

G. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

Introduction

1. The purpose of this report is to provide an update on the progress made by Member States in the Region of the Americas and by the Pan American Health Organization (PAHO) towards fulfilling their obligations and commitments to implementing the International Health Regulations (IHR; hereafter also referred to as the “Regulations”). It updates the last report presented in 2011 to the 51st Directing Council (1).
2. Additionally, this report is intended to encourage States Parties to use the IHR not only as a framework for ensuring global health security. The IHR are also an opportunity and a tool to institutionalize essential public health functions¹ through the mobilization of sustainable resources to support efficient mechanisms for intersectoral collaboration and multi-hazard public health preparedness.
3. This report is structured around selected strategic areas of work as defined in the WHO document *International Health Regulations (2005): Areas of work for implementation* (2). It focuses on the status of national core capacities as detailed in Annex 1 of the Regulations, due to be present by 15 June 2012.

Promote Regional and Global Partnerships

4. PAHO continues to collaborate with subregional integration mechanisms and initiatives.² The most important objective in this regard is to promote the ownership and leadership of States Parties in their IHR implementation efforts. Other objectives are to optimize the use of technical and financial resources and to increase awareness with respect to rights and obligations stipulated by the Regulations among partners and States Parties.

¹ Document *La Salud Pública en las Américas – Instrumento para la Medición del Desempeño de las Funciones Esenciales de Salud Pública* (PAHO 2001) is available from:
http://new.paho.org/hq/dmdocuments/2010/FESP_Instrumento_Medicion_Desempeno.pdf.

² These subregional integration mechanisms and initiatives include the Southern Common Market (MERCOSUR), through its Working Group on Health (SGT-11) in charge of the Intergovernmental Commission for the International Health Regulations (CIRSI); the Andean Community (CAN), through the Andean Network for Epidemiological Surveillance (RAVE) coordinated by the Andean Regional Health Agency-Hipólito Unanue Agreement (ORAS-CONHU); the Union of South American Countries (UNASUR), through its Technical Working Group for Surveillance and Response (GTVR); the Central America Integration System (SICA), through the Executive Secretariat of the Council of Central American Health Ministers (SE-COMISCA); and the Caribbean Community (CARICOM), though the PAHO/WHO’s Caribbean Epidemiology Centre (CAREC).

5. Although the implementation of the IHR is reflected in the programmatic and strategic documents of the subregional initiatives, and is supported by PAHO/WHO through dedicated subregional work plans,³ the diverse governance mechanisms, organizational structures, and technical expertise of the subregional initiatives continue to be characterized by lack of clarity as for their roles and responsibilities vis-à-vis the IHR. These, among others, include: the perception that subregional initiatives can be delegated responsibilities that are States Parties' prerogatives (e.g. management of public health events of potential international concern); being driven by the agendas of donors that is resulting in the diversion of attention from the implementation of National IHR Action Plans; sub-optimally exploiting their potential to secure political commitment and intersectoral coordination needed for the implementation of the National IHR Action Plans.

6. Mechanisms to maximize the contribution of existing networks for technical cooperation need to be further explored and developed by the Organization. The results of such an evaluation should be used by national authorities to strengthen existing efforts.⁴

7. PAHO/WHO and the International Civil Aviation Organization (ICAO) have conducted joint assessments of international airports in 15 countries of the Region, as part of the *Cooperative Arrangement for the Prevention of Spread of Communicable Disease through Air Travel* (CAPSCA).⁵

8. As a result of PAHO's partnership with the International Atomic Energy Agency (IAEA), a unique project will be launched in June 2012 to strengthen national

³ Southern Common Market (MERCOSUR), Andean Regional Health Agency-Hipólito Unanue Agreement (ORAS-CONHU), Executive Secretariat of the Council of Central American Health Ministers (SE-COMISCA), Caribbean Epidemiology Centre (CAREC).

