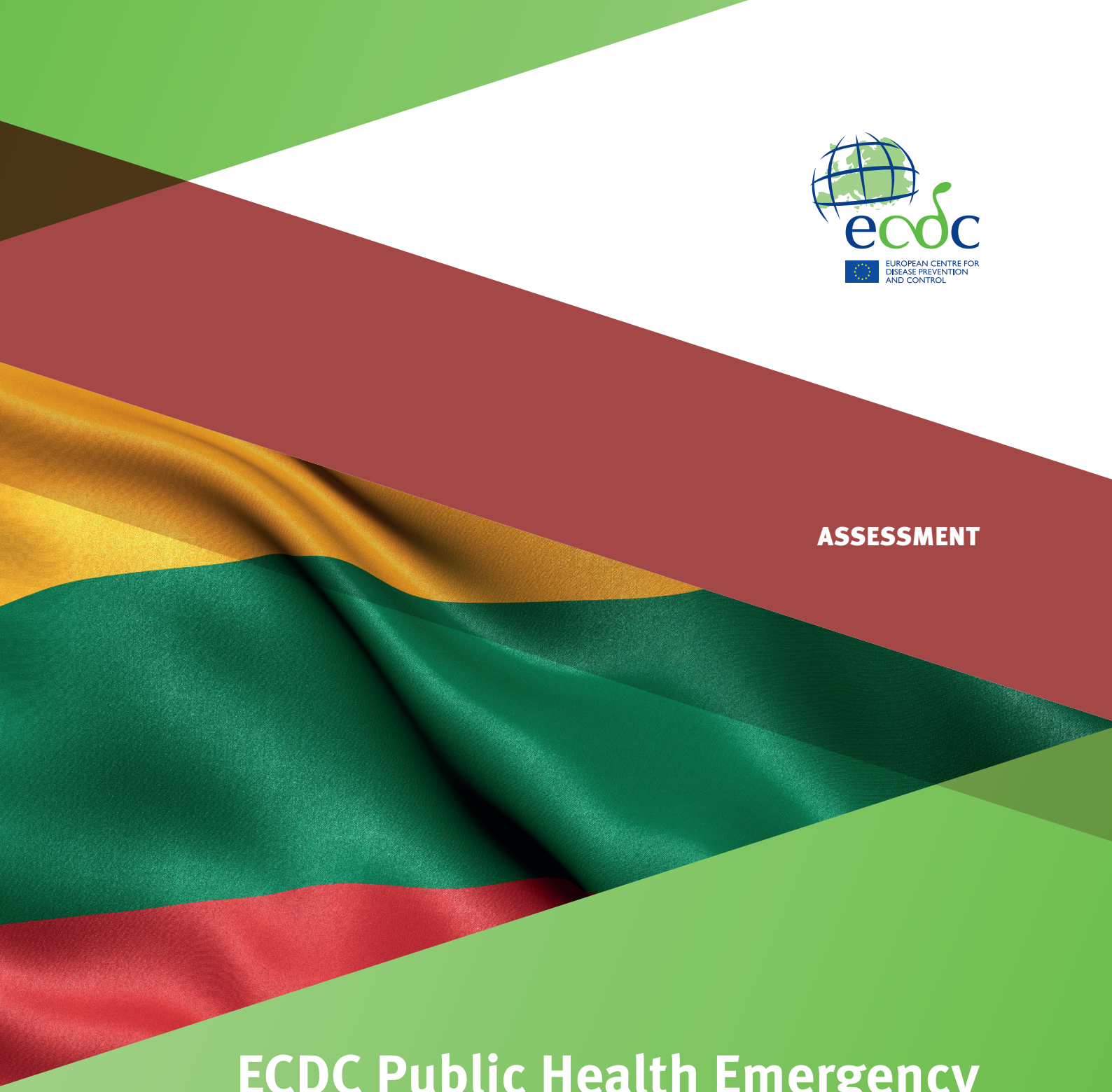

ASSESSMENT

ECDC Public Health Emergency Preparedness Assessment for Lithuania, 2024

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

ECDC ASSESSMENT

Country report: ECDC Public Health Emergency Preparedness Assessment for Lithuania, 2025

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

EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

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Abbreviations

AAR	After-action review
AMC	Antimicrobial consumption
AMR	Antimicrobial resistance
ARI	Acute respiratory infections
EEA	European Economic Area
ESSC	Health Emergency Situation Centre of the Ministry of Health
EU	European Union
HAI	Healthcare-associated infection
HI	Institute of Hygiene
IHR	International Health Regulations
ILI	Influenza-like illness
IPC	Infection prevention and control
MCMs	Medical countermeasures
MDRO	Multidrug-resistant organism
NATO	North Atlantic Treaty Organization
NMVRVI	National Food and Veterinary Risk Assessment Institute
NVSC	National Public Health Centre under the Ministry of Health
NVSPL	National Public Health Surveillance Laboratory
PHEPA	Public Health Emergency Preparedness Assessments
PHSMs	Public Health and Social Measures
PoEs	Points of Entry
PPE	Personal protective equipment
SARI	Severe acute respiratory infection
SOP	Standard operating procedure
SPAR	State Party Self-Assessment Annual Report
VMVT	State Food and Veterinary Service
VVKT	State Medicine Control Agency
ULSVIS	State Information System on Communicable Diseases and its agents
WHO	World Health Organization

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 threat 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 Lithuania. This involved a desk review of relevant documents, followed by a five-day country visit that took place between 15 September and 19 September 2025. As per the assessment methodology, all of the 16 capacities included in Article 7 of the Implementing Regulation (EU) 2023/1808 self-assessment template and in SPAR were assessed, with five of them considered in-depth: Health Emergency Management (Capacity 6); Laboratory (Capacity 3); Surveillance (Capacity 4); Antimicrobial resistance (AMR) and healthcare-associated infections (Capacity 12) and Zoonotic diseases and threats of environmental origin, including those due to the climate (Capacity 10).

Key findings

Lithuania is administratively divided into 10 counties (referred to in this document as regions) and 60 municipalities. In public health emergencies, the National Crisis Management Centre leads strategic decision-making, while the Minister of Health directs operations with support from the Health Emergency Situation Centre (ESSC), the National Public Health Centre under Ministry of Health (NVSC) and its 10 regional departments, the Institute of Hygiene, and the National Public Health Surveillance Laboratory (NVSPL). Each institution can activate its own emergency operations centre. Hospital cooperation follows regional principles.

The country benefits from a strong legal framework applied across all administrative levels. This framework is currently being revised in parallel to the revision of the State Emergency Management Plan. While this provides a solid foundation, it can potentially affect operational flexibility during extraordinary situations. Lithuania's response structures are robust, though prevention and preparedness frameworks remain less developed. Strengthening civil–military collaboration offers potential benefits.

The health sector participates in numerous exercises organised by the Ministry of Interior or the military. However, from the perspective of the health sector, there is a need for a more strategic and coordinated approach to engagement with and planning exercises, which could include well-defined objectives and a systematic process for capturing lessons learnt. Finally, closely related institutional mandates foster collaboration but may risk fragmented or resource-intense coordination.

Main recommendations for each capacity assessed in depth

Health emergency management (Capacity 6)

- Finalise the revision of the national respiratory pathogen pandemic preparedness plan, developed with the One Health approach through close involvement of the animal health and other relevant sectors.
- Maintain and improve the approach for conducting rapid risk assessments for high and very high risks identified through the 24/7 alert process or event-based surveillance.
- Leverage civil-military and international partnerships to draw in further resources to strengthen preparedness planning, coordination, capacities, and the availability of medical countermeasures (MCMs).

Laboratory (Capacity 3)

- Develop a national plan for scaling up laboratory capacity during crises, integrated into the generic prevention preparedness and response plan. This should include mechanisms for engaging laboratories across sectors and key lessons learnt from the COVID-19 pandemic.
- Strengthen the national laboratory network by clarifying the roles of national reference laboratories. The ECDC document 'Core Functions of Microbiology Reference Laboratories for Communicable Diseases' should be used as a reference.
- Establish a formal agreement with an EU-based BSL-4 laboratory to ensure access to high-containment laboratory services when required.
- Create a legal framework for biosafety and biosecurity, ensuring that all laboratories handling communicable diseases adhere to basic standards and receive appropriate training.

Surveillance (Capacity 4)

- Continue the digitalisation of the surveillance system to allow for automations and in-depth analysis of indicators, enabling a faster detection of signals such as changes in trends, severity and risk factors.
- Strengthen the event-based surveillance capacities within the N (NVSC) to enable more timely detection, validation and assessment of signals related to unusual/unexpected health events beyond reported case data.
- Assess the representativeness of the sentinel network for respiratory viruses and adapt the sites accordingly.

Antimicrobial resistance and healthcare-associated infections (Capacity 12)

- Monitor and evaluate implementation of sectoral AMR plans. Identify common priorities and actions across sectors, to be integrated into the next One Health action plan for AMR.
- Further develop national-level antimicrobial stewardship activities, including: 1) sensitisation of prescribers to the WHO AWaRe classification of antibiotics and 2) analysis of antimicrobial consumption (AMC) and antimicrobial use (AMU) data to guide training materials and awareness campaigns.
- Further develop national-level programme for AMR and infection prevention and control (IPC), implementing the WHO guidelines on core components of IPC programmes. Develop process for regular synthesis of relevant epidemiological and laboratory data to identify national AMR and HAI risks that could be addressed by the NVSC, HI and NVSPL.

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

- Improve cross-sectoral tools and procedures for epidemiological and laboratory surveillance data exchange, joint risk assessments, outbreak investigations and response (including response measures targeting groups with occupational risks).
- Establish regular cross-sectoral stakeholder meetings and joint trainings at technical level to facilitate timely information exchange and the operationalisation of the One Health approach in preparedness and response.
- Establish the involvement of the environmental sector in the surveillance and response to zoonotic diseases at the wildlife/domesticated animal/human interfaces.
- Re-assess the predicted public health risks of climate change and reconsider mosquito vector management (i.e. entomological monitoring and control).

Conclusions

Lithuania is revising its governance framework for public health emergency prevention, preparedness, and response, building on lessons from the COVID-19 pandemic and recent geopolitical challenges. Much of the legal foundation has been updated, with the State Emergency Management Plan under review and subsequent steps planned for a generic prevention, preparedness and response plan at the Ministry of Health level, and a dedicated respiratory pathogen pandemic plan. To ensure flexibility and rapid implementation, the legislative framework should be complemented by simple operational procedures. Strengthening intersectoral coordination, surge laboratory capacity, after-action reviews, community engagement, infodemic management, and multidisciplinary approaches would further reinforce the country's solid response capacity, in line with PHEPA and previous recommendations. An action plan will be essential to operationalise these measures, enabling systematic follow-up across stakeholders and alignment with broader national priority initiatives.

