level exercises for major facilities. Exercises routinely include CBRN scenarios, and Romania has hosted EU- and International Atomic Energy Agency (IAEA)-level international exercises. Lessons learned are used to update plans and procedures, however, not all relevant stakeholders have always participated.

Overall, chemical threats are managed effectively from an emergency response perspective, but they are not yet fully addressed as public-health chemical risks across their entire lifecycle. Chemical risks are instead embedded horizontally across multiple risk categories rather than treated as a distinct end-to-end chemical risk domain, and prioritisation is not explicitly defined. This can lead to systemic gaps, particularly at the interface between environmental, emergency management, and public-health functions.

Recommendations

- Ensure that all relevant agencies participate in capacity building exercises, irrespective of who organises them (e.g. JADE exercises).
- Create a multi-sectoral, multi-layered coordination mechanism that anchors collective capacity building ownership and sustained collaboration among the different ministerial actors in relation to health and public health.
- Collectively identify and prioritise health threats related to chemicals.

Other capacities not assessed in-depth

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

Romania has a clear governance structure supporting implementation of the International Health Regulations. Decision 758/2009 focuses on the implementation of the IHR (2005) and designates a National IHR Focal Point within the INSP. An Annex to Decision 758/2009 outlines the competent authorities for the implementation of the IHR 2025 provisions. There is a national plan for the implementation of the IHR that outlines actions, deadlines, and responsible authorities (Order of the Ministry of Health No. 800/2014).

Romania has four designated points of entry, including one airport, one sea port, and three river ports.

The National Focal Point for IHR regularly disseminates and receives information from a wide range of governmental ministries and institutes, but this is inconsistent with some entities, and is often reliant upon informal networks. In addition, as the National IHR Focal Point is with the Institute of Public Health, it can be a challenge to engage with ministries from other sectors.

The 2024 amendments to the IHR (2005) are currently being translated and inscribed into Romanian law. This offers an opportunity to raise multisectoral awareness about the obligations under IHR, and to further formalise the authority of the national IHR focal point.

Recommendation

- Capitalise on 2024 amendments to the IHR to strengthen the authority of the National IHR Focal Point.

Financing (Capacity 2)

Romania's preparedness and response financing relies on a mixed model, providing for flexibility in fund allocation. In general, emergency medical services and national public health programmes are funded via the state budget, while this and the national health insurance fund finance healthcare delivery. When a public health emergency occurs, Romania can mobilise extraordinary public funds from the government budgetary reserve fund within approximately 48 to 72 hours.

While there is a push for modernisation, chronic structural underfunding presents challenges in terms of securing and sustaining the operation and maintenance of programme and infrastructure investments (including surveillance and laboratory), as well as efforts to modernise these pieces and address workforce shortages. Further to this, there are no clear plans to test contingency financing, fragmented financing complicates real-time monitoring and reporting, while differences in knowledge of legal frameworks, human resource capacities and procurement processes limit assurances that funds would reach/be used in executing activities at a local level quickly in emergency scenarios. In public health emergencies, procurement responsibilities remain decentralised (e.g. with MS, MAI, ANRSPS, ANSVSA, etc.) which means that there is no central procurement mechanism. As a result, there is a risk of overlapping rather than complementary stockpiles.

Recommendations

- Develop a protocol for coordinating centralised procurement between institutional actors with responsibilities in managing public health emergencies.

Human resources (Capacity 5)

Human resources remain a major challenge for both healthcare and public health in Romania. Firstly, the density of medical doctors and, to some extent, nurses is low. In 2023, there were 3.7 physicians per 1 000 population compared to an EU average of 4.3, and 8.2 nurses per 1 000 population compared to 8.5[5]. Secondly, there are important geographical disparities, with poor regions having a lower density of healthcare professionals than wealthier ones. Although there are more medical and nursing graduates per capita in Romania than in many EU countries, this does not compensate for both an ageing and migrating workforce. Similarly, public health professionals are scarce, and many counties do not have a single epidemiologist.

To address these challenges, in 2022 Romania adopted the Multiannual Strategy for the Development of Human Resources in Health 2022–2030. This strategy includes increasing training capacity and implementing financial incentives for healthcare workers to work in underserved areas. Another important objective of this strategy is the implementation of a digital platform – the National Registry of Healthcare Professionals – to provide data on human resources at national level. It should be noted that most epidemiologist positions at regional and national level are only open to medical doctors.