⁴ Information available from the following sources:

- International Food Safety Authorities Network (INFOSAN):
http://www.who.int/foodsafety/fs_management/infosan/en/index.html.
- Global Foodborne Infections Network (GFN):
http://thor.dfvf.dk/portal/page?_pageid=53,1&_dad=portal&_schema=PORTAL
- PulseNet: <http://www.pulsenetinternational.org/networks/Pages/latinamerica.aspx>
- Poison Centres Network:
http://www.who.int/gho/phe/chemical_safety/phe_poison_centres_20110701.xls
- Strategic Approach to International Chemicals Management (SAICM) of the United Nations Environment Programme:
<http://www.saicm.org/documents/List%20of%20SAICM%20National%20Focal%20Points%20web.doc>
- *Red de Emergencias Químicas de Latinoamérica y el Caribe (REQUILAC)*:
<http://www.bvsde.paho.org/requilac/e/miembros.html>
- *Red de Toxicología de Latinoamérica y el Caribe (RETOXLAC)*:
<http://www.bvsde.paho.org/bvstox/e/retoxlac/review.html>
- Radiation Emergency Medical Preparedness and Assistance Network (REMPAN):
http://www.who.int/ionizing_radiation/a_e/rempan/REMPAN_directory_2007.pdf

⁵ For information on the CAPSCA country visits, see <http://www.capsca.org/AmericasEventsRefs.html>.

infrastructure for radiation safety and the security of radioactive sources in Member Countries of the Caribbean Community (CARICOM).

9. During the session on integrated surveillance at the 16th Inter-American Meeting, at Ministerial Level, on Health and Agriculture (RIMSA)—which PAHO will convene in Chile in July 2012—the Organization will be using the IHR framework to further foster intersectoral collaboration with international agencies and organizations. The meeting will focus on the animal-human interface and raise awareness of national obligations vis-à-vis the IHR among sectors other than health.⁶

10. PAHO continues to strengthen partnerships with the WHO Collaborating Centre (WHO CC) for the Implementation of IHR National Surveillance and Response Capacity, at the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Additional efforts made by PAHO to grant access to the highest level of technical expertise include the involvement of WHO CC during the management of specific events and during the decision making process related to the extension of the 2012 deadline.

11. In June 2011, PAHO played a facilitating role in establishing the Regional component of WHO's Global Outbreak Alert and Response Network (GOARN).

12. In order to promote the exchange of experiences and best practices among States Parties in the Region—as well as to identify common challenges and common solutions—PAHO organized the *Second Regional Meeting on the Implementation of the International Health Regulations (IHR) in the Americas*, held in Cancún, Mexico, on 1–2 September 2011.

13. The FIFA World Football Cup and Summer Olympics that Brazil will be hosting in 2014 and 2016, respectively, will constitute additional opportunities to forge partnerships, and accelerate public health preparedness in the Region. To this end, on 12–13 December 2011 PAHO and the Ministry of Health of Brazil organized the *First Meeting in Latin America on Actions of the Health Sector for Mass Gathering Events / Fifth Meeting of the Health Task Force for the FIFA World Football Cup 2014* in Brasilia, Brazil.

Strengthen National Disease Prevention, Surveillance, Control and Response Systems, and Public Health Security in Travel and Transport

14. In the Regulations, according to the provisions of Articles 5 and 13 as well as Annex 1, States Parties should have assessed their core capacities for surveillance and response, including at designated points of entry, by 15 June 2009. In addition, they

⁶ For example, the Food and Agriculture Organization of the United Nations (FAO), Inter-American Institute for Cooperation on Agriculture (IICA), International Regional Organization for Plant and Animal Health (OIRSA), and World Organisation for Animal Health (OIE).

should have developed a National IHR Action Plan for attaining core capacities by 15 June 2012 and have institutionalized the mechanisms to maintain them after that date.

15. The deadlines stipulated in the Regulations should be regarded more as milestones in an ongoing public health preparedness process. Nevertheless, the target dates are challenging to meet. Therefore, in compliance with the above-mentioned provisions that allow the target date to be extended to 15 June 2014 in a first instance, in September 2011 both WHO and PAHO informed States Parties about the procedures to request the extension.

16. To this effect, starting in February 2012, PAHO has been holding meetings with national authorities, both virtual and face-to-face. For purposes of transparency and accountability during these sessions, all States Parties were invited to communicate to PAHO/WHO their respective position about any possible extension prior to the 65th World Health Assembly (WHA)—but no later than 15 June 2012. Similarly, in a first attempt to compile the list of designated points of entry meant to have a response function, States Parties were invited to explicitly communicate the list of designated points of entry that have either attained the core capacities or need an extension.

