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INTERNATIONAL HEALTH REGULATIONS AND EBOLA VIRUS DISEASE

Introduction

1. The purpose of this report is to provide an update on the status of the implementation of the International Health Regulations ("IHR" or the "Regulations"). It updates the last report presented in 2014 to the 53rd Directing Council *(1)* and, focusing on preparedness and response activities undertaken by States Parties and the Pan American Sanitary Bureau (PASB) in response to the public health emergency of international concern (PHEIC) related to Ebola virus disease (EVD), highlights issues requiring concerted action by States Parties in the Region of the Americas for the future implementation of the Regulations.

Situation Analysis

2. The Pan American Health Organization (PAHO) serves as the World Health Organization (WHO) IHR Contact Point for the Region of the Americas and facilitates the management of public health events through the established communication channels with the National IHR Focal Points (NFP). In 2014, all 35 States Parties in the Region submitted an annual confirmation or update of the contact details for their NFP. Routine connectivity tests, performed in 2014, between the WHO IHR Contact Point and the NFP in the Region were successful for 34 of the 35 States Parties (97%) by e-mail and for 33 of the 35 States Parties (94%) by telephone.

3. In the period from 1 January to 31 December 2014, a total of 121 public health events of potential international concern were identified and assessed in the Region. For 92 of the 121 events (76%), national health authorities, including through the NFP on 75 occasions, were the initial source of information. Verification was requested and obtained for 18 events identified through informal or unofficial sources. Of the 121 events considered, 63 (51%), affecting 29 countries and territories in the Region, were of substantiated international public health concern. The largest proportion of these 63 events was attributed to infectious hazards (42 events; 67%), and the etiology most frequently recorded was chikungunya virus (21 events). The remaining 21 events of substantiated international public health concern were attributed to the following hazards:

food safety (9), zoonosis related (5), product related (3), disaster related (2), chemical (1), and radiation related (1).

4. Significant public health events that affected, or had public health implications for, States Parties in the Americas from 1 January 2014 to 20 March 2015 are highlighted below:

a) Since the "IHR Emergency Committee concerning the international spread of wild poliovirus" (Polio IHR EC) first met in April 2014, with subsequent determination by the Director-General of WHO that the international spread of wild poliovirus constituted a Public Health Emergency of International Concern, the Polio IHR EC has met on three additional occasions. During its last meeting in February 2015, the Polio IHR EC concluded that the spread of wild poliovirus still constitutes a PHEIC, and temporary recommendations were refined and extended for a further three months with a focus on the following States Parties: *i)* states that are currently exporting wild poliovirus (Cameroon, Equatorial Guinea, Syrian Arab Republic), with a tailored set of temporary recommendations for Pakistan; *ii)* states that are infected with wild poliovirus but not currently exporting (Afghanistan, Ethiopia, Iraq, Israel, Nigeria, and Somalia); and *iii)* states that are no longer infected by wild poliovirus but remain vulnerable to international spread (Ethiopia, Syrian Arab Republic, Israel). PAHO continues to advise that States Parties in the Americas apply the recommendations of the Technical Advisory Group on Vaccine-preventable Diseases to maintain the Americas free of wild poliovirus.

b) The two, non-epidemiologically linked, confirmed cases of Middle East respiratory syndrome coronavirus (MERS-CoV) infection in the United States in May 2014 remain the only cases detected in the Americas. MERS-CoV began to spread in 2012 and, as of 20 March 2015, was still mainly affecting the Eastern Mediterranean Region, with the Kingdom of Saudi Arabia accounting for over 85% of the more than 1,000 cases, including nearly 400 fatal ones, reported to WHO. Confirmed cases of MERS-CoV infections have been reported by 23 States Parties worldwide, including 12 with documented local transmission. In response to the spread of MERS-CoV, the Director-General convened the "IHR Emergency Committee concerning Middle East respiratory syndrome coronavirus" (MERS-CoV IHR EC), and the committee met eight times between July 2013 and February 2015. The advice provided by the MERS-CoV IHR EC, disseminated to all States Parties, did not lead to the determination of a PHEIC by the Director-General.