[5] OECD/European Observatory on Health Systems and Policies (2025), Country Health Profile 2025: Romania. State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

There is no central mechanism to ensure additional capacity in terms of human resources in the event of a public health emergency. It is the responsibility of hospitals to ensure adequate staffing levels. During the COVID-19 pandemic, the Romanian government took exceptional measures, including the use of legal instruments, to address shortages in healthcare workers. For example, a legal decision allowed reallocation of medical staff, resulting in thousands of medical doctors being redeployed across the country, including a small proportion who did so reluctantly. Another initiative involved offering nursing contracts to medical students in their last two years of residency. For laboratories, there was no strategy for deploying personnel. Private laboratories contributed to the need for extra testing capacity. However, this is not a preferred option for future crises since it was costly.

There are limited human resources for IHR implementation, especially at sub-national level. The National IHR Focal Point for Romania works for the INSP and collaborates with colleagues at the Ministry of Health. To perform tasks according to IHR provisions, the Focal Point relies on the five INSP regional centres (CRSP), who are then responsible for communicating with the lower levels (i.e. the 42 counties). However, since these administrative entities have some autonomy, communication and/or collaboration can sometimes be challenging.

Recommendations

- Attract young professionals (i.e. not only medical students) to careers in public health (e.g. greater diversity of career paths and more flexible hiring strategies).
- Monitor the number and distribution of public health human resources (e.g. via the National Registry of Healthcare Professionals).

Health service provision (Capacity 7)

During health crises, Romania can respond rapidly to expand emergency and hospital care services, through established collaboration between the Ministry of Health and the Ministry of Interior. An online platform with hospital bed availability is used on a daily basis for ambulance dispatch at national level. The Ministry of Health 'Alerte MS' system can be launched for more detailed reporting on hospital capacities (e.g. oxygen and ventilator use, case numbers) during a health emergency. Ministry of Health orders implemented during the COVID-19 pandemic that designate hospitals to provide specialised care, or deploy human resources rapidly can be adapted quickly to new health emergencies.

Hospitals are required to have 'white plans' for mobilising personnel and resources in response to a massive influx of patients. Hospital preparedness plans are required and monitored through hospital accreditation activities, including periodically announced and unannounced hospital inspections. Certain business continuity measures are regularly checked, such as the availability and use of oxygen tanks. Inter-institutional exercises have found hospital breaking points to be low, triggering reallocation of patients. Medical staff shortages also pose a challenge to maintaining healthcare system resilience.

It is recognised in the National Health Strategy 2023–2030 that with the development of emergency and hospital care and organisation of the primary and post-hospital care sectors has been under-prioritised, leading to a reliance on hospitals for healthcare provision. Pressure on health services is therefore exacerbated by limited coordination of preventive care, primary care, and post-hospital care. While hospitals are mostly public and overseen by county councils, primary care services are mostly privatised, making coordination with public health services more challenging if needed during a health crisis. In addition, hospital laboratory services are often contracted to private laboratories, although there are also local public health laboratories with varying levels of capacity.

Recommendation

- Prioritise the increase of capacities to provide preventive, primary, and post-hospital care, as outlined in the National Health Strategy 2023–2030, to support health system resilience for health emergencies.

Risk communication and community engagement (Capacity 8)

Communication of risk to the public is coordinated at the policy and structural level, and there is a formally approved national framework for emergency/public communication anchored within the broader national emergency management and civil protection system (National Strategy for Communication and Public Information in Emergency Situations, 2008). Coordination structures exist at national and county levels. In terms of the former, the system is multi-tiered and pyramidal, moving from central authorities to regional prefects. Foundational tools for public communication and risk communication are also in place, including the national joint 112/119 system, 'RO-Alert' and the 'Be Prepared' platform. Other channels, including radio, remain central given that digital tools may be constrained by reliance on internet access during blackouts.

In an event, the communicator is the 'owner of the risk' (e.g. counties, prefects, Ministry of Health, Ministry of Internal Affairs, Prime Minister's Office) and that entity speaks with 'one voice' to avoid creating mixed messages. Depending on need, communication and preparedness resources are adapted for different audiences, and there are examples of this being done with support from civil society partners and communities (e.g. disability associations, Ukrainian refugees).

It is acknowledged that effective communication should be two-way, not top-down only; that it needs to be clear, consistent, and community-based; that the 'one voice' intent is challenging in practice, and that the weakest communicator can undermine the entire system. Managing infodemics and foreign information manipulation and interference is a major challenge to health resilience that needs to be addressed, requiring high-level strategic consideration.