17. As anticipated in the *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009*, which was submitted to the 64th WHA, “many States Parties lack core capacities to detect, assess, and report potential health threats and are not on a path to complete their obligations for plans and infrastructure by the 2012 deadline specified in the IHR” (3). Globally, it is estimated that approximately 70% of the 194 States Parties will request an extension of the 2012 deadline. As of 15 April 2012 PAHO/WHO had received from five States Parties in the Region an official communication of their position about the extension. Based on communications with national authorities, PAHO anticipates that about 28 (~80%) of the 35 States Parties in the Americas will request an extension of the 2012 deadline.

18. The status of core capacities in the Region is rather heterogeneous across the subregions, as can be seen from the picture emerging from direct interactions with national authorities as well as from the *State Party Annual Report* submitted to the 65th WHA by 31 of the 35 States Parties (89%).⁷ The table in the annex shows the average

⁷ Submission status by country of the *State Party Annual Report* (hereafter referred to as “the Report”) to the 65th World Health Assembly as of 15 April 2012 is as follows:

- The Dominican Republic, Peru, Uruguay, and Venezuela had not yet submitted the Report.
- Argentina, Bolivia, Brazil, Chile, Colombia, and Paraguay had submitted the Report using the MERCOSUR tool, subsequently migrating data from the relevant sections to the format proposed by WHO as per the agreement with the UNASUR Technical Working Group for Surveillance and Response.
- Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago had submitted the Report using modified versions of the format proposed by WHO.

core capacities score by subregion (in percent)—as defined in the WHO document *IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties (4)*, which constitutes the basis of the format proposed by WHO for reporting to the WHA. The current situation at global level and in other Regions is being presented at the 65th WHA (2012) in *Implementation of the International Health Regulations (2005): Report by the Director-General (5)*.

19. The most critical weaknesses identified included the following areas: radiation emergencies, chemical events, points of entry, human resources, and preparedness. These areas are expected to be addressed in the action plan(s) due to be submitted by States Parties, together with their requests to extend the 2012 deadline. These areas will require resource mobilization efforts at the international level.

20. The following must be taken into account: the substantial variance in capacity and quality observed across States Parties as to their approach adopted for the planning process in terms of degree of intersectoral involvement and commitment; the comprehensiveness of the capacities addressed in the plan(s); priority setting for the components aimed at ensuring the sustainability of the capacities attained; the status and integration of the plan(s) within the context of the national health strategy, planning processes, financial cycles, and monitoring and evaluation mechanisms; anticipated strategies on the use the plan(s) as a resource mobilization tool; and the role of monitoring and evaluation for the implementation of said plan(s).

21. High staff turnover within the health sector, which extends to the institutions of the National Focal Points (NFPs), hampers the sector's ability to build sustained human resource capacity. In some countries with small populations and limited government capacity, it is common for one person to be responsible for a range of duties. Such challenges impede the efforts and investments being made both by the Organization and by other partners since the Regulations entered into force. The *PAHO Regional Plan for Training in Epidemiology in the Americas, 2010*, should be revitalized as an attempt to establish and maintain competencies in field epidemiology according to models that best fit each national context.

22. In compliance with the recommendations formulated by the *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*, and following the request made by various WHO Member States during the 130th Session of the Executive Board, WHO headquarters and its Regional Offices carried out an analysis of factors that limit country progress towards achieving national core capacities, as well as any possible actions that the Organization should take to overcome these obstacles. The full analysis will be presented to the 65th WHA.

23. WHO is currently considering convening an IHR Review Committee to advise on monitoring and evaluation methods related to the implementation of the Regulations, including core capacities. The prospective scope of the IHR Review Committee's work may include those aspects related to a potential additional extension period of 2014–2016, as well as the feasibility of assessing the impact of the Regulations in terms of both health and economics.