c) Chikungunya virus was first detected in December 2013 in the Caribbean subregion. As of 20 March 2015, autochthonous transmission of the virus had been documented in 29 States Parties and 15 territories across the subregions. Imported cases of chikungunya virus were reported in five States Parties (Canada, Cuba, Peru, Argentina, and Chile) and one territory (Bermuda). Between the detection of its introduction in the Region and 20 March 2015, nearly 1.3 million

cases, including over 180 fatal ones, were recorded in the Americas. Further information is presented in the Report on Chikungunya Virus Transmission and Impact in the Americas (Document CE156/INF/6 [2015]).

d) The first EVD cases in Guinea were notified to WHO in March 2014. The outbreak rapidly spread to the neighboring countries of Liberia and Sierra Leone, also involving the capitals of the three countries. The spiraling out of control of the outbreak, which reached an unprecedented and unforeseeable magnitude—with nearly 25,000 cases and more than 10,000 deaths as of 20 March 2015 in the three West African countries still experiencing transmission—led to the convening, on 6 August 2014, of the "IHR Emergency Committee regarding Ebola" and, upon its advice, to the determination by the Director-General of the EVD outbreak in West Africa as a PHEIC. The determination of the event as a PHEIC implied the issuance of temporary recommendations subdivided into three subsets applicable, depending on their specific EVD epidemiological and risk status, to countries across the globe. Up to 20 March 2015, an additional 35 EVD cases, including 15 fatal ones, had been recorded in six other countries (Mali, Nigeria, Senegal, Spain, United Kingdom, United States). Cases recorded in these countries, all EVD-free as of 20 March 2015, resulted from importation and/or local transmission, and one of the two imported cases in the United States led to local nosocomial transmission to two health care workers. In addition to the confirmed EVD cases in the United States, as of 20 March 2015, individuals in eight countries in the Americas (Bahamas, Brazil, Canada, Chile, El Salvador, Honduras, Mexico, United States) with illness compatible with EVD had been investigated and subsequently determined not to have the disease. Since its first meeting in August 2014, the "IHR Emergency Committee regarding Ebola" has met on three additional occasions, and temporary recommendations have been further refined. As also highlighted through in-country missions organized by PAHO to support EVD-related preparedness efforts in 25 States Parties in the Region, a concern has been the adoption of public health measures that unnecessarily interfere with international travel and trade and contravene one of the temporary recommendations. On the basis of Article 43 of the Regulations,[1] at least 14 States Parties in the Region were requested to provide the public health rationale for the adoption of such measures. Between July 2014 and March 2015, 17 PASB staff members were deployed to West Africa to support response efforts. The commitment of the international community to step up efforts to bring the EVD outbreak in West Africa under control was crystallized in Resolution EBSS3.R1 *(2)*. The sections to follow further elaborate on EVD-related preparedness efforts undertaken in the Region by States Parties and by PASB.

5. At the end of July 2014, PASB substantially intensified activities to support States Parties in their EVD-related preparedness efforts as well as to enhance its own level of

[1] The text of the International Health Regulations, Resolution WHA 58.3, is available at: http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf

readiness. An extremely limited number of EVD cases introduced by air travel was regarded as the most likely scenario to drive preparedness activities, consistent with temporary recommendations applicable to EVD-free countries and ultimately aiming at containing and preventing the establishment of chains of local transmission, minimizing any unnecessary interference with international travel and trade.

6. Initial activities undertaken by PASB included: *a)* the development and dissemination of technical guidelines,[2] including protocols for the shipment of samples for confirmatory tests to the WHO Collaborating Centers at the Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, United States, and the Public Health Agency of Canada (PHAC), Winnipeg; *b)* the organization of virtual meetings with national competent authorities from different disciplines and sectors regarding the implementation of the temporary recommendations; *c)* the intensification of interactions with international partner organizations and agencies, including the International Air Transport Association, the International Civil Aviation Organization (ICAO), the Cruise Lines International Association, the Caribbean Public Health Agency, United States government Agencies, and PHAC; *d)* the creation of a regional stockpile of personal protective equipment (PPE) in the PAHO warehouse in Panama; *e)* the establishment of a PAHO Task Force on Ebola that includes senior staff at different organizational levels; *f)* the activation of an incident management mechanism; *g)* the provision of training on clinical management, laboratory biosafety, and risk communication at the national, subregional, and regional levels; and *h)* the development of the Framework for Strengthening National Preparedness and Response for Ebola Virus Disease in the Americas (PAHO EVD Framework), broadly applicable to any emerging or reemerging infectious disease *(3)*.