Recommendations

- Establish/consolidate/improve guidelines for engaging and building trust with communities and third-party organisations during 'peacetime', drawing on existing models of good practice (e.g. community engagement during the Ukraine crisis).
- Provide media/communication training for a broader range of staff at the INSP, Ministry of Health and Ministry of Internal Affairs, and at sub-national levels.

Points of Entry and border health (Capacity 9)

Romania has a strong and coherent legal framework supporting the management of Points of Entry, underpinned by comprehensive border legislation, public health laws, and inter-ministerial cooperation mechanisms. Together, these instruments provide clear authority for border control operations and enable the application of public health measures, such as access to medical assessment and referral, quarantine, isolation, and movement restrictions, to travellers arriving from areas of epidemiological risk, in alignment with the International Health Regulations. However, while the legal foundation is robust, the framework remains largely enabling rather than operational, with limited PoE-specific public health provisions. There is no single instrument that consolidates health-related roles, standard operating procedures, and emergency workflows at PoE, and practical implementation relies on complementary regulations, protocols, and site-level arrangements. As a result, further operationalisation is needed to ensure consistent, clearly defined public health preparedness and response capacities across all designated Points of Entry.

Recommendation

Establish guidance for Points of Entry public health that clearly defines institutional responsibilities, staffing arrangements, governance structures, and standard operating procedures.

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

Documents provided for this capacity and the discussion during the country visit show that there are long-term personal contacts between the human public health, food safety and veterinary sectors, which facilitate the response to foodborne outbreak etc. However, collaboration may be difficult at the local level between the different sectors. Romania has a strong veterinary-led system for zoonotic disease surveillance and control. The veterinary public health has established a stronger legal background in the area of control of epizootics, whereby an inter-ministerial management body within the National Committee for Emergency Situations, the National Centre for Disease Control, can be established in the event of 'an epizootic disease posing particular danger to public health and the national economy'. Unfortunately, little coordinated work is done to ensure regular technical meetings, decide a common list of priority diseases for surveillance, exchange or combine surveillance data or conduct common epidemiologic investigations. A significant step was a bridging workshop organised by WHO in 2024, which brought together human and veterinary public health experts to discuss various aspects of potential collaboration from a One Health perspective. However, a follow-up survey one year later still showed little progress. This is attributed to the lack of legal basis underpinning the collaboration and the need to exchange data.

Integration of environmental data lags even further behind, although there has been one case study where public health collaborated closely with entomologists and other scientists and this focused on the emergence and subsequent annual circulation of West Nile Virus (WNV). However, entomological surveillance is currently conducted through EU-funded projects and grants and data are not exchanged with the INSP.

Since 2020, the INSP has also established a registry (RESANMED) to monitor two particular syndromes (infant meth-hemoglobinemia connected to exposure to nitrates and congenital iodine deficiency) and illness connected to extreme events (e.g. post flooding, heatwave- or extreme cold -related). The system platform is being further developed, and the data is entered by public health staff at the local level every quarter. Not many such systems exist in EU countries, and it could offer valuable insights on the effects of climate change on health; however, it appears to be underutilised.

One Health coordination and integration of data from all sectors remains limited, limiting early detection of emerging zoonotic and climate-sensitive threats.

Recommendation

- Establish and implement a One Health legal framework (ANSVSA, Ministry of Health, Ministry of Environment) that will enable the systematic coordination of activities between animal health, public health and environmental health (e.g. joint risk assessments, data sharing, joint outbreak investigations).

Union level coordination and support functions (Capacity 13)

Romania participates in EU coordination mechanisms through information exchange, joint risk assessments and coordinated decision-making. Key partners include the European Commission, ECDC, and the Health Security Committee (HSC). In the domain of health, national coordination is led by the Ministry of Health, with input from the INSP and the Ministry of Internal Affairs' Department for Emergency Situations.

National legislation provides a basis for coordination and alignment with EU mechanisms and regulations. There is experience using and carrying out exercises through the EU Civil Protection Mechanism (UCPM). Furthermore, Romania hosts rescEU assets, including strategic MCM and PPE stockpiles, and has a certified rescEU Emergency Medical Team.

Romania has benefited from EU funding, including support from EU4Health (e.g. through projects on CBRN countermeasures and diagnostics), but it has not taken full advantage of specific funding opportunities.

Romania contributes surveillance and epidemic information to EWRS and EpiPulse, although the frequency of information exchange could be enhanced. Attendance at HSC meetings can sometimes be challenging due to competing priorities; therefore, representation at different levels could be reconsidered.