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 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 Lithuania. 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 European Union (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 Regulation (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 European Union and European Economic Area (EU/EEA) countries every three years. The procedures, standards and criteria for the assessments of the state of implementation of national prevention, preparedness and response plans and their relation with the Union prevention, preparedness and response plan are defined by the Commission Delegated Regulation (EU) 2024/1232, adopted in March 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 consistency within the EU/EEA countries throughout the three-year cycle, taking into account respective 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 the receipt of the ECDC report.

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

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

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

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

The specific objectives of the assessment process are to:

- Assess the countries' self-assessments of preparedness in the 16 capacities covered by the outputs from the most recent International Health Regulation State Party Self-Assessment Annual Report and the Article 7 template.
- Collaborate with countries to identify good practice, challenges, bottlenecks, gaps or areas for improvement concerning the 16 capacities referred to in Article 7 (a list of the capacities assessed is available in Annex 1).
- Encourage the inclusion of key elements within the prevention, preparedness and response planning structure such as cross-sectoral and cross-border coordination, crisis management, response governance, communication, plan testing, evaluation and regular reviews, according to the lessons identified from the response to public health emergencies.
- Use the opportunity of a standardised approach to the assessment process to contribute to the improvement of EU/EEA prevention, preparedness and response capacities by promoting a common understanding of key elements and a coordinated approach.
- Provide support to countries in enhancing their national prevention, preparedness, and response capacities through recommendations based on the assessment, and provide targeted assistance upon request.

Assessment process

An ECDC-led team composed of seven ECDC experts and six experts from the European Commission's Directorate-General for Health and Food Safety (DG SANTE) units B2 and F2, the Health Emergency Preparedness and Response Authority (DG HERA), the World Health Organization Regional Office for Europe (WHO Europe), and a country expert from Germany was assembled to conduct the assessment, in collaboration with the PHEPA country focal points and national experts from Lithuania. The assessment process consisted of a desk review phase and a country visit that took place between 15 and 19 September 2025.

As per the established process, the team reviewed Lithuania's responses to the Article 7 self-assessment questions and SPAR, with five capacities considered in depth: Health Emergency Management (Capacity 6); Laboratory (Capacity 3); Surveillance (Capacity 4); Antimicrobial resistance (AMR) and healthcare-associated infections (Capacity 12) and Zoonotic diseases and threats of environmental origin, including those due to the climate (Capacity 10). The last capacity was selected by the country.

The country's transparency in portraying a clear picture of their situation has supported the assessment team during the whole process. The country focal points have ensured that Lithuania's unique and distinctive aspects could emerge through every session, providing key legislative documents and inviting stakeholders from relevant sectors, mainly working at the national level. Further details regarding the practical aspects of the mission are available in Annex 2.

This mission marked the first joint effort combining an ECDC Public Health Emergency Preparedness Assessment (PHEPA) with a DG SANTE One Health fact-finding mission. Members of the DG SANTE team contributed to the evaluation of Capacity 10 'Zoonotic diseases and threats of environmental origin, including those linked to climate change' while a member of the PHEPA team supported DG SANTE during their field visits and meetings at the regional and local levels. This collaboration between ECDC and DG SANTE enabled a more in-depth assessment of intersectoral capacities and generated interconnected recommendations, fully aligned with the One Health approach.

Main findings and overarching recommendations

Lithuania, with a population of 2.9 million inhabitants, of whom 70% live in urban settings, has a life expectancy of approximately 76 years. Administratively, the country is organised into 10 counties (referred to in this document as regions) and 60 municipalities.

During public health emergencies, the National Crisis Management Centre, a specialised division of the government, acts as the strategic decision-making and coordinating body, while the Ministry of Health assumes responsibility at the operational level. The Ministry of Health works closely with its Health Emergency Situation Centre (ESSC), the National Public Health Centre under the Ministry of Health (NVSC) and its 10 regional departments, the Institute of Hygiene and the National Public Health Surveillance Laboratory (NVSPL). Each of these institutions (excluding ESSC) has the capacity to activate its own emergency operation centre if needed. Key healthcare institutions and their networks, both within and across regions, are mapped, and in emergencies regional cooperation principles guide collaboration between hospitals.

The country operates under a strong legal framework that is applied at all administrative levels. National-level directives are cascaded top-down to ministerial, institutional, agency and municipal structures. This approach is also reflected in the ongoing revision of the State Emergency Management Plan, whose structure will subsequently be adapted and aligned across the lower levels.

Throughout the cross-cutting scenario on the first day of the mission, and consistently across the assessment week, several themes repeatedly emerged. In particular, the existence of a strong legal framework regulating the public health sector was frequently highlighted. While this provides a solid and unquestionable foundation, it can also affect operational flexibility in extraordinary events.

Overall, Lithuania has developed a robust response structure, with prevention and preparedness frameworks appearing less advanced. This imbalance can also be noticed in the emergency management plans currently under revision. An increasing emphasis on civil-military collaboration could emerge as a potentially valuable asset for strengthening the health sector preparedness.

Exercises, recognised as a core element of preparedness, are frequently conducted and often involve multiple stakeholders. The health sector participates in numerous exercises organised by the Ministry of Interior or the military. However, from the perspective of the health sector, there is a need for a more strategic and coordinated approach to engagement with and planning exercises, which could include well-defined objectives and a systematic process for capturing lessons learnt.

Finally, Lithuania's complex landscape of agencies and authorities with closely related mandates supports close collaboration but can also risk be leading to resource-intense coordination.

Recommendations

- Utilise revisions to the national emergency management framework to integrate key cross-cutting topics (e.g. intersectoral coordination, laboratory scale-up, recovery and after-action reviews, risk communication, community engagement and infodemic management, and public health and social measures).
- Strengthen implementation of the One Health approach, ensuring coordination structures and joint activities are in place for zoonotic diseases, AMR, and the generic prevention, preparedness and response plan.
- Strengthen risk assessment methodology and processes for health emergency management, zoonotic diseases, AMR and healthcare-associated infections, chemical events and at points of entry.
- Develop a strategic, cross-sectoral exercise plan and test key capacities (emergency financing, intersectoral coordination, health emergency management, medical countermeasures deployment, IHR implementation and points of entry). Involve all stakeholders and integrate lessons into national planning to strengthen public health coordination and action across sectors and administrative levels.

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

Health emergency management in Lithuania is anchored in the country's comprehensive system for crisis management and civil protection, which details roles and responsibilities at national and sub-national levels for a wide range of societal threats. At the national level, emergencies are managed by the relevant authorities/ministries, while at the subnational level they are managed by municipalities.

The detailed overall governance structure for civil protection includes a National Crisis Management and Civil Protection Law and a State Emergency Management Plan, which designates the Ministry of Health as the Responsible Authority for epidemics, pandemics, and bioterrorism, and supporting authority for other threats that might impact the health sector. Similarly, the legal structure requires the Ministry of Health to ensuring monitoring and early warning for threats within its jurisdiction, including communicable diseases. State level guidance on emergency planning, a Regulation on recommendations for preparation on crisis and emergency plans, is currently be revised, which will in turn inform a revision of the generic prevention, preparedness and response plan for public health emergencies.

There is routine all-hazard risk profiling conducted in the country through a national analysis of potential threats and emergency risks, carried out by the National Crisis Management Centre. While certain of these risks are under the responsibility of the Ministry of Health, further assessments of health sector risks have also been conducted.

Lithuanian legislation provides for the establishment of operation centres both at the state and municipal levels. These operation centres implement an incident management system with functional groups; in the case of the operation centre of the Ministry of Health there are two groups covering operational evaluation, emergency prevention, information management and public information as well as organisation and maintenance of administration, material support and electronic communications. The coordinator of the operation centre may request aid from other institutions and bodies, and representatives from various institutions including the National

Public Health Centre under the Ministry of Health (NVSC) participate in meetings. Past events as well as exercises have led to technical changes (e.g. virtual meetings and digitisation of procedures) as well as structural changes (e.g. depending on the level of the threat, the operation centre may be activated at the governmental, ministerial and/or municipal levels). It is important to ensure that, during emergency responses, one function of incident management is to log actions and decisions made, which can then support subsequent reviews and learning during the recovery phase (see Capacity 15).

The main institutions responsible for health emergencies at the national level include the Ministry of Health, which also implements the Emergency Operation Centre; the Health Emergency Situation Centre (ESSC), which is responsible for threat notifications and information exchange; and the National Public Health Centre, which provides disease-specific expertise and is responsible for infectious disease surveillance and outbreak management. At the ESSC, there are a series of standard operating procedures containing decision-making algorithms for matters such as activating response systems, responding and coordinating events. For example, one sub-process is on assessing the threat of public health emergencies of international concern and another is on coordinating medical evacuations. There is also a 24/7 function for the receipt and transmission of urgent information.

In the wake of the COVID-19 pandemic, the country undertook an after-action review on contact tracing, and the country regularly participates in a wide range of simulation exercises. Given that simulation exercises can be resource-intensive to design, implement, and participate in, it would be important to develop an overarching strategic plan for exercises, focusing on exercises that address priority risks and preparedness gaps, involve relevant stakeholders, and, importantly, lead to the systematic integration of findings into national emergency planning. Notably, this should not necessarily lead to a higher number of exercises, which can be labour-intensive, but to a more strategic consideration of which exercises to undergo based upon identified gaps and national priorities.

Lithuania contributes to and can potentially benefit from the EU Civil Protection Mechanism and has contributed emergency medical teams through the (WHO) EMT (emergency medical team) initiative. Furthermore, Lithuania has established bilateral arrangements with both Estonia and Latvia for mutual assistance in health emergencies.

As a NATO Member State, Lithuania contributes to a range of military preparedness exercises, and civil-military collaboration in preparedness has notably been a key point of emphasis in recent years. There are clear arrangements in place to respond to a potential intentional release, with coordination established between first responders, security agencies, and public health authorities, including the national reference laboratories.

There are threat-specific plans with regard to pandemic influenza, smallpox and poliomyelitis, but in the case of pandemic influenza this plan has now expired. The pandemic influenza preparedness plan is currently under revision to encompass a broader set of respiratory viruses with pandemic potential. In addition, the NVSC is in the process of developing algorithms for notifiable diseases categorised as 'A-diseases' within the surveillance system, while also providing general guidelines on case investigation and outbreak management.