7. In order to effectively and sustainably support national authorities, PASB activities outlined in the PAHO EVD Framework were tailored to the context of each country and encompassed three phases—preparatory, in-country missions, and follow- up—all requiring actions at both the political and technical organizational levels.

a) The preparatory phase focused on a review of existing technical documents and infrastructures by national authorities and the PAHO/WHO country offices in order to identify gaps and needs warranting provision of additional technical cooperation through in-country missions. To defuse EVD-related fear fueled by the media and to prepare the ground for the implementation of recommendations resulting from in-country missions, letters from the PASB Director were sent to national authorities at the highest level and contact established with the leaders of the Inter-American Development Bank, the Organization of American States, the World Bank, and donor agencies.

b) Between October 2014 and March 2015, multidisciplinary technical missions (with a duration of 3 days on average) involving several partner institutions were led by PASB in 25 States Parties. Country-specific findings of the mission teams

[2] http://www.paho.org/hq/index.php?option=com_content&view=article&id=10137&Itemid=41116&lang=en

were subsequently shared with heads of states and ministers of health. The in-country missions focused on elements of preparedness critical for a country to manage a potential EVD case during the first 72 hours after its detection. Findings and observations regarding the status of EVD-specific preparedness across the Region are presented below.

i. *General observations:* There is no one-size-fits-all approach to preparedness. Ownership, leadership, and knowledge of the local context by national authorities are essential if preparedness and response efforts are to be effective, especially considering the need to induce behavioral changes in the public and specific occupational groups as well as to ensure the public's acceptance of measures that might be restrictive. Mindful that strategies to ensure sustainability and institutional memory should be an inherent component of preparedness efforts, and after action review exercises, the in-country missions demonstrated that with the due level of political commitment and dedication, significant progress can be made over short periods of time without the need for major financial investments. Cross-cutting issues that emerged during the in-country missions were the need to precisely characterize in practical terms the added value of subregional integration mechanisms to national preparedness as well as the need to rapidly address legal and ethical matters not previously contemplated.

ii. *Coordination:* Although intersectoral coordination mechanisms need to be further refined and constantly tested, significant momentum has been gained in terms of implementation of concerted actions. While there is a need for leadership roles to be clearly attributed and exercised, there is also a need to more clearly provide to the most competent technical institution the tools to exercise its guidance to ensure a technically coherent approach to preparedness and response. Although the development of plans is critical to preparedness, the status of these plans is still uncertain, and the operability and interoperability of different plans and procedures appeared to be suboptimal. There is a need for plans and procedures to become more relevant tools for guiding preparedness and response operations, and they should be tested in real-life situations as well as simulations.

iii. *Detection:* The early warning function of surveillance is not homogeneously present across health services, and thus coordination between public health authorities and the private sector is suboptimal. There is a substantial need for improving the capacity of health care workers to systematically triangulate clinical and epidemiological information. An excessive dependence on, and unjustified confidence in, screening at points of entry for identifying and preventing the introduction of potential EVD cases was observed. Together with the need to improve quality control and biosecurity aspects of laboratories, management of samples for potential EVD cases remains challenging, with the lack of

truly operational arrangements for international shipment of samples to WHO Collaborating Centers being the main stumbling block to carrying out EVD confirmatory tests.

iv. *Isolation:* A wide range of designated isolation areas were observed during the in-country missions, and virtually all of them presented gaps and posed concerns regarding sustainability in terms of adequacy of the layout of the infrastructure and of infection prevention and control (IPC) procedures, including availability and appropriateness of PPE and waste management. Comprehensive and sustainable IPC strategies, including a strong, continuous training component, should become the utmost national priority to ensure routine implementation of IPC practices driven by risk assessment.

v. *Response:* For a variety of reasons, the capacity to investigate and implement control measures in response to a potential EVD case is not always homogeneously distributed across country territories. Additionally, fragmentation of health services (public, private, social security) poses an obstacle to the management of potential EVD cases, from detection to referral, clinical management, and disinfection. With respect to adoption of measures that could interfere with international travel and trade, a poor ability to comply with temporary recommendations for EVD-free countries was observed, as well as limited knowledge and understanding of Article 43 of the Regulations. However, factors that could partially explain the adoption of such measures were the global shortage of PPE, suboptimal procurement mechanisms and logistic chains, and the changes in the PPE specifications published by WHO and other international agencies in October 2014 *(4)*. The extent of the implementation of risk communication plans was difficult to gauge. However, levels of community engagement in preparing for a possible EVD introduction appeared to be insufficient, and use of media to defuse anxiety was suboptimal.

c) The follow-up phase will focus on supporting national authorities in the implementation of recommendations formulated during the in-country missions, and the Secretariat is closely interacting with international development banks and other donor agencies to secure access to the resources needed.