Recommendation

- Strengthen engagement across EU platforms such as HSC, EWRS and EpiPulse, while continuing to make use of EU funding opportunities, including under EU4Health.
- Ensure alignment with the Union prevention, preparedness and response plan.

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

Romania has a rich medical/clinical research environment that includes public health centres, universities and research centres. Funding for studies in link with public health is provided by different sources: Ministry of Health through the National Health Programme, Ministry of Education and Research through the National Research Authority, European Union.

During COVID-19, Romania implemented a seroprevalence study led by the CNSCBT of the INSP within the first six months of the pandemic. The protocol was developed using the WHO UNITY reference protocol and was rapidly approved by the ethical committee. The study made use of residual sera collected throughout the country.

Although procedures for ethical approval can be rapid for studies based on surveillance or diagnostic activities, this may not be the case for other types of studies (for example interventional studies). Participants at the session discussion mentioned that Romania would be welcome exchange of experience in rapid approval of clinical trials and other interventional studies between EU/EEA countries.

Concertation between the different actors involved in medical/clinical research linked to public health could be improved, especially during a public health emergency, to ensure coherence with the public health needs and study protocol quality.

Recommendation

- Identify the medical/clinical research and innovation priorities that might be needed in case of public health emergencies and should be defined collaboratively by the Ministry of Health, INSP and the Ministry of Education/Research.

Recovery elements (Capacity 15)

In Romania, recovery is addressed by means of a whole-of-government and inter-institutional approach that links public health preparedness with the national emergency management system. Recovery-related responsibilities are shared mainly between the Department for Emergency Situations, the Ministry of Health, and the INSP, and are embedded across preparedness, response, and post-event phases rather than being treated as a separate public health function. Key recovery elements include maintaining continuity of essential services, restoring healthcare delivery and surge capacity, supporting the return to normal function, and evaluating system performance following crises and large-scale exercises.

Recovery is operationalised primarily through national planning documents, such as the National Concept for Response to Epidemics, and through experience gained from simulation exercises and real events, including national-level mass casualty and disaster scenarios. Post-exercise evaluation reports and lessons-identified processes, including recent national exercises such as MC24 and SEISM25, are used to identify shortcomings in coordination, communication, fatality management, continuity of essential services and medical surge capacity. These mechanisms support institutional learning and can inform updates to plans, procedures and coordination arrangements.

At the same time, recovery activities remain largely implicit and are distributed across several plans, procedures and institutional mandates, as they are not yet formalised within a dedicated public health recovery framework. Follow-up and long-term monitoring of lessons identified, corrective measures and improvement plans have not yet been applied in a fully standardised manner across institutions and levels. While Romania demonstrates relevant experience, strong interinstitutional cooperation, and a clear focus on continuity of essential services, further structuring recovery as a distinct function within public health emergency preparedness would strengthen resilience and ensure more systematic implementation of post-event improvements.

Recommendations

- Make it routine to conduct AARs following public health emergencies, major exercises and health responses, ensuring the participation of all relevant public health, emergency management and healthcare actors.
- Establish a structured lesson-management mechanism to translate findings into corrective action plans with clear responsibilities, timelines and monitoring arrangements, and use these lessons to strengthen recovery planning and the transition from response to recovery.

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

Romania addresses Capacity 16 through a comprehensive set of laws, government decisions, and ministerial orders that define roles, responsibilities, and operational arrangements. Key actions to improve identified gaps include the regular testing of national and inter-institutional capacities through large-scale simulation exercises. These exercises looked at how coordination, information sharing, public communication and medical response work function during high-impact scenarios. They revealed important strengths, such as the resilience of the medical system, the continuity of essential health services and effective coordination through national command structures, while also identifying weaknesses that require corrective action. Lessons identified from these exercises have informed proposals to strengthen both legislative and operational frameworks.

At the regulatory level, Romania has adopted and updated several legal instruments that operationalise corrective actions, including measures on quarantine and isolation, emergency procurement, mobilisation of medical resources, and flexibility in human-resource deployment during health emergencies. Recent amendments have also strengthened the organisational and enforcement roles of County Public Health Directorates and the State Sanitary Inspection, clarifying responsibilities for surveillance, coordination and compliance in emergency contexts.

In parallel, strategic documents such as the National Health Strategy 2023–2030, the National Concept for Response to Epidemics, and updated regulations on epidemic emergency management, provide a framework for strengthening health system resilience, standardising response procedures, and ensuring continuity of operations. Capacity-building actions further support implementation, including participation in ECDC training courses, workshops, rapid risk assessments, and EU-funded projects, as well as the development of national training programmes for public health professionals.