An interdisciplinary approach to decision-making for public health and social measures (PHSMs) was applied in some municipalities during the COVID-19 pandemic, but no standardised approach was available. The evaluation of effectiveness of some PHSMs was performed as a post hoc analysis, and unofficial evaluation of the measures in place was conducted as part of other practices but without a specific methodology. Pre-established processes and agreements to monitor the implementation and compliance to PHSMs, and the evaluation of their effectiveness, timeliness and social impact could be considered.

Recommendations

- Finalise revision of the national respiratory pathogen pandemic preparedness plan, developed with the One Health approach through close involvement of the animal health and other relevant sectors.
- Maintain and improve the approach for conducting rapid risk assessments for high and very high risks identified through the 24/7 alert process or event-based surveillance.
- Leverage civil-military and international partnerships to draw in further resources to strengthen preparedness planning, coordination, capacities, and MCM availability.

Laboratory (Capacity 3)

There is a robust legal framework in place that defines the laboratory system. The law of the Republic of Lithuania establishes the management of the prevention and control of infectious diseases and links to specific legal acts that defines laboratory services at national reference level as well as for local laboratories performing clinical diagnostic services. The clinical and public health microbiology system in Lithuania includes public, private and hospital laboratories, and reference laboratories are officially nominated for both food and veterinary sectors. The National Public Health Surveillance Laboratory (NVSPL) is the central institution in the Lithuanian laboratory system. Funded by Ministry of Health, the institution has capacity, equipment and competence for reference diagnostics and advanced characterisations including whole genome sequencing. The national Lithuanian reference laboratories in the human sector are located in NVSPL.

The baseline laboratory capacity in Lithuania was strengthened during and after COVID-19 pandemic. This has included increased capacity for PCR testing, higher efficiency and more automated solutions for pre-analytical steps and capacity for advanced laboratory methods, including whole genome sequencing. During the COVID-19 pandemic, a plan was defined describing how laboratory testing could be scaled up and services offered at all levels and covering all geographical areas. Initial set up of diagnostic test, validation and early testing was performed at NVSPL. As demands grew for additional capacity, tests were introduced in the public health laboratory system, involving both public, hospital and private laboratories. Funding could be mobilised through reallocation of state reserve funds, and veterinary laboratories were rapidly licenced to enable them to contribute to human testing and increase laboratory surge capacity. An operational plan for the scaling up of laboratory capacity during the pandemic was defined as part of the initial pandemic response, but this plan was made specifically for the pandemic and is not kept for activation in future crisis. Lithuanian laboratory preparedness would benefit from defining a generic plan for operations in emergency situations and specifically how increased capacity can be mobilised. The plan should be part of, or linked to, the generic prevention, preparedness and response plan, and include lessons learnt from the COVID-19 pandemic, including how to rapidly deploy and scale up testing for novel pathogens, references to formal agreements for inclusion of additional laboratory capacity in other sectors, coordination of best practices for ensuring reagents and consumables across laboratories involved in the response, etc.

There is a clear role for NVSPL in the laboratory system related to confirmatory testing and performing advanced analysis of samples referred from local laboratories. The concept of national networks of laboratories within Lithuania, with NSVPL in a leading role as national reference laboratory, could however be strengthened. This can for example include identification of key laboratories in the laboratory network, increased awareness of strengths and weaknesses in the laboratory system by organisation of regular meetings with key stakeholders, further strengthening of the role of national reference laboratories and inclusion of additional responsibilities in this role. For the latter, reference can be given to the ECDC technical report 'Core Functions of Microbiology Reference Laboratories for Communicable Diseases'.

During the COVID-19 pandemic, a plan was defined describing how laboratory testing could be scaled up and services offered at all levels and covering all geographical areas. Initial set up of diagnostic test, validation and early testing was performed at NVSPL. As demands grew for additional capacity, tests were introduced in the public health laboratory system, involving both public, hospital and private laboratories. Funding could be mobilised through reallocation of state reserve fundings and veterinary laboratories were licenced to increase surge capacity for human clinical testing. The plan for the scaling up of laboratory capacity during the pandemic was defined for this emergency only. Lithuanian laboratory preparedness would benefit from defining a plan for laboratory scaling up in crisis situations. The plan should be linked to the generic prevention, preparedness and response plan, and include lessons learnt from the COVID-19 pandemic, including how to rapidly deploy and scale up testing for novel pathogens, references to formal agreements for inclusion of additional laboratory capacity in other sectors, coordination best practices for ensuring reagents and consumables across laboratories involved in the response etc.

NVSPL has capacity to perform laboratory services that requires BSL-3 facilities. Inactivation of samples belonging to BSL-4 category is also available. However, Lithuania has not access to BSL-4 services. It is therefore recommended that a formal agreement is set up with a laboratory in the EU for such services. The agreement should be set up in peace time and ensure that samples can be referred for laboratory services requiring BSL-4 class.

Biosafety and biosecurity guidelines are in place for the laboratory activities in NSVPL. However, no legislative framework for laboratories working with communicable diseases in laboratories is in place. To reduce occupational risk and risk for malicious use of laboratory samples and isolates, a legal framework should be set up for biosafety and biosecurity for laboratories at all levels. Guidelines and standard operating procedures should be defined and trainings offered to relevant laboratories working with communicable diseases.

National reference laboratories in both human and food and veterinary sector are accredited and certified according to international standards. Most laboratories performing clinical diagnostic services are also accredited and certified according to international standards. At minimum all such laboratories are licenced following national standards. Collaboration between services and laboratories in the human-food/animal intersection exist, but would benefit from further strengthening. The setting up of a common database, where critical data from surveillance and outbreak investigations from all involved sectors could be shared, would significantly improve the efficiency of the intersectoral work.

A standard operating procedure for the validation and verification of clinical tests is available. It provides useful guidelines for the rapid set up of new diagnostic tools that can be applicable in the event of a novel pandemic threat or outbreak of emerging pathogens.

Recommendations

- Develop a national plan for scaling up laboratory capacity during crises, integrated into the generic prevention, preparedness and response plan. This should include mechanisms for engaging laboratories across sectors and key lessons learnt from the COVID-19 pandemic.
- Strengthen the national laboratory network by clarifying the roles of national reference laboratories. The ECDC document 'Core Functions of Microbiology Reference Laboratories for Communicable Diseases' should be used as a reference.
- Establish a formal agreement with an EU-based BSL-4 laboratory to ensure access to high-containment laboratory services when required.
- Create a legal framework for biosafety and biosecurity, ensuring that all laboratories handling communicable diseases adhere to basic standards and receive appropriate training.

Surveillance (Capacity 4)

Lithuania has established a robust legal and institutional framework for epidemiological surveillance, anchored in national legislation and aligned with EU regulations. The National Public Health Centre, under the Ministry of Health (NVSC), serves as the central coordinating body, supported by regional public health departments, the National Public Health Surveillance Laboratory (NVSPL), and other key stakeholders including the State Food and Veterinary Service (VMVT), the Health Emergency Situations Centre (ESSC), and the healthcare institutions.

According to the legislation, the surveillance of infectious diseases falls under the responsibility of the NVSC. The NVSC has a central unit and 10 departments located in the 10 regions of Lithuania. The surveillance system encompasses 105 mandatorily notifiable communicable diseases, seven special health problems, and 74 communicable disease agents. The diseases are categorised in three categories (A, B and C) and the agents into two categories (A and B) with defined actions for guiding the reporting procedures. In addition to general legislation, a dedicated legislative framework is in place for measles, rubella, HIV, tuberculosis and poliomyelitis describing the reporting process. During mass gathering events, syndromic surveillance is activated.

The surveillance of influenza-like illness (ILI) and acute respiratory infections (ARI) is mixed, including the comprehensive collection from all healthcare institutions and a sentinel network of healthcare institutions collecting samples for virus characterisation. The NVSC currently receives weekly aggregated information for ILI and ARI from ESPBI IS electronic health records. Data on ILI and ARI are collected from PIs based on predefined ICD-10 codes that are included in the State Information System for Communicable Diseases (ULSVIS), which is undergoing its second phase of modernisation to enhance emergency preparedness and integrate surveillance functions. Analysis of indicators on morbidity and affected age groups is performed weekly and communicated to relevant stakeholders including the public via the NVSC website. A sentinel surveillance system for respiratory infections is in place and complements the epidemiological data for sampling and virus characterisation, which is integrated with the ILI and ARI data. However, the network's coverage is about 3% of the Lithuanian population, with ongoing efforts to expand to more institutions. The sentinel network's representativeness is not assessed, thus reducing the generalisability of the findings. The surveillance of severe acute respiratory infection (SARI) was piloted via the Vaccine Effectiveness, Burden and Impact Studies (VEBIS) project, but is still not fully implemented.

The analysis of surveillance data remains partially manual and important indicators during emergencies such as transmissibility, route of transmission, effective reproduction number, modelling of diseases trajectories, and vaccine effectiveness are not performed. However, Lithuania has demonstrated its ability to scale up surveillance during public health emergencies, as evidenced during the COVID-19 pandemic. For example, during the COVID-19 pandemic the National Office for Statistics produced an interactive dashboard allowing for automatic real-time visualisation of key indicators related to SARS-CoV-2 infection. The dashboard is still operational, but Respiratory Syncytial Virus (RSV) and influenza data are not integrated into it. Strengthening analytical capabilities, including modelling and assessment of pandemic threats, will be critical for future preparedness. Continued collaboration with EU and international partners should be leveraged to support these improvements.

The surveillance of respiratory viruses is mixed, comprising a comprehensive component based on electronic health records and a sentinel network used for virus characterisation. The sentinel system operates year-round, and the viruses for which samples are tested vary seasonally.

Lithuania has implemented a national wastewater surveillance system as part of its public health strategy to monitor infectious diseases. Since November 2022, the country has been collecting weekly wastewater samples from major urban centres – Vilnius, Kaunas, and Klaipėda. These samples are processed by NVSPL, with results forwarded to the NVSC. The surveillance system is designed to detect SARS-CoV-2 and its variants, providing a non-invasive and cost-effective method to monitor virus circulation in the population, including asymptomatic cases. A component of the program is genomic sequencing, which allows for the identification of emerging strains and supports early warning capabilities.

Event-based surveillance (EBS) reporting in Lithuania is primarily governed within the IHR framework, with the ESSC holding the central responsibility for its implementation. While this legislative foundation provides a basis for

action, operational capacities, particularly within NVSC, require further development to ensure timely and effective detection of public health threats.