8. Pursuant to Articles 5 and 13 of the IHR, all 35 States Parties in the Region formally communicated to WHO their position vis-à-vis the potential additional 2014-2016 extension for attaining core capacities (detailed in Annex 1 of the Regulations) and maintaining them beyond that date. Twenty-two of the States Parties (63%) requested the extension. The six States Parties that determined in 2012 that core capacities were present reiterated their ability to maintain them. In 2014, seven additional States Parties determined that core capacities had been attained and could be maintained. While two of the three European States Parties with overseas territories geographically located in the Region—France and the Netherlands—also requested the 2014-2016

extension because of the challenges encountered in their overseas territories, the United Kingdom, which was granted a 2012-2014 extension, did not communicate its position vis-à-vis the 2014-2016 extension. The Annex presents a summary of the States Parties Annual Reports to the Sixty-eighth World Health Assembly (May 2015) and the status of requests for the additional 2014-2016 extension for establishing core capacities.

9. Following the advice of the IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, which met in Geneva, Switzerland, on 13-14 November 2014, the Director-General granted the extension, until June 2016, to all States Parties that had requested it. Three States Parties for which the 2014-2016 National IHR Extension Action Plan submitted was regarded as incomplete or absent subsequently received a communication from the Director-General inviting them to refine or elaborate the plan.

10. States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2015 showed steady improvements at the regional level in all core capacities. However, the status of the core capacities across the subregions continues to be heterogeneous, with the lowest scores consistently registered in the Caribbean subregion. As of 20 March 2015, 30 of 35 States Parties in the Americas (86%) had reported to the Sixty-eighth World Health Assembly.

11. When the most recent reports are compared with the States Parties Annual Reports submitted to the Sixty-seventh World Health Assembly, variations in regional average scores are in the range of five percentage points in the case of all capacities. With the exception of the capacities to respond to events associated with chemical (54%) and radiation-related (55%) hazards, the regional average score for all remaining capacities is close to or above 75%; the highest score is for surveillance (89%). As noted above, the Annex presents a summary of the States Parties Annual Reports to the Sixty-eighth World Health Assembly and the status of requests for the additional 2014-2016 extension for establishing core capacities.

12. To support institutional strengthening efforts in States Parties in the Region, PAHO continues to intensify joint activities with other international specialized agencies (e.g., the International Atomic Energy Agency [IAEA] and ICAO) and partners with relevant expertise in the Region (e.g., the WHO Collaborating Center for Prevention, Preparedness and Response to Chemical Emergencies at the Companhia Ambiental do Estado de São Paulo in Brazil; the WHO Collaborating Center for Implementation of IHR Core Capacities at the CDC in the United States; and PHAC in Canada).

13. As of 20 March 2015, 484 ports in 27 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates *(5)*. Nine additional ports were authorized in six overseas territories of France and the United Kingdom. Procedures for voluntary certification of designated airports and ports will soon be disseminated by WHO headquarters. The Global Symposium of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) is

being convened by ICAO in collaboration with WHO in Montreal, Canada, on 28-30 April 2015.

14. In the absence of rejections and/or reservations, due to be notified by States Parties to the Director-General by 11 January 2016, the amendment of Annex 7 of the Regulations—recognizing that one single dose of yellow fever vaccine is sufficient to confer lifelong protection—will enter into force in June 2016 *(6)*. However, in order to minimize discomfort to travelers and accelerate harmonization of practices, Resolution EB136.R5 of 2015 ("Yellow fever risk mapping and recommended vaccination for travellers") *(7)*, submitted to the Sixty-eighth World Health Assembly for approval, requests that the WHO Secretariat publish a list of countries accepting the certificate of vaccination against yellow fever with one single dose. Similarly, in order to guarantee the use of a participatory process in mapping areas at risk for yellow fever transmission, also needed to update the WHO publication "International Travel and Health" *(8)*, Resolution EB136.R5 requests the establishment of a formal scientific and technical advisory group on geographical yellow fever risk mapping that will include the participation of countries with areas at risk of yellow fever transmission. As of 20 March 2015, 24 of the 35 States Parties in the Region (69%) had provided contributions to the 2015 update of the WHO publication "International Travel and Health."