Despite these efforts, challenges remain to ensure consistent operationalisation and follow-up of identified gaps, in particular standardising procedures across sectors, clarifying institutional coordination mechanisms, strengthening communication with the public, and fully integrating recovery considerations into preparedness planning.

Recommendations

Develop an action plan that combines and prioritises all PHEPA recommendations, using the National Action Plan for Health Security (NAPHS) or a similar tool, clearly assigning responsibilities, timelines, resource needs, and the source of each recommendation, and closely monitor implementation of the plan.

Conclusions

The assessment indicates that Romania's public health emergency preparedness system is built on well-established structures whose effectiveness depends on how well they operate together under pressure. The system demonstrates a strong institutional basis, clear mandates, and committed expertise. This provides a reliable platform for responding to acute crises.

However, overall system performance depends less on the existence of capacities and more on their coherence, flexibility, and ability to function as an integrated whole. An important point is that fragmentation, both across sectors and within information systems, limits the full potential of otherwise well-developed components. Coordination mechanisms are in place, but their effectiveness can be uneven, particularly when rapid adaptation is required. This suggests that the next stage of system strengthening does not primarily require the addition of new structures, but rather better connection, alignment and streamlining of existing coordination mechanisms.

Another important implication is the need to rebalance the system towards prevention and preparedness, rather than relying predominantly on response. While emergency response capacities are comparatively strong, upstream elements such as risk communication, community engagement, and preventive measures remain less consistently developed. Strengthening these areas would not only reduce the impact of future crises but also alleviate pressures on response systems. Gains made during 'peace time' in strengthening public trust and reducing overall health burdens will directly translate into enhanced health resilience.

The assessment also highlights to the matter of workforce sustainability and the ability to manage resources effectively at all levels. Investments in people, skills, and retention are critical to ensure continuity and adaptability.

Overall, the most significant message is that the country is well-positioned to enhance its preparedness, but future progress will depend on making the system more integrated, agile, and prevention-oriented. By focusing on these cross-cutting dimensions, the country can move from a functional system to a truly resilient one, capable not only of responding to crises, but of anticipating and mitigating them more effectively.

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

This document aims to describe the main practical arrangements before the start of the PHEPA process, under Article 8 of the Serious Cross-Border Threats to Health Regulation.

The arrangement refers to the country visit to Romania that took place on 20–24 April 2026 in Bucharest.

The five capacities that will be assessed in-depth in the first cycle (2024–2026) are:

1. Capacity 3. Laboratory
2. Capacity 4. Surveillance
3. Capacity 6. Health Emergency Management
4. Capacity 12. Antimicrobial resistance (AMR) and healthcare-associated infections (HAIs)
5. Capacity 11. Chemical event.

Assessment team and national experts

Assessment team

The assessment team experts involved in this assessment are detailed in the table below. Please note that due to unexpected changes of circumstances, some experts in the assessment team may change. Any such change will be communicated to the country as soon as possible.

Members of the assessment team			
Name	**Institution**	**Role in the team**	**Capacities assessed**
Jonathan Suk	ECDC	Team leader	1, 2, 13, 15, 16
Vivian Leung	ECDC	Expert	3, 7, 12, 14
Cyril Barbezange	ECDC	Expert	3,4, 10, 14
Julien Beaute	ECDC	Expert	4, 5
Agoritsa Baka	ECDC	Expert	6, 8, 10
Janelle Sandberg	ECDC	Expert	2, 8, 11
Emma Lof	ECDC	Expert, Coordinator	9, 10, 15, 16
Gábor Belak	SANTE	Expert	5, 6, 13, 16
Sebastiano Lustig	HERA	Expert	6
Emanuele Bruni	WHO	Expert	1, 6, 7. 9
Greta Waissi	ECHA	Expert	6, 11
Silvia Herrera Leon	EU MS	Expert	3, 4, 10, 12, 14

National experts supporting the document sharing

The aim of this section is to facilitate the identification of the country Focal Point that will coordinate the implementation of the PHEPA at country level and act as ECDC contact point. Additionally, the table includes information about the national experts that will have access to the SharePoint site set up by ECDC and support the document collection and sharing with the assessment team for the first phase, the desk review. It is suggested that around two to five experts are involved in this task together with the country Focal Point.

Country Focal Point(s) and national experts involved in the document sharing process		
Name	**Organisation**	**Role (focal point/document sharing)**
Lavinia-Cipriana Rusu	National Institute of Public Health – Director National Centre for Surveillance and Control of Communicable Diseases	Focal point and document sharing
Mihaela Gîză	Ministry of Health -Foreign Relations and European Affairs Service	Focal point
Claudiu Damian	Ministry of Health – Secretary of State	Focal point

National experts participating in the assessment process

The table below aims at sharing the names and area of expertise of the experts from the assessed country involved in the assessment process.