To enhance national preparedness and response capabilities, the NVSC's role in EBS should be reinforced through targeted capacity-building, intersectoral coordination, and the integration of event management tools. Strengthening event-based surveillance capacities within NVSC will enable earlier detection of outbreaks and unusual health events, especially those involving communicable diseases, and will support rapid validation and reporting across sectors and administrative levels.

The ability to promptly identify and assess signals is especially critical when dealing with novel/emerging, or unknown threats. Therefore, a robust EBS system must facilitate real-time signal detection, validation, and risk assessment.

Lithuania currently lacks a dedicated event management information system to support the documentation, assessment, communication, and coordinated management of signals and events. The absence of such digital infrastructure limits the efficiency and scalability of EBS operations. Adopting a national event management IT platform would not only streamline workflows but also improve data-sharing, situational awareness, setting baselines and decision-making during health emergencies.

Recommendations

- Continue the digitalisation of the surveillance system to allow for automations and in-depth analysis of indicators, enabling a faster detection of signals such as changes in trends, severity and risk factors.
- Strengthen the event-based surveillance capacities within the NVSC to enable more timely detection, validation and assessment of signals related to unusual/unexpected health events beyond reported case data.
- Assess the representativeness of the sentinel network for respiratory viruses and adapt the sites accordingly.

Antimicrobial resistance and healthcare-associated infections (Capacity 12)

The Ministry of Health's Public Health Department coordinates the Interinstitutional Group of Experts on the Prevention of the Spread of Antimicrobial-Resistant Microorganisms, established in 2019. This Group of experts, with representatives from the animal, human, and environmental sectors, takes a One Health approach to coordinating national strategies for antimicrobial resistance (AMR). There are however separate AMR action plans for human and animal sectors with funding for the actions provided by participating agencies. Action plans and budgeting have typically followed the government's three-year cycles; a cross-sectoral budget dedicated to AMR is not feasible. A One Health AMR management strategy for 2026–2030 is now being prepared. This strategy will be a compilation of collaborative AMR actions across sectors and more detailed plans for the environmental and plant sectors, as plans already exist for the human and animal sectors.

The compilation of AMR actions across sectors and strategic discussions of the Group of Experts reflects Lithuania's efforts in advancing One Health intersectoral collaborations. To strengthen the next One Health National Action Plan for AMR (OH NAP AMR), lessons should be drawn from implementation of the current sectoral action plans. While there are established criteria to assess completion of activities in 2027, Lithuania's One Health action plan could benefit from systematic monitoring and evaluation of AMR activities, their impact, and potential areas for improvement. Such evaluation should identify common priorities and action areas across sectors that will serve as the basis of the next OH NAP AMR, which could be a joint strategy that links to sectoral-specific plans.

Surveillance of AMR is coordinated by National Public Health Surveillance Laboratory (NVSPL), which relies on case notifications from laboratories. Isolates of carbapenem-resistant organisms are submitted to NVSPL, where molecular characterisation, including whole genome sequencing, is conducted. Molecular outbreaks of carbapenem-resistant Enterobacterales (CRE) have been found by NVSPL, and detected clusters are communicated to reporting hospital laboratories. All hospitals are mandated to have infection prevention and control (IPC) staff, and National Public Health Centre under the Ministry of Health (NVSC) and the Institute of Hygiene (HI) collaborate in engaging these IPC teams in sharing best practices for controlling CRE and other multidrug-resistant organisms (MDROs) through regular meetings. In case of MDRO outbreaks, NVSC has the authority to collect epidemiological and clinical data from healthcare records for investigation. Otherwise, detailed clinical and epidemiological data for cases of AMR is not easily available for analysis of factors associated with risk for infections with AMR at national level. There are national guidelines for CRE screening for patients upon admission to hospitals if they have been hospitalised in the past year, underwent dialysis or chemotherapy in the past year, had CRE, or is a contact of someone with CRE infection or colonisation. Adherence to these guidelines has not been formally assessed; NVSC and HI could have roles in identifying potential barriers to implementing these CRE guidelines in practice and help address of implementation challenges.

Mandated surveillance of healthcare-associated infections (HAIs) is very comprehensive, with requirements for hospitals (including palliative care and nursing hospitals) to conduct annually: a HAI prevalence survey, surgical site infection surveillance, HAI surveillance in ICUs, and *Clostridioides difficile* surveillance. Surveillance data are synthesised annually by HI and published online; reports name facilities that did not report data for the year. In

addition to outcome indicators, process indicators for IPC are collected to emphasise the importance of IPC implementation in facilities. Discussions regarding optimising reporting requirements are ongoing; the reporting burden must be weighed, along with how the reported data are being used to drive preventive actions on an annual basis.

Surveillance of antimicrobial consumption (AMC) is also under HI's mandate and encompasses three separate systems for collecting i) national wholesale distribution data from the State Medicines Control Agency, ii) reimbursed antimicrobials dispensed for outpatient treatment from the National Health Insurance Fund, and iii) inpatient AMC data from healthcare institutions. Data on AMC are used for benchmarking with other EU countries as well as inter-hospital benchmarking. Consumption data are published annually, disseminated to stakeholders, and presented at an annual conference. National recommendations on rational use of antimicrobials published in 2023 offer a comprehensive guide to empiric antimicrobial treatment for primary care, with suggestions for reducing the use of broad-spectrum beta-lactam antibiotics, fluoroquinolones, and other antimicrobials without clear indications. Data on indications for prescribing AMU is incomplete at national level; some prescribers are still using paper-based prescriptions. In hospitals, stewardship programmes are being piloted in 10 hospitals with national-level support, with plans to expand to all hospitals across the country. The WHO AWaRe classification is used in national-level analyses of consumption data; however, the AWaRe classification is not widely promoted as a tool for prudent use of antimicrobials.

Monitoring of IPC in healthcare facilities occurs annually with self-reporting of process measures during HAI point prevalence surveys (e.g. number of IPC specialists per 250 beds, volume of hand sanitiser consumption per bed-day). Additionally, NVSC inspects healthcare facilities' adherence to a rigorous and well-documented Lithuanian Hygiene Standard. While the WHO 'Infection prevention and control assessment framework at the facility level' tool is used at least partly during ECDC point prevalence surveys, fulfilment of the WHO Core Components for the national IPC programme has not been systematically assessed. Use of HAI and MDRO data for driving IPC improvement actions at the national level is an integral part of national IPC programmes; the recently established multidisciplinary national CRE response management team provides an opportunity for further development of a data-driven national IPC programme.

Recommendations

- In preparation for the next OH NAP AMR, monitor and evaluate implementation of sectoral AMR plans for 2023–2027. Strengthen the One Health approach to AMR by identifying common priorities and actions across sectors, to be integrated into the next One Health strategy for AMR. Consider public reporting of progress towards objectives and targets of the One Health National Action Plan for AMR to raise public awareness of national efforts in AMR and the One Health approach. While dedicated funding for AMR actions across sectors is not possible, consideration could be given to long-term monitoring of funding for AMR activities to measure trends in investments.
- Further develop national-level antimicrobial stewardship activities, including 1) sensitisation of prescribers to the WHO AWaRe classification of antibiotics to promote prudent use of antimicrobials and 2) analysis of AMC and AMU data to guide antimicrobial stewardship actions. AMC and AMU data can be used to set needed AMC targets, then to develop targeted materials, trainings, and awareness campaigns to help meet those targets.
- Further develop the national-level programme for AMR and IPC in human health, aiming for full implementation of the WHO core components of IPC programmes. With CRE outbreaks occurring in multiple facilities, HI's and NVSC's role in facilitating outbreak prevention and control across facilities should be strengthened. Develop processes for regular synthesis of relevant epidemiological and laboratory data to identify national AMR and HAI risks that could be addressed by NVSPL, NVSC and HI. Timely integration of epidemiological and laboratory data for MDROs is needed to identify clusters to be investigated for source control and effective outbreak prevention.

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

The surveillance, prevention and control of zoonoses in Lithuania is regulated by national legislation (i.e. basic, general and specific acts) both in the human health and animal health sectors. Although separate legislations regulate the two sectors' activities, some acts specify activities or provisions for the other sectors. However, mutual cross-references in the sectorial legislations are not sufficient, which might make joint implementations challenging. The legislations also specify the lists of zoonotic diseases under epidemiological/epizootiological surveillance in humans and in animals. The two lists overlap for the most important zoonotic diseases. The priority zoonoses for cross-sectoral cooperation are avian influenza, salmonellosis and rabies. The most frequent zoonotic diseases reported in humans in Lithuania are foodborne zoonoses (e.g. salmonellosis, campylobacteriosis, yersiniosis, which are not in the scope of the PHEPA) and tick-borne diseases (e.g. tick-borne encephalitis and Lyme borreliosis).

The implementation of zoonotic disease surveillance, prevention and control on the human health side is organised by the National Public Health Centre under Ministry of Health (NVSC) and the State Food and Veterinary Service (VMVT) on the animal health side, with the involvement of the National Public Health Surveillance Laboratory and

the National Food and Veterinary Risk Assessment Institute (hosting the food and animal health national reference laboratory), and several other stakeholders (e.g. ministries of health, agriculture, environment, National Crisis Management Centre, Health Emergency Situation Centre, Institute of Hygiene, healthcare providers and laboratories).

There is no dedicated legislation or action plan for the cross-sectoral cooperation using the One Health approach, neither a defined One Health coordinating authority between sectors. However, national plans (e.g. pandemic influenza preparedness plan, avian influenza contingency plan for animals) exist with some One Health cooperation elements; procedures (e.g. epidemiological diagnostic procedure for foodborne communicable disease outbreaks) and algorithms are also in place that can allow joint management of certain zoonotic outbreaks. The communication, coordination and cooperation between the human and veterinary health authorities are event/outbreak/emergency-oriented.

Surveillance systems for zoonotic diseases and databases exist at both sides, but there is no direct, mutual access to those databases. Sectors share laboratory and surveillance data and epidemiological information on individual/ event-associated basis. Ad hoc cross-sectoral meetings are organised at high managerial level and at technical level. Joint risk assessments for zoonotic disease outbreaks are not developed; outbreak investigations and response actions are implemented in the human and animal health sectors independently.