15. As of 20 March 2015, the IHR Roster of Experts included 424 experts, 117 of whom are from the Region of the Americas, including eight designated by the respective State Party.

16. The EVD outbreak in West Africa put virtually all IHR provisions to the test. Although fueled by fear, the political and public health shockwave in States Parties in the Americas generated by this event should be regarded as wakeup call that offers States Parties and the WHO Secretariat an opportunity to capitalize on the momentum gained through the reactive, strenuous, and accelerated EVD-related preparedness efforts undertaken since August 2014. The EVD outbreak also offers the opportunity to reconsider the actual operational meaning and practical public health implications of States Parties' commitment to national and global public health, expressed through the IHR, and to establishing and maintaining essential public health functions, including across-sector (core capacities detailed in Annex 1 of the Regulations). This implies an approach to preparedness beyond a checklist and quantitative indicators, beyond a legal focus on the implementation of the Regulations, and beyond set deadlines, which should be regarded as milestones. Finally, it highlights that public health preparedness requires a continuous and holistic approach to health system strengthening to ensure that health systems are sufficiently robust and resilient to allow the desired degree of flexibility in preparing for and responding to rapidly emerging and/or changing risks in an interconnected world, as well as ensuring the sustainability of essential public health functions.

17. This substantial shift in perspective—from the Regulations as a merely legal instrument to a tool that will support continuous public health preparedness processes in all States Parties and globally—was crystallized in the "Report of the Review Committee

on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation" *(9),* whose 10 recommendations have been submitted for approval by the Sixty-eighth World Health Assembly *(10)* and revolve around the following two conclusions:

a) *The work to develop, strengthen, and maintain the core capacities under the IHR should be viewed as a* continuing *process for all countries:* The fact that 22 States Parties in the Region requested the 2014-2016 extension should be regarded as a sign of responsibility, highlighting the understanding that public health preparedness is a continuous process and reflecting, in most cases, considerations regarding institutional robustness and political context. Also, the EVD-related preparedness efforts of small island states and overseas territories have magnified the drawbacks of a one-size-fits-all approach to the implementation of the Regulations. Similarly, these efforts highlight the challenges at the national level in ensuring coordination with multiple external partners and donors.

b) *The implementation of the IHR should now advance beyond simple "implementation checklists" to a more action-oriented approach to periodic evaluation of functional capacities:* As indicated in Decision CD52(D5), "Implementation of the International Health Regulations" *(11),* a significant challenge in implementing the IHR is the lack of adequate metrics that demonstrate actual public health benefits of the IHR, the degree of compliance by the parties (Secretariat and States Parties), as well as the lack of satisfactory mechanisms to ensure the desired levels of mutual accountability among States Parties. Options for monitoring the implementation of the Regulations beyond 2016 were offered during the "Regional Meeting in the Americas on the Implementation of the International Health Regulations (IHR)" in Buenos Aires, Argentina, on 29-30 April 2014 and were captured in the recommendations of the IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation. They include *(i)* the need to revise the global monitoring scheme in an institutionally participatory manner, on the basis of a roadmap reflecting the calendar of regional and global WHO Governing Bodies; *(ii)* the need for a holistic monitoring scheme encompassing all parties and provisions; *(iii)* the use of quantitative and qualitative approaches that involve States Parties individually and collectively and focus on public health events, institutionalization of essential public health functions, administrative obligations, use of existing international monitoring mechanisms employed by other relevant international organizations (e.g., IAEA, ICAO), and the performance of the WHO Secretariat.

Action by the Executive Committee

18. The Executive Committee is invited to take note of this report and provide any recommendations it may have.

Annex

References

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Annex

Summary Table: States Parties Annual Reports to the 68th World Health Assembly and Status of Requests for the Additional 2014-2016 Extension for Establishing Core Capacities