National experts participating in the assessment process			
Name	**National institution**	**Role in the assessment (Capacity Lead, Expert)**	**Main capacity to assess**
Dragoș Dragomir	National Institute of Public Health – IHR Compartment	Capacity lead Expert	C1 C9
Mihaela Bardoș	Ministry of Health – General Directorate of Healthcare and Public Health	Capacity lead	C2
Teodora Vremeră	National Institute of Public Health – National Laboratory of Public Health	Capacity lead	C3
Odette Popovici	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Capacity lead	C4
Marilena Chivu	Ministry of Health – Public Health Human Resources Centre	Capacity lead	C5
Călin Alexandru	Ministry of Internal Affaire – Department for Emergency Situations	Capacity lead	C6
Gabriel Diaconu	Ministry of Health – Counsellor	Capacity lead Expert	C8; C16 C15
Adrian Călugăru	Air Border Sanitary Control Point - Bucharest Henri Coandă International Airport	Capacity lead	C9
Costin Iliuță	Ministry of Health – General Directorate of Healthcare and Public Health	Capacity lead Expert	C7 C6a; C15; C16
Teodora Solomon	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Capacity lead Expert	C10 C3; C4
Adrian Ticu	Ministry of Internal Affairs – General Inspectorate for Emergency Situations	Capacity lead	C11

National experts participating in the assessment process			
Name	**National institution**	**Role in the assessment (Capacity Lead, Expert)**	**Main capacity to assess**
Amalia Luca	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Capacity lead Expert	C12 C1; C6b; C10; C13
Claudiu Damian	Ministry of Health – Secretary of State	Capacity lead	C13
Florentina Furtunescu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control/University of Medicine & Pharmacy, Bucharest	Capacity lead Expert	C14 C5
Mihai Nedu	Ministry of Internal Affaire – General Direction of Medical Emergency	Capacity lead	C15
Alina Aliman	National Institute of Public Health – Communication Department	Expert	C8
Raluca Bădulescu	Institute for Diagnosis and Animal Health	Expert	C3
Cristian Boeriu	University of Medicine & Pharmacy Tg. Mureș	Expert	C5
Claudia Boloagă	Ministry of Health – General Directorate of Medical Assistance, Emergency Medicine and Public Health Programmes	Expert	C6b
Bogdan Bran	Ministry of Health – Emergency Operations Committee	Expert	C6a; C7; C8; C13; C15; C16
Dan Bujor	National Road Infrastructure Management Company S.A.	Expert	C7
Camelia Bunaciu	Ministry of Health – Pharmaceuticals and Medical Devices Directorate	Expert	C15
Cristina Buzatu	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C6b
Mihai Buzatu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control/University of Medicine & Pharmacy, Bucharest	Expert	C8; C14
Monica-Laura Cara	University of Medicine & Pharmacy, Craiova	Expert	C14
Ionuț Dragoș Căpraru	University of Medicine & Pharmacy, Timișoara	Expert	C5
Ioan Chirilă	National Institute of Public Health – Iași Regional Public Health Centre	Expert	C10
Magda Costache	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C8
Ani Ioana Cotar	NIRDMM Cantacuzino	Expert	C3
Florin Cristea	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C5
Cristian Dudu	Ministry of Health – Department for Foreign Relations and European Affairs	Expert	C8; C13
Diana Dumitrescu	Institute for Diagnosis and Animal Health	Expert	C3
Elena Dumitru	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C6b
Laura Enache	National Agency for Environment and Protected Areas	Expert	C11
Florina Gabor-Harosa	University of Medicine & Pharmacy, Cluj Napoca	Expert	C5
Mirela Gheorghiță	Constanta Public Health Directorate – Border Sanitary Control Point – Constanta Port	Expert	C9
Roxana Gheorghiț	Unifarm SA Company	Expert	C6b