Inter-sectoral communication on the availability and appropriate use of personal protective equipment of people with occupational risk and/or exposure to zoonoses (e. g. farmers, slaughterhouse workers, veterinarians) is not clearly defined. Communication about PPE is provided by public sector, but also by animal sector, depends on situation. But there is no communication between labour inspection services and public or animal sectors Joint simulation exercises (e.g. on avian influenza and on foodborne zoonotic disease outbreaks) are periodically organised at national and regional levels. However, there are no joint trainings organised for both sectors to facilitate common understanding and cooperation with the One Health approach.

Cross-sectoral cooperation in outbreak situations was tested during the COVID-19 outbreak (i.e. SARS-CoV-2 infections in mink farms), which resulted in amendments in legislation, development of joint algorithms for zoonosis management, broader and strengthened cross-sectoral collaboration and awareness raising about zoonoses among healthcare professionals and animal-keepers. The cross-sectoral cooperation has also been successfully implemented/tested in food production related and foodborne salmonellosis outbreaks and avian influenza outbreaks in poultry and waterfowl. For the prevention of avian influenza virus spillover to humans, zoonotic influenza vaccine (Aflunov) has been stockpiled and offered for free of charge to risk groups, including people with occupational exposure (e.g. poultry farmers, veterinarians). However, those people are not classified as risk groups eligible for free seasonal influenza vaccination, although such immunisations could reduce the likelihood of simultaneous infections with human and zoonotic influenza serotypes. Occupational risk groups are not informed distinctly about the importance and possibility of seasonal flu vaccination. All information about the zoonotic influenza vaccine is provided to risk groups, information on vaccine uptake is published on the NVSC website.

Although priority zoonotic diseases (e.g. avian influenza and rabies) are affecting wildlife (e.g. wild birds and wild carnivores), the nature protection and conservation authorities are very limitedly involved in the surveillance of and response to outbreaks in wildlife. The detection of carcasses of wild animals is predominantly based on the reports of citizens. Response measures are implemented by the veterinary authorities.

The management of health threats of environmental origin in Lithuania are focusing on the areas of extreme weather events, air pollution and air-borne allergic diseases, UV radiation, pathogens in drinking water and open water for recreational use, and arthropod vectors of pathogens. The climate change mitigation and adaptation targets and objectives had been set in National climate change management agenda measures (e.g. greenhouse gas emission reduction) are outlined in the National energy and climate action plan 2021–2030, while the adaptation to the adverse effects of the climate change are specified in related legislation measures had been set in the National Climate Change Adaptation Plan 2024–2030. The adaptation plan assesses climate change-related public health risks in Lithuania as 'low' or 'very low', with little increments to 'average' predicted until 2050 and 2100. The plan specifies 13 climate adaptation policies in the area of public health to be implemented between 2021 and 2030. Regarding monitoring of arthropod vectors of communicable diseases in Lithuania, the current legislation is focusing on *Ixodes ricinus* ticks in forests, recreational areas and malarial mosquitoes (i.e. *Anopheles spp.*) in ponds. However, invasive mosquito species (e.g. *Aedes albopictus*) has been spreading northwards in Europe in the past decades, which are competent vectors of arboviruses (e.g. dengue and chikungunya virus disease). Additionally, West Nile virus infections (vectored by *Culex spp.*) emerged in recent years in countries neighbouring Lithuania (i.e. Poland and Latvia). Therefore, reconsideration of vector monitoring strategies and practices might support the early detection of arbovirus emergencies in the country. The revision of vector control policies and practices could strengthen the preparedness for emerging vector-borne diseases connected to the expected climatic changes in the Baltic area of Europe.

Recommendations

- Improve cross-sectoral tools and procedures for epidemiological and laboratory surveillance data exchange, joint risk assessments, outbreak investigations and response (including response measures targeting groups with occupational risks).
- Establish regular cross-sectoral stakeholder meetings and joint trainings at technical level to facilitate timely information exchange and the operationalisation of the One Health approach in preparedness and response.
- Establish the involvement of the environmental sector in the surveillance and response to zoonotic diseases at the wildlife/domesticated animal/human interfaces.
- Re-assess the predicted public health risks of climate change and reconsider mosquito vector management (i.e. entomological monitoring and control).

Other capacities not assessed in-depth

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

The Republic of Lithuania has established a comprehensive framework of legislative and regulatory instruments, including laws, resolutions, ministerial orders, and presidential decrees, with European Union law being integral to its legislation. The International Health Regulations 2005 (IHR) were ratified by the Lithuanian Parliament on January 18, 2008 (Law No X 1430).

In 2011, the Ministry of Health created a legal and financial framework for IHR implementation through the Order on Programme IHR Implementation (Order V081), which designated the Health Emergency Situation Centre (ESSC) as the IHR National Focal Point. This framework established a clear decision-making process for public health emergencies involving multiple authorities and included key arrangements like the 24/7 on-call duty for the National IHR Focal Point, and the coordination of national participation in related exercises and assessments.

In 2024, a new order, the Order on Preparedness of Healthcare Institutions, came into effect, unifying national and international information exchange processes. Following this, the ESSC released updated standard operating procedures for managing emergencies, outlining the information exchange process within the ESSC and a clarified decision-making process involving the Ministry of Health's Emergency Operations Centre (EOC).

Overall, these legislative instruments and processes aim to enhance Lithuania's health security and emergency preparedness in alignment with international standards, including implementation of the IHR (2005).

The 2024 IHR amendments are due to enter into force on 19 September 2025, unless States Parties reject or reserve on certain amendments and/or the package as a whole by 19 July 2025. Lithuania has not submitted any rejections or reservations, and therefore the 2024 IHR amendments came into force in Lithuania by 19 September 2025. Although there is no separate parliamentary ratification process needed, the country will now need to align the existing legislation with the 2024 IHR amendments and obligations, including the designation or establishment of the National IHR Authority, as stipulated in the amended Article 4.

Recommendations

- Increase awareness and understanding of the IHR beyond the health sector by conducting targeted advocacy campaigns at the local level, especially in municipalities, and organising high-level and technical briefings on the functioning of the IHR, the specifics of the 2024 amendments, and key obligations, including notification requirements and their importance.
- Plan and execute a national IHR exercise comparable to the WHO's international Joint Assessment and Detection of Events (JADE) exercise, to test and improve intersectoral coordination mechanisms among government entities and other relevant sectors beyond health.

Financing (Capacity 2)

The Lithuanian health budget, at both national and municipal levels, is approved on a three-year cycle, as is the case for all state sectors. The financing of health emergencies is governed by several laws, including:

i) the Law on Crisis Management and Civil Protection (reviewed in 2024), which defines the operational response;

ii) the Law on the State Reserve (reviewed in 2024, covering 1% of the overall budget), which funds the purchase of items and materials during emergencies;

iii) the Law on the Government Fund (2011), which provides financial support during emergencies; and

iv) the Compulsory Health Insurance Fund (reviewed in 2025), which ensures financing for healthcare capacity in emergencies.

This strong and up-to-date legal foundation enables financial planning across all administrative levels and sectors. It provides a degree of flexibility in funding preparedness and response functions, particularly during emergencies, and supports IHR implementation through appropriations for the Ministry of Health and its subordinate institutions (the Health Emergency Centre and the National Public Health Centre). While coordination among institutions in

allocating resources could be strengthened, funds may be reallocated within a municipality (across levels), but not between municipalities.

Financial support to other countries is foreseen through bilateral agreements and EU mechanisms. Although financial mechanisms are not routinely tested, financing aspects are incorporated into the planning of simulation exercises, and the current support provided to Ukraine effectively serves as a real-time test.

Recommendation

Regularly assess, at least every three years, emergency financing procedures through stress tests, after-action reviews (AAR) or simulation exercise to ensure smooth reallocation of resources within the updated legislative package.

Human resources (Capacity 5)

National mandates are in place for healthcare institutions to prepare for workforce surges in case of crises. When health crises arise, facilities manage any necessary reorganisation of their work and reallocations of their internal workforce. If needed, coordination of additional support is coordinated regionally by the organising facility in each of the five regional healthcare networks. These organising healthcare facilities can adjust regional patient flows for inpatient services and dispatch mobile healthcare specialist teams to healthcare institutions in their region. Additionally, non-governmental organisations (NGOs) are also involved in responding to surges in healthcare workforce needs, in coordination with the Minister of Health. If a health crisis constitutes a state of 'lock down', the Minister of Health has further authority to reorganise provision of healthcare services and reallocate corresponding human resources. During the COVID-19 crisis, additional human resources were mobilised from the Lithuanian Armed Forces, volunteers, businesses, medical and other health profession students, and others.

A register of healthcare and public health workers is maintained by the Institute of Hygiene. The use of ESVIS (Lithuania's 'Emergency Situations Management Information System') to manage human resource surges and allocations is yet to be determined. Nonetheless, rapid mobilisation of the human resources during health crises was not considered a challenge during COVID-19. On the other hand, shortages of personnel skilled in infectious disease prevention and control was identified as a challenge. Workforce competencies for crises are clearly outlined in legal text, and the Institute of Hygiene is developing training programmes to build these competencies among the healthcare workforces. Additional funds for building capacity in public health competencies are in a dedicated budget for training at the National Public Health Centre under the Ministry of Health (NVSC). Particular attention is needed in building a skilled and sustained workforce to detect, assess, and respond to public health events. Skills in applied epidemiology should be strengthened in public health institutions. Engaging university students in public health projects can be one way to support a sustainable skilled workforce.

Recommendations

- Identify bottlenecks and practical solutions to optimise the coordination of workforce mobilisation.
- Conduct an HR needs assessment (covering workforce size and competencies) to reinforce development of long-term strategies for a sustainable and skilled public health workforce. Consider the inclusion of participation to EU-level training opportunities (e.g. field epidemiology training offered by ECDC).

Health service provision (Capacity 7)

The provision of healthcare services is governed by key legal acts, including the Law on Healthcare Institutions, the Law on the Health system, and the Law on Civil Protection and Emergency Management.

The healthcare system consists of public and private actors, with hospitals, local healthcare units, and pharmacies distributed across the country's municipalities. The private healthcare sector is now being integrated into national preparedness and response activities. There are also arrangements in place to utilise the capacity of NGOs to provide healthcare services during crises.

There is a principle for regional coordination between hospitals which specifies topics including the management of patient flows, the distribution of personal protective equipment received from the State Reserve, the organisation of mobile healthcare specialist teams, and the dissemination of information received from the Ministry of Health. The country has five dispatch centres and 214 emergency medical service crews. There is also an Emergency Medical Team (EMT).