States Parties	Requested and obtained 2012-2014 extension	Formally communicated position vis-à-vis 2014-2016 extension	Requested and obtained 2014-2016 extension	Submitted State Party Annual Report to 68th WHA	Legislation Policy Financing	Coordination and NFP communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Antigua and Barbuda	yes	yes	yes	yes	100	100	100	82	73	71	100	95	86	100	100	85	23
Argentina	yes	yes	no	yes	50	73	80	83	100	86	100	90	86	100	60	69	62
Bahamas	yes	yes	yes	yes	75	83	100	70	41	86	40	96	74	44	47	38	0
Barbados	yes	yes	yes	yes	75	53	70	82	70	71	80	86	97	89	60	46	38
Belize	yes	yes	yes	no	-	-	-	-	-	-	-	-	-	-	-	-	-
Bolivia (Plurinational State of)	yes	yes	yes	yes	100	90	80	76	60	43	20	71	31	78	53	15	77
Brazil	no	yes	no	yes	100	100	100	100	100	100	100	96	80	100	100	85	92
Canada	no	yes	no	yes	100	100	95	100	100	100	100	100	100	100	100	100	100
Chile	no	yes	no	yes	75	83	95	94	66	71	60	86	35	100	93	23	62
Colombia	no	yes	no	yes	100	63	50	94	33	100	80	76	91	78	67	69	69
Costa Rica	no	yes	no	yes	100	100	95	100	71	100	80	76	97	100	100	77	62
Cuba	yes	yes	no	yes	100	100	100	100	100	100	100	50	83	100	100	85	100
Dominica	yes	yes	yes	yes	75	100	90	83	60	100	20	73	64	89	87	31	23
Dominican Republic	yes	yes	yes	yes	75	90	85	76	81	100	100	90	64	56	27	23	69
Ecuador	yes	yes	yes	yes	75	100	85	76	71	71	80	71	73	89	80	54	100
El Salvador	yes	yes	no	yes	100	100	100	100	90	86	100	100	100	100	93	62	77
Grenada	yes	yes	yes	no	-	-	-	-	-	-	-	-	-	-	-	-	-
Guatemala	yes	yes	no	yes	0	73	75	76	45	57	50	75	60	78	100	67	50
Guyana	yes	yes	yes	yes	100	83	90	100	100	86	100	100	38	100	73	62	0
Haiti	yes	yes	yes	yes	0	46	95	69	20	86	40	96	6	44	27	0	0

Summary Table *(cont.)*

Honduras	yes	yes	yes	yes	50	53	90	52	33	43	40	71	36	78	47	8	31
Jamaica	yes	yes	yes	yes	50	73	60	75	73	57	20	53	70	67	47	38	31
Mexico	yes	yes	no	yes	100	80	95	94	90	100	100	100	94	100	100	85	100
Nicaragua	yes	yes	no	yes	100	83	100	94	90	100	100	86	90	100	80	92	100
Panama	yes	yes	yes	yes	75	100	95	88	60	71	40	96	65	89	60	15	31
Paraguay	yes	yes	yes	no	-	-	-	-	-	-	-	-	-	-	-	-	-
Peru	yes	yes	yes	yes	100	83	100	94	90	100	80	100	27	100	100	46	85
Saint Kitts and Nevis	yes	yes	yes	no	-	-	-	-	-	-	-	-	-	-	-	-	-
Saint Lucia	yes	yes	yes	yes	25	20	65	58	25	86	40	86	6	89	60	23	0
Saint Vincent and the Grenadines	yes	yes	yes	yes	75	73	80	66	53	43	20	35	48	100	40	8	0
Suriname	yes	yes	yes	yes	50	83	90	100	83	71	40	100	84	67	87	62	0
Trinidad and Tobago	yes	yes	yes	yes	50	56	95	76	71	71	20	81	77	89	87	62	77
United States	no	yes	no	yes	100	100	100	100	100	100	100	50	100	100	100	100	100
Uruguay	yes	yes	no	no	-	-	-	-	-	-	-	-	-	-	-	-	-
Venezuela (Bolivarian Republic of)	yes	yes	yes	yes	50	90	100	100	100	71	100	90	59	100	93	92	85

Caribbean* (n=12)	65	73	86	80	64	77	52	79	61	82	68	45	24
Central America (n=7)**	71	86	91	84	67	80	73	85	73	86	72	49	60
South America* (n=8)**	81	85	86	90	78	80	78	85	60	93	81	57	79
North America** (n=3)**	100	93	97	98	97	100	100	83	98	100	100	95	100

Region of the Americas (n=30)	74	81	89	85	72	81	68	83	67	87	76	54	55

* Caribbean subregion includes: Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago

** Central America subregion includes: Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama

*** South America subregion includes: Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela (Bolivarian Republic of)

**** North America subregion includes: Canada, Mexico, United States

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