National experts participating in the assessment process			
Name	**National institution**	**Role in the assessment (Capacity Lead, Expert)**	**Main capacity to assess**
Mihaela Gîză	Ministry of Health – Department for Foreign Relations and European Affairs	Expert	C8; C13
Andrei George Iancu	National Institute for Blood Transfusion	Expert	C4; C10
Cosmin Adrian Ilie	University of Medicine & Pharmacy Timișoara	Expert	C14
Ioana Ivănoiu	National Agency for Medicines and Medical Devices of Romania	Expert	C14
Lucian Lerescu	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C11
Victor Lungu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C1; C9
Denisa Georgiana Janță	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C4; C13; C15; C16
Ionuț Machiș	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C6a
Mioara Calipsoana Matei	University of Medicine & Pharmacy, Iași	Expert	C5
Robert Matei	Ministry of Finance	Expert	C2; C6b
Mariana Mărdărescu	National Institute of Infectious Diseases Prof. Dr. Matei Balș	Expert	C4
Larisa Mezinu-Bălan	National Health Insurance House	Expert	C2; C7
Maria Mija	Ministry of Environment – National Environmental Guard	Expert	C11
Nicoleta Miliță	Institute for Diagnosis and Animal Health	Expert	C10
Oana Mitea	Ministry of Labour, Family, Youth and Social Solidarity	Expert	C5
Ximena Moldovan	Ministry of Health – General Directorate of Medical Assistance, Emergency Medicine and Public Health Programmes	Expert	C6a
Marius Mosor	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C15
Andra Neamțu	National Institute of Public Health – National Centre for Monitoring Community Environmental Risks	Expert	C11
Ioana Alexandra Neghirlă	National Sanitary, Veterinary and Food Safety Authority	Expert	C10
Maria Nica	Clinical Hospital of Infectious and Tropical Diseases Dr. Victor Babeș	Expert	C3
Carmen Nicolae	National Agency for Environment and Protected Areas	Expert	C11
Mirela Nicola	National Sanitary, Veterinary and Food Safety Authority	Expert	C12
Ionuț Nițulescu	National Sanitary, Veterinary and Food Safety Authority	Expert	C12
Carmen Oglakci	Ministry of Health – Department for Foreign Relations and European Affairs	Expert	C8; C13
Gabriela Oprea	National Institute for Blood Transfusion	Expert	C6b
Roxana Pătru	Ministry of Health – Public Health Human Resources Centre	Expert	C5
Elena Perju	Ministry of Labour, Family, Youth and Social Solidarity	Expert	C5
Radu Petrescu	National Sanitary, Veterinary and Food Safety Authority	Expert	C10
Adriana Pistol	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C3; C4; C12; C13

National experts participating in the assessment process			
Name	**National institution**	**Role in the assessment (Capacity Lead, Expert)**	**Main capacity to assess**
Avian Pop	Ministry of Health – General Directorate of Healthcare and Public Health	Expert	C13
Cristian Popa	Institute of Pneumology Marius Nasta	Expert	C4
Alina Popescu	Institute for Diagnosis and Animal Health	Expert	C3
Gabriel Popescu	National Institute of Infectious Diseases Prof. Dr. Matei Balș	Expert	C12
Rodica Manuela Popescu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C4
Lavinia Cipriana Rusu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C1; C4; C6b; C10; C13; C16
Gabriela Sarchizian	Tulcea Public Health Directorate – Border Sanitary Control Point - Danube Delta-Tulcea, Sulina/land - Isaccea-Orlivka	Expert	C9
Oana Sîndulescu	University of Medicine & Pharmacy, Bucharest	Expert	C14
Claudiu Sbârcea	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C11
Violeta Sburlea	Ministry of Health – Public Health Human Resources Centre	Expert	C5
Anca Mirela Sîrbu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C4; C10
Ion Slubschi	Bucharest Public Health Directorate - National Road Infrastructure Management Company S.A.	Expert	C9
Emilian Smadea	Ministry of Health – General Directorate of Healthcare and Public Health	Expert	C1
Laura Socaciu	Ministry of Environment – National Environmental Guard	Expert	C11
Mariana Stanciu	Ministry of Health – Emergency Operations Committee	Expert	C6a; C7
Aurora Violeta Stănescu	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C4
Cristina Stoica	Institute for Diagnosis and Animal Health	Expert	C10
Alin Suciu	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C6a
Janos Szederjesi	University of Medicine & Pharmacy Tg. Mureș	Expert	C5
Alexandra Ioana Șerban	National Institute for Blood Transfusion	Expert	C3
Roxana Ioana Șban	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C12
Daniela Tălăpan	National Institute of Infectious Diseases Prof. Dr. Matei Balș	Expert	C3
Irina Tănase	National Institute of Public Health – National Centre for Monitoring Community Environmental Risks	Expert	C11
Doina Adina Todea	University of Medicine & Pharmacy Cluj Napoca	Expert	C14
Teodora Sorana Truță	University of Medicine & Pharmacy Tg. Mureș	Expert	C14
Adrian Tudor	Institute of Pneumology Marius Nasta	Expert	C3
Radu Țincu	Emergency Clinical Hospital Floreasca – Toxicology yard	Expert	C11
Ancuța Vardianu	National Institute of Public Health – National Centre for Monitoring Community Environmental Risks	Expert	C10
Ioana Vasilescu	Ministry of Agriculture and Rural Development	Expert	C9; C10
Anca-Meda Văsieșu	University of Medicine & Pharmacy Tg. Mureș	Expert	C14