Lithuania has interdisciplinary crisis management coordination between all actors of the healthcare system in case of emergency. Both public and private actors in the healthcare system are now required to maintain preparedness for emergency situations, including developing emergency plans, ensuring the continuity of services, and maintaining critical infrastructure (e.g. ensuring oxygen/nitrogen supply infrastructure, ensuring water supply infrastructure, etc.), maintaining sufficient supplies of personal protective equipment, and organise their activities during emergencies according to emergency plans. They must also ensure training and exercises take place.

Healthcare institutions must assess potential risk scenarios and monitor their preparedness to provide services during emergencies. This is conducted in alignment with the WHO Safe Healthcare Institution Index. Should certain thresholds not be met, measures for improvement should then be implemented.

Lithuania can map available healthcare services in the event of a public health emergency. For example, during the COVID-19 pandemic, the State Data Governance Information System was used for this purpose (e.g. hospital occupancy, proportion of vaccinated healthcare professionals, outbreaks in personal healthcare institutions, etc.) were monitored. From 2026, the ESSC Emergency Management Information System module will be launched and will involve annual reporting on healthcare system preparedness and capacities. It would be important to ensure that the ability to receive rapidly updated information about healthcare system availabilities during crises is maintained.

Lithuania has a bilateral agreement with Latvia on the provision of cross-border healthcare, which provides a mechanism for requesting and providing assistance in regions near the border. Lithuania also plans to join the European Commission Medevac mechanism. Furthermore, there are processes in place for the medical transfer of patients, also to third countries, for care during acute crises. However, there have not been concerted efforts to prepare for situations where external support is provided to the country, in the form of additional health workforce or EMTs.

Recommendations

- Develop procedures and preparedness to receive medical teams or assistance from other countries during crisis situations.
- Map capacity gaps in human and material resources required for case management for priority hazards.
- Maintain the ability to receive rapidly updated information about critical healthcare system availability.

Risk communication and community engagement (Capacity 8)

The risk communication coordination is very well structured in Lithuania, with the National Crisis Management Centre being responsible for risk communication during national emergencies. A Regulation on recommendations for preparation for crises and emergency plans is being revised and will continue provisions for public communications. Moreover, the Order on the preparedness and organisation of activities of healthcare institutions in the event of incidents, emergencies and crises mandates that emergency plans should account for providing information to the media, and to relatives of victims.

At the national level, there is an advanced system for risk communication, which includes deploying sirens, radio and television, and sending alerts directly to citizens' mobile phones.

The Ministry of Health has a designated national communication coordinator to liaise with ECDC, the Health Security Committee's network of communication specialists, and WHO.

While there is some experience in the country on working with civil society organisations to reach particular communities, there is no systematic approach to community engagement.

The absence of a social media plan in the country represents a potential gap in its risk communication, community engagement and infodemic management (RCCE-IM) capacity. Similarly, infodemic management is also not systematically addressed. This gap limits its ability to respond swiftly to infodemics and to foster meaningful dialogue with communities. This is an identified issue that should be addressed.

Recommendations

- Develop a community engagement strategy to complement existing risk communication activities and ensure that the provision of health information during emergencies is trusted and accepted by affected communities.
- Develop an infodemic management strategy that would allow for early detection of rumours and the effective management of them.
- Establish the required capacities to implement the RCCE-IM strategy for health emergency management.

Points of Entry and border health (Capacity 9)

Lithuania has two points of entry (PoE) designated under the International Health Regulations (IHR, 2005): Klaipeda State Seaport and Vilnius Čiurlionis International Airport (VNO). These designated PoE are supervised by the Ministry of Health, the National Public Health Centre under the Ministry of Health (NVSC), seaport and airport administrations, the State Border Guard and customs services. Lithuania has the legislation in place for medical and quarantine procedures at the designated PoE.

The Medical Quarantine Unit of the Klaipeda Department of the NVSC and the Communicable Diseases Management Unit of the Vilnius Department of the NVSC carry out medical-quarantine controls. The airport has a contingency plan for biological threats that has been tested in drills, and representatives from the seaport reported having an emergency response plan. After-action reviews are not routinely conducted after an event; however, lessons learnt during the COVID-19 pandemic and during exercises are integrated in the plans. Contact tracing poses challenges in both ad hoc (e.g. when a suspected case is detected on an arriving ship or airplane) and post hoc settings (e.g. when a case of infectious disease who had travelled on an airplane is detected after passengers' disembarkment).

In 2019, the NVSC organised two exercises at VNO: a table-top exercise predicting an imported case of suspected measles and a functional exercise predicting an imported case of suspected Ebola virus disease. NVSC specialists from designated PoE also participated in various international trainings and simulation exercises, with the last training to be joined by the NVSC of Klaipeda State Seaport in October 2025 in Greece and more exercises planned for VNO in 2026. Regular exercises for PoEs staff should be developed and implemented, focusing on multisectoral collaboration and emergency response protocols, including all relevant stakeholders to improve coordination and communication. While no regular meetings are held between the private and public sectors cooperating at PoEs, cooperation occurs on ad-hoc basis, and all stakeholders are involved in the revision of the plans and in exercises.

Data collected at PoE are not directly integrated into the national surveillance system; however, ad-hoc information from airport incidents (including on arriving crew or passengers with illness) is reactively collected and communicated. Currently, there are no regular vector monitoring and control measures in place at either of the designated PoEs. Although an informal risk assessment for the need of vector control was conducted in 2021, there are no regular plans to routinely reconduct such assessment.

Recommendation

Carry out regular risk assessments for vector management (i.e. monitoring and control) at designated points of entry to identify vulnerabilities and take appropriate mitigation actions.

Chemical events (Capacity 11)

Lithuania has a strong legal framework defining roles and responsibilities, key procedures, and link to crisis management for chemical events. Preparedness and response plans exist at local and national levels across stakeholder groups, and exercises are routinely performed to test and improve the system. Innovative solutions for coordination and communication in crisis situations have been developed, and an example was given during the assessment visit of the use of SIGNAL as a tool to define and rapidly inform and coordinate key stakeholders in crisis situations. Laboratory services in public health, food, environmental and animal sector are available and can support the confirmation and quantification of chemical events. Laboratories are generally licenced and majority of methods accredited. Efficient risk communication and training of staff in prevention and response to chemical events have been identified as challenges, however activities are ongoing to strengthen these capacities.

The NVSC is the most important institution that, after assessing an incident of chemical origin, provides recommendations to the public on how to avoid the consequences of the incident on health. In the institution there is a wide expertise in managing chemical events, including experiences and documentation of past events, contacts with key stakeholders, deployment of laboratory services, risk communication etc. The process for production of rapid risk assessment would however need strengthening. This includes documentation of overall procedure for assessing and quantifying risk, definition of timelines for delivery of assessments, strengthening recommendations of laboratory analysis to be conducted to further define an event and its consequences.

Recommendation

Document and strengthen the National Public Health Centre procedure for risk assessment to increase capacity to timely inform and coordinate response to chemical events

Union level coordination and support functions (Capacity 13)

Coordination and cooperation between Lithuania and the EU are embedded with established legal frameworks and instruments for communicable disease prevention, control, and public health emergency preparedness and response. At the national level, the Health Security Committee (HSC) member, based in the Ministry of Health's Public Health Department, plays a key role in these coordination structures, ensuring a two-way flow of information between the HSC and national authorities.

Opinions, recommendations and guidance on the prevention and control of serious cross-border threats to health from the EU Council, EC, HSC, and ECDC are regularly incorporated into Lithuania's national response measures. These are implemented through legislation, national recommendations and information to the public. The flow of such information aligns the mandates and areas of competences of the Lithuanian institutions, including the Ministry of Health and its subordinate bodies, such as the Health Emergency Situation Centre, the National Public Health Centre, the National Public Healthcare Laboratory, the Institute of Hygiene, the State Medicines Control Service, along with the related administrative levels. At times, however, this flow of information may lack consistency or completeness in reaching all stakeholders. Introducing simple standardised procedures could help improve the system, while also facilitating the sharing of information from the country to EU risk management and risk assessment platforms (e.g. EpiPulse), which currently remains limited.

Recommendations

- Develop standardised workflows to ensure the consistent dissemination of opinions and guidance from HSC, EC, ECDC, and other EU agencies and bodies across all national sectors and administrative levels.
- Enhance information-sharing through EU platforms for alert notification, risk assessment and risk management.

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

There are approximately 25 universities, national institutes, and public and private organisations active in health research in Lithuania.

Lithuania has mechanisms to launch competitive research programmes in response to societal challenges, and this was implemented during the COVID-19 pandemic. The Lithuanian Scientific Council has an ongoing funded research programme to strengthen societal resilience and crisis management in the context of current geopolitical events.

Lithuanian research institutes are actively involved in EU funded research, such as in Horizon Europe and EU4Health, and participates in projects such as VEBIS (Vaccine effectiveness, burden and impact studies), which is implemented by ECDC. Lithuania also participates in VACCELERATE, a pan-European clinical research network for accelerating vaccine trials as part of pandemic preparedness strengthening and takes part in the Clinical Trials Coordination Mechanism coordinated by DG HERA.

The State Medicines Control Agency, together with the State Healthcare Accreditation Service and the Lithuanian Bioethics Committee, regulate the conduct of clinical trials. During the COVID-19 pandemic, a rapid clinical trials protocol approval mechanism was utilised, but this mechanism is not currently valid. Maintaining the national infrastructure to quickly promote and/or mobilise clinical trials to assess the effectiveness of medicines and vaccines, would be optimal.

There is a promising national initiative to establish 'scientific translators' within Ministries, who can serve as bridges between domains to inform scientific communities about policy priorities and, conversely, to inform governmental officials about scientific developments.

The National Public Health Centre under the Ministry of Health is responsible for conducting outbreak investigations. However, there is no formal approach in emergency planning in relation to 'research preparedness', such as operational research protocols to quickly mobilise during emergencies to ensure that scientific knowledge relevant to decision-making can rapidly become available. Such protocols may be for research to be implemented in clinical and community settings. For infectious diseases, questions to address may focus on critical disease parameters (e.g. transmissibility, route of transmission), risk factors for severe outcomes, and the effectiveness of interventions. Methodologies might include, for example, case-control studies, intervention studies, first few X cases and contacts (FFX) investigations, and/or investigations to assess transmission in specific settings (such as in healthcare settings, households, schools). Descriptive approaches, such as cross-sectional analyses, may also be appropriate.

Recommendations

- Strengthen the links between research communities and state agencies responsible for health emergencies (e.g. via mapping, liaison/'translator' roles, establishment of networks).
- Develop operational research protocols and processes to ensure that research can quickly be mobilised to inform decision-making during health emergencies.