National experts participating in the assessment process			
Name	**National institution**	**Role in the assessment (Capacity Lead, Expert)**	**Main capacity to assess**
Andra Vieriu	Ministry of Internal Affaire – General Direction of Medical Emergency	Expert	C6a
Camelia Vitan	Institute for the Control of Biological Products and Veterinary Medicines	Expert	C12
Daniela Voicu	National Institute for Blood Transfusion	Expert	C7
Viorel Vulturescu	National Research Authority	Expert	C14
Vlad Vuță	Institute for Diagnosis and Animal Health	Expert	C10
Alina Daniela Zaharia	National Institute of Public Health – National Centre for Communicable Diseases Surveillance and Control	Expert	C4; C13

Agenda for the country visit

	Monday 20.04.2026	Tuesday 21.04.2026	Wednesday 22.04.2026		Thursday 23.04.2026		Friday 24.04.2026
08:30	**Welcome & Registration**	**Registration**	**Registration**		**Registration**		
08:45							
09:00	Opening Remarks (country)						
09:15	Overview and key aspects of the assessment process (ECDC and DG SANTE)	C.10 Zoonotic diseases and threats of environmental origin, including those due to the climate	Breakout room 1 **C.12 AMR/HAIs** *(Assessment of in-depth capacities)*	Breakout room 2 - **C.6 Health Emergency Management** - planning, IMS, risk profiling, PHSM *(Assessment of in-depth capacities)*	Breakout room 1 - **C.4 Surveillance** *(Assessment of in-depth capacities)*	Breakout room 2 **C.11 Chemical events** *(Assessment of in-depth capacities)*	Internal assessment team meeting/meeting with focal points
09:30							
09:45							
10:00	Overview of the country public health structure, prep and resp mechanisms and generic and specific plans available relevant to the assessment (country)						
10:15							
10:30							
10:45	**Break**	**Break**	**Break**		**Break**		**Registration**
11:00	Assessment of Cross-Cutting Aspects - Scenario based discussion	C.1 IHR	Breakout room 1 **C.12 AMR/HAIs** *(Assessment of in-depth capacities)*	Breakout room 2 - **C.6 Health Emergency Management** - planning, IMS, risk profiling, PHSM *(Assessment of in-depth capacities)*	Breakout room 1 - **C.4 Surveillance** *(Assessment of in-depth capacities)*	Breakout room 2 **C.11 Chemical events** *(Assessment of in-depth capacities)*	Main findings, conclusions, recommendations and next steps (ECDC presentation and discussion with Country)
11:15							
11:30							
11:45		C.13 Union level coordination					
12:00							
12:15							
12:30							
12:45	**Lunch**	**Lunch**	**Lunch**		**Lunch**		Concluding remarks (country)
13:00							Debrief on the ECDC assessment process (structure, preparation, organization)
13:15							
13:30							Debriefing with senior national representatives
13:45	C.5 Human Resources	C.9 PoE	Breakout room 1 - **C.3 Laboratory** (Assessment of in-depth capacities)	Breakout room 2 - **C.6 Health Emergency Management** - Medical Counter Measures *(Assessment of in-depth capacities)*	Buffer for further in-depth dicussion Wrap-up session		**Take away Lunch**
14:00							
14:15							
14:30	C.7 Health service provision	C.15 Recovery and C.16 Action plan (together in the same session)					
14:45							
15:00							
	Break		**Break**		Internal assessment team meeting		
15:30	C.2 Financing	**Break**	Breakout room 1 - **C.3 Laboratory** (Assessment of in-depth capacities)	Breakout room 2 - **C.6 Health Emergency Mangement** - Medical Counter Measures *(Assessment of in-depth capacities)*			
16:15	C.8 RCCE	C.14 Research					
17:00							
17:30	Wrap-up Day 1	Wrap-up Day 2	Wrap-up Day 3	Wrap-up Day 3	Wrap-up Day 4		

Plenary
Breakout
Break

20:00 Social dinner

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