Recovery elements (Capacity 15)

The concept of recovery, intended as the process of returning to normal, is present in several parts of the Lithuanian legal framework and plans (e.g. Law on Crisis Management and Civil Protection). However, no plan nor chapter of a plan is entirely dedicated to recovery. As this process entails several steps, including restoring a 'new' normality and reflecting on the lessons learnt, it is important to articulate the recovery in a strategy with a consistent methodology. In this regard, after-action reviews (AARs) should be a cornerstone of this methodology.

In Lithuania, an AAR facilitated by ECDC through the EU Health Task Force has been conducted in November 2023 with a specific focus on contact tracing and case management during the COVID-19 pandemic. The request itself of this AAR supports the country's understanding of the relevance of these activities. However, the concept of routinely conducting AARs after events is not part of the country's recovery system. No other AARs have been conducted since then nor are foreseen at this time.

Once a consistent recovery methodology is integrated in the generic prevention, preparedness and response plan, it should be tested through simulation exercises.

Recommendation

Until the formal requirement to conduct AARs is integrated into the generic prevention, preparedness and response plan, AARs should already be carried out as a routine activity following public health events (e.g. outbreaks or public health emergencies) to capture lessons learned and strengthen future response.

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

Lithuania has spontaneously conducted several assessments and exercises in recent years. These include a Joint External Evaluation in 2018, a JADE exercise and a separate national audit on 'Ensuring sustainability of healthcare in emergencies' in 2022, the EURO-MED REACT simulation exercise in 2023 and an after-action review co-lead by ECDC and focused on the response to COVID-19 in 2023. Related recommendations and lessons learnt have partially been implemented, although not systematically, also due to national priority shifting after the COVID-19 pandemic and the new geopolitical situation.

Following after-action reviews, intra-action reviews, or other activities that identify lessons and relative recommendations, an action plan should be developed stating the recommendations, how they will be implemented in the planning (actions) and through which expected process (including the responsible actors, the implementation timelines, the source of the budget, if any, etc.). Establishing a clear and structured process for developing and monitoring the action plan(s) is valuable.

The current PHEPA will also provide several recommendations that the country will have to address in an action plan within nine months since receiving this report, as per the Serious Cross-Border Threats to Health Regulation. The same action plan can be used for keeping track of recommendations originating from different processes, as long as the ones deriving from the PHEPA are clearly recognisable.

Recommendation

Consolidate pending (from previous assessments) and new (from PHEPA) recommendations into an action plan (e.g. using the National Action Plan for Health Security (NAPHS) or equivalent tools) specifying for each action the responsible actors, timelines, required resources and origin of each related recommendation, and ensure close follow-up of implementation.

Conclusions

Lithuania is updating its governance framework for the prevention, preparedness, and response to public health emergencies, drawing on the experience from the COVID-19 pandemic and recent geopolitical challenges. Much of the legal basis has already been revised, and the State Emergency Management Plan is currently under review. The next steps will include the development of a generic prevention, preparedness, and response plan at the Ministry of Health level, followed by a dedicated national respiratory pathogen pandemic preparedness plan. This sequence is logical and will help ensure coherence across all national levels. To safeguard flexibility and resilience, the legislative framework should be complemented by clear, simple operational procedures that enable rapid implementation.

The revised governance framework should be further strengthened by enhancing key elements such as intersectoral coordination, surge laboratory capacity, systematic after-action reviews within the recovery process, strategies for community engagement and infodemic management, and a standardised multidisciplinary approach to public health and social measures. These additions would reinforce Lithuania's already solid response capacity, in line with the recommendations of the PHEPA and previous evaluations.

The next step will involve the preparation of an action plan to translate these recommendations into practice. Such a plan would facilitate systematic follow-up of multiple actions over time and across stakeholders, while leveraging synergies with other national priority initiatives, including those not directly related to public health.

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 at describing the main practical arrangements before the assessment process takes place regarding the PHEPA (under Article 8 of the SCBTH Regulation).

The arrangement refers to the country visit to Lithuania that will take place from 15 to 19 September in Vilnius.

The five capacities that will be assessed in-depth in this cycle 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 10*: Zoonotic diseases and threats of environmental origin, including those due to the climate

*The fifth capacity has been chosen by the country and agreed with ECDC.

Assessment team and national experts

Assessment team

The experts involved in this assessment are detailed in the table below. Please note that due to unexpected changes of circumstances some experts from 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 (ECDC/other agencies)**	**Role in the team (team leader/expert)**	**Capacities assessed**
Ettore Severi	ECDC	Team lead	Financing PoE Zoonotic diseases Union level coordination Recovery elements Actions taken to improve gaps
Vivian Leung	ECDC	Expert	AMR/HAI Surveillance Research HR
Daniel Palm	ECDC	Expert	Laboratory Surveillance Chemical events AMR
Leonidas Alexakis	ECDC	Expert	Surveillance IHR Laboratory RCCE Chemical events AMR
Jonathan Suk	ECDC	Expert	Health Emergency Management HSP HR Research RCCE
Tamas Bakonyi	ECDC	Expert	Zoonotic diseases
Elisabetta Pierini	ECDC	Expert	Financing PoE HEM Recovery elements Actions taken to improve gaps

Members of the assessment team			
Meike Schöll	Country expert from Germany	Expert	HEM PoE Recovery elements
Frederik Copper	WHO EURO	Expert	IHR PoE
Rimalda Voske	DG SANTE B2	Expert	Union level coordination HSP
Pierre-Francois Baulieu	DG HERA	Expert	Health emergency management (medical countermeasures)
Faye Ioannou	DG SANTE F2	Expert	Zoonotic diseases
Ana Victoria Pascual Linaza	DG SANTE F2	Expert	Zoonotic diseases

National experts supporting the document-sharing

The names of the experts that formed the national focal point team to coordinate the implementation of the PHEPA at country level and act as ECDC contact point are listed in the table below. The team supported the document collection, which was shared with the assessment team for phase 1: the desk review and the organisation of the country mission. In addition, the focal point team involvement includes collection of feedback from the interested parties on the draft report.

Country focal point(s) and experts involved in the document-sharing process			
Name	**Email address**	**Organisation**	**Role (focal point/document-sharing)**
Jurgita Pakalniškienė	jurgita.pakalniskiene@sam.lt	Ministry of Health (MoH)	Focal Point
Nerija Kuprevičienė	nerija.kupreviciene@sam.lt	Ministry of Health (MoH	Focal Point
Lina Balaišienė	lina.balaisiene@nvsc.lt	National Public Health Centre under the Ministry of Health (NVSC)	Document-sharing
Paulius Gradeckas	paulius.gradeckas@essc.sam.lt	Health Emergency Situations Centre of the Ministry of Health (ESSC)	Document-sharing
Asta Jurkevičienė	asta.jurkeviciene@hi.lt	Institute of Hygiene (HI)	Document-sharing
Jonas Žvirgždas	jonas.zvirgzdas@nvspl.lt	National Public Health Surveillance Laboratory (NVSPL)	Document-sharing

National experts participating to 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			
Alvyda Naujokaitė	Ministry of Health (MoH)	Expert	Health services provision
Ana Paleckytė-Prokopovič	National Public Health Surveillance Laboratory (NVSPL)	Expert	Laboratory
Artūras Purlys	Ministry of Transport and Communication	Expert	Point of Entry
Artūras Gromovas	Migration Department under the Ministry of Interior	Expert	Point of Entry
Asta Jurkevičienė	Institute of Hygiene (HI)	Coordinator	AMR and HAIs
Asta Razmienė	NVSC (regional level – Vilnius department)	Expert	Chemical events
Asta Šlepetienė	NVSC(regional level- Klaipėda department)	Expert	Chemical events
Audrius Ščeponavičius	MoH	Expert	All sessions (except Surveillance and Laboratory)

National experts participating in the assessment process			
Aurelija Žvirblienė	Vilnius University	Expert	AMR and HAIs / Research
Aušra Subotkevičienė	NVSC (regional level – Klaipeda department)	Expert	Points of Entry
Aušra Valaikienė	NVSC(national level)	Coordinator (capacity 10), expert (other capacities)	Laboratory / Surveillance / Zoonotic diseases and environmental threats
Birutė Zablockienė	Lithuanian Society for Infectious Diseases	Expert	Surveillance
Česlova Ambrozevičienė	National Food and Veterinary Risk Assessment Institute (NMVRVI) (national level)	Expert	AMR and HAIs
Daiva Visockienė	State food and veterinary Service (VMVT)	Expert	Points of Entry
Darija Platūkytė	ESSC	Coordinator (capacity 1 and 6)	IHR / Health Emergency Management / Risk communication and community engagement
Darius Domarkas	Ministry of Interior	Expert	Health Emergency Management
Darius Nienius	NMVRI	Expert	Zoonotic diseases and environmental threats / Laboratory
Domantas Žilėnas	Environmental Protection Department	Expert	Chemical events
Dovilė Marcinkė	VVKT	Expert	Health Emergency Management
Dovilė Zacharkienė	VVKT	Expert	Research
Dovydas Karoblis	NVSPL	Expert	Chemical events
Edita Jegelevičienė	NVSC(national level)	Expert	AMR and HAIs
Edita Kurienė	NVSC(national level)	Expert	Human resources
Egidijus Mecelis	VMVT	Expert	Zoonotic diseases and environmental threats
Eglė Burbienė	State Medicines Control Agency	Expert	Chemical events
Elvina Vadapalienė	NMVRVI	Expert	Zoonotic diseases and environmental threats
Erika Gedraitienė	Police Department	Expert	Chemical events
Erika Grigorevičė	NVSC (regional level – Klaipeda department)	Coordinator	Points of Entry
Gabija Bulotaitė	HI / Vilnius University	Expert	Research
Gabrielia Malgožata Liachovič	NVSC (regional level – Vilnius department)	Expert	Human Resources / Points of Entry
Gediminas Toleikis	State Health Insurance Fund	Expert	Financing / Health services provision
Giedrė Aleksienė	NVSC (national level)	Expert	Financing / Health Emergency Management / Points of Entry / AMR and HAIs
Giedrė Čiuberkytė	VMVT	Expert	Zoonotic diseases and environmental threats
Giedrius Viganauskas	Fire and Rescue Department under the Ministry of the Interior of the Republic of Lithuania	Expert	Health Emergency Management / Chemical events
Ginreta Megelinskienė	MoH	Coordinator (capacities 8), expert (other capacities)	All sessions (except AMR and HAIS, Health Emergency Management)
Gintaras Makštutis	Lithuanian Society of Laboratory Medicine	Expert	Laboratory
Gintarė Jatkevičiūtė	Laboratory medicine Society	Expert	Research
Gitana Aukštuolienė	Ministry of Transport and Communication	Expert	Points of Entry
Gražvydė Norkienė	HI	Expert	Zoonotic diseases and environmental threats

National experts participating in the assessment process			
Greta Gargasienė	NVSC (national level)	Coordinator (capacity 10), expert (other capacities)	Laboratory / Surveillance / Health services provision / Risk communication and community engagement / Zoonotic diseases and environmental threats / Recovery and Actions taken to improve gaps in implementation of PPR plans
Greta Undžytė	MoH	Expert	Health services provision
Henrikas Armoška-Eismontas	JSC Lithuanian Airports (Vilnius airport)	Expert	Points of Entry
Ilona Burkauskienė	HI (national level)	Expert	Zoonotic diseases and environmental threats
Indrė Stoškuvienė	VMVT	Expert	Zoonotic diseases and environmental threats
Ineta Pranskūnaitė	HI (national level)	Expert	AMR and HAIs
Ingrida Skridailienė	NVSC (national level)	Expert	Chemical events
Irena Taraškevičienė	NVSC(national level)	Expert	Risk communication and community engagement / Research
Irma Diržinauskaitė-Butkienė	MoH	Expert	AMR and HAIs
Iveta Paludnevičiūtė	ESSC	Expert	Health Emergency Management
Jekaterina Sinotova	NVSPL (national level)	Expert	AMR and HAIs
Jelena Razmuk	NVSPL (national level)	Expert	Laboratory / AMR
Jolanta Mikulevič	VMVT	Expert	Chemical events
Jonas Žvirgždas	(NVSPL) (national level)	Coordinator (capacity 3), expert (other capacities)	Zoonotic diseases / IHR / Surveillance / Laboratory/ Research /Risk communication / Union level coordination / Recovery and Actions taken to improve gaps in implementation of PPR plans
Jovita Einorytė	VMVT	Expert	AMR
Judita Liukaitytė - Kukienė	Ministry of Environment (MoE)	Expert	Zoonotic diseases and environmental threats
Julijanas Gališanskis	MoH	Expert	Risk communication and community engagement
Jūratė Buitkuvienė	NMVRVI (national level)	Expert	Zoonotic diseases and environmental threats
Jurgita Pakalniškienė	MoH	Coordinator (capacities 5, 15), expert (other capacities)	All sessions (except Surveillance and Laboratory)
Jurgita Šakalienė	NMVRVI (national level)	Expert	Zoonotic diseases and environmental threats
Kristina Rudžinskaitė	NSC(regional level – Kaunas department)	Expert	Surveillance
Kristina Stakytė	VMVT	Expert	Zoonotic diseases and environmental threats
Lina Balaišienė	NVSC(national level)	Coordinator (capacity 4), expert (other capacities)	IHR / Surveillance / Health services provision / Points of Entry / Chemical events / Union level coordination / Recovery and Actions taken to improve gaps in implementation of PPR plans
Lina Grinytė-Jauniškienė	NVSC (national level)	Expert	Risk communication and community engagement
Marijona Žalynaitė	Fire and resque departament	Expert	Chemical events
Mindaugas Kirstukas	MoE	Expert	Zoonotic diseases and environmental threats
Mindaugas Valančius	ESSC	Coordinator (6b), expert (other capacities)	Health Emergency Management / / Union level coordination

National experts participating in the assessment process			
Modestas Ružauskas	Lithuanian academy of Science	Expert	Research
Nerija Kuprevičienė	MoH	Coordinator (capacities 2, 13, 14, 16), expert (other capacities)	All sessions (except AMR and HAIS, Health Emergency Management)
Orina Ivanauskienė	NVSC(national level)	Expert	Zoonotic diseases and environmental threats
Otilija Špūrienė	Environmenatl Protection Agency	Expert	Chemical events
Paulius Bušauskas	VMVT	Expert	Zoonotic diseases and environmental threats
Paulius Gradeckas	ESSC	Coordinator (capacity 1 and 6)	IHR / Health Emergency Management / Risk communication and community engagement
Petras Mačiulskas	NMVRVI (national level)	Expert	Zoonotic diseases and environmental threats
Povilas Rudinskis	MoE	Expert	AMR and HAIs
Raminta Mitkuvienė	Klaipėda University Hospital	Expert	AMR and HAIs
Ramunė Andrušaitienė	MoH	Coordinator	Health services provision
Rasa Liausėdienė	NVSC(national level)	Coordinator (capacity 4), expert (other capacities)	IHR / Surveillance / Health emergency management / Health services provision / Points of Entry / Chemical events / Union level coordination / Recovery and Actions taken to improve gaps in implementation of PPR plans
Renata Pilipavičienė	ESSC	Expert	Health Emergency Management
Renata Totorienė	Ministry of Finance	Expert	Financing / Human resources / Health services provision
Rima Živatkauskaitė	VMVT	Expert	Zoonotic diseases and environmental threats
Rimantas Šikas	Ministry of Transport and Communication	Expert	Point of entry
Rimantas Zajarskas	NVSC(national level)	Expert	Points of Entry
Rita Gaidelytė	HI	Expert	Human resources
Rolanda Lingienė	NVSC(regional level - Vilnius department)	Expert	Human Resources
Rolanda Valintėlienė	HI (national level)	Expert	AMR and HAIs
Romaldas Mačiulaitis	State Health Insurance Fund	Expert	AMR and HAIs
Saida Stankevičiūtė	NVSC (regional level- Kaunas department)	Expert	Zoonotic diseases and environmental threats
Sandra Idienė	ESSC	Expert	Health Emergency Management
Saulius Kunickis	Ministry of Agriculture	Expert	AMR and HAIs
Saulius Tuska	Environmenatl Protection Department	Expert	Zoonotic diseases and environmental threats
Silvija Kiverytė	Vilnius University Hospital Santaros klinikos	Expert	AMR and HAIs
Silvija Steckytė	NVSC (national level)	Coordinator	Chemical events
Simona Adamkevičiūtė	State Health Insurance Fund	Expert	Financing
Simona Pilevičienė	NMVRVI (national level)	Expert	AMR and HAIs / Laboratory
Simona Sviackevičienė	MoH	Expert	Human resources
Svajūnė Muralytė	NVSPL (national level)	Coordinator (capacity 3), expert (other capacities)	IHR / Surveillance / Laboratory/ Research /Risk communication / Union level coordination / Recovery and Actions taken to improve gaps in implementation of PPR plans

National experts participating in the assessment process			
Tomas Kaniauskas	Vilnius University	Expert	Research
Vaida Mitkuvienė	NVSC (regional level- Tauragė department)	Expert	Zoonotic diseases and environmental threats
Viktorija Morkevičiūtė	NVSC (regional level – Vilnius department)	Expert	Human Resources / Points of Entry
Vilija Grigaliūnienė	VMVT	Expert	Zoonotic diseases and environmental threats
Vilija Gurkšnienė	Vilnius University Hospital Santaros klinikos	Expert	AMR and HAIs
Vilma Bukauskienė	NVSC(national level)	Expert	Financing
Violeta Aleknavičienė	NVSC (national level)	Expert	Laboratory / AMR and HAIs
Violeta Andriejūnienė	Environmenatl Protection Agency	Expert	Chemical events
Violeta Masoit	VMVT	Expert	Chemical events
Žydrūnas Nesteckis	Klaipeda State Seaport Authority	Expert	Points of Entry
Žydrūnas Vaišvila	VMVT	Expert	Zoonotic diseases and environmental threats
Žilvinė Našlėnė	HI	Expert	Zoonotic diseases and environmental threats

Agenda for the in-country visit

	Monday	Tuesday		Wednesday	Thursday	Friday
08:30	Welcome & Registration	Registration		Registration	Registration	
09:00	Opening Remarks (country)	Breakout room 1 - **C.3 Laboratory** Combined with **site visit at National Public Health Laboratory** *F2 could join if relevant. (Assessment of in-depth capacities)	Breakout room 2 - **C.6 Health Emergency Management** - planning, IMS, risk profiling, PHSM *(Assessment of in-depth capacities)*	C.5 Human Resources	C.13 Union level coordination	Internal assessment team meeting
09:15	Overview and key aspects of the assessment process (ECDC and DG SANTE F2)					
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)			C.7 Health Service Provision	C.9 PoE	Registration and welcome coffee
10:30	Break	Break		Break		
11:00	Assessment of Cross-Cutting Aspects - Scenario based discussion	Breakout room 1 - **C.3 Laboratory** *(Assessment of in-depth capacities)*	Breakout room 2 - **C.6 Health Emergency Management** - planning, IMS, risk profiling, PHSM *(Assessment of in-depth capacities)*	C.2 Financing	Break	Main findings, conclusions, recommendations and next steps (ECDC presentation and discussion with Country)
11:30						
11:45				C.11 Chemical events	C.15 Recovery and C.16 Action plan (together in the same session)	
12:00						Concluding remarks (country)
12:30	Lunch	Lunch		Lunch	Lunch	Debrief on the ECDC assessment process (structure, preparation, organization)
12:45						
13:15						**OPTIONAL** - Lunch
13:30	Breakout room 1 - **Capacity 10. Zoonotic diseases and threats of environmental origin, including those due to the climate** *(Assessment of in-depth capacity) (ECDC and DG SANTE F2 joint)* / Breakout room 2 **C.12 AMR/HAIs** *(Assessment of in-depth capacities)*	Breakout room 1 - **C.4 Surveillance** *(Assessment of in-depth capacities)*	Breakout room 2 - C.6 **Health Emergency Management** - Medical Counter Measures *(Assessment of in-depth capacities)*	C.14 Research	Buffer for further in-depth dicussion Wrap-up session	
14:15						
14:45						
15:00	Break	Break		Break	Internal assessment team meeting	
15:30	Breakout room 1 - **Capacity 10. Zoonotic diseases and threats of environmental origin, including those due to the climate** *(Assessment of in-depth capacity) (ECDC and F2 joint)* / Breakout room 2 **C.12 AMR/HAIs** *(Assessment of in-depth capacities)*	Breakout room 1 - **C.4 Surveillance** *(Assessment of in-depth capacities)*	Breakout room 2 - C.6 **Health Emergency Mangement** - Medical Counter Measures *(Assessment of in-depth capacities)*	C.1 IHR		
16:15				C.8 RCCE		
17:00	Wrap-up Day 1 (ECDC and F2 together with country)					

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