Strengthen PAHO/WHO Regional and Global Alert and Response Systems

24. PAHO serves as the WHO IHR Contact Point for the Region of the Americas by facilitating the process of managing public health events: this includes risk detection, risk assessment, response, and risk communication. In the period from 1 January to 31 December 2011, a total of 196 public health events of potential international concern were detected and assessed. For 94 of the 196 events considered (48%), national health authorities—via the NFP—were the initial source of information. For the remaining 102 events, verification was requested and obtained from the NFP for all but 2. Of the events considered, 82 (42%) were of actual international public health concern, affecting 22 States Parties in the Region. The largest proportion of these events was attributed to infectious hazards (52 events, 63%): the etiologies most frequently recorded were imported measles (10), influenza viruses (9), and dengue (6). These were followed by events related to food safety (11), zoonosis-related events (8), events of undetermined origin (5), product-related events (3), events occurring in a disaster context (2), and a single event related to a radionuclear hazard.

25. PAHO continues to support the authorities in Haiti and the Dominican Republic in their efforts to control the cholera outbreak. On 11 January 2012, the Presidents of Haiti and the Dominican Republic—together with PAHO/WHO, UNICEF, and CDC—called for major international investments in water and sanitation infrastructure to eliminate cholera from the island of Hispaniola.⁸ This was followed by a binational meeting, attended by PAHO Assistant Director and held in Haiti in March 2012, aiming at harmonizing the cholera national action plans of Haiti and the Dominican Republic.

26. During the period considered, PAHO supported national authorities in their efforts to respond to several outbreaks in the Region, mobilizing experts from institutions that are members of the Regional GOARN network.

27. Within the framework of regionalizing the GOARN network, an exercise aimed at drawing lessons from joint CDC-PAHO responses was held in Atlanta, Georgia, United States, in May 2012.

⁸ *Call to Action: A Cholera-Free Hispaniola*; see <http://new.paho.org/colera/>.

Sustain Rights, Obligations and Procedures; Conduct Studies and Monitor Progress

28. Several countries reviewed the provisions of the Regulations and harmonized national provisions accordingly within the legal and normative framework. Nevertheless, a challenge remains for the countries in approving and enforcing the revised norms and laws. To that end, PAHO organized an *IHR Legislation Workshop for Eastern Caribbean Countries* in Bridgetown, Barbados, on 22–23 November 2011.

29. In 2011, all 35 States Parties in the Region either submitted their annual NFP confirmation or updated their NFP contact details. As of 31 March 2012, the IHR Roster of Experts includes 309 experts, 71 of whom were from the Region of the Americas. In 2011, procedures for the renewal or discontinuation of membership in the Roster—which is valid for four years—were activated and are currently ongoing.

30. As of 31 March 2012, 412 ports in 19 States Parties of the Region of the Americas were authorized to issue Ship Sanitation Certificates. The list of authorized ports is being regularly updated and posted online.⁹

31. In 2011, 15 States Parties from the Region informed WHO of their vaccine requirements for travelers. This information has been included in the 2012 edition of the WHO publication *International Travel and Health (ITH)*, currently available in English (6). PAHO has taken action to increase the transparency of procedures and participation related to the definition of areas at risk for yellow fever transmission. A two-step approach for updating yellow fever vaccination requirements for travelers should be introduced at global level and should be reflected in the 2013 edition of the ITH.

References

1. Pan American Health Organization. Implementation of the International Health Regulations [Internet]. 51st Directing Council of PAHO, 63rd Session of the WHO Regional Committee for the Americas; 2011 Sep 26-30; Washington (DC), US. Washington (DC): PAHO; 2011 (Document CD51/INF/1) [cited 2012 March 25]. Available from: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=14421&Itemid=.
2. World Health Organization. International Health Regulations (2005) - Areas of work for implementation. Geneva: WHO, 2007 [cited 2012 March 25]. Available from: <http://www.who.int/ihr/finalversion9Nov07.pdf>

⁹ The list of authorized ports is available at http://www.who.int/ihr/training/ihr_authorized_ports_list.pdf.

3. World Health Organization. Implementation of the International Health Regulations (2005) – Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009 [Internet]. 64th World Health Assembly; 2011 May 16-24; Geneva (Switzerland). Geneva: WHO; 2011 (Document A64/10) [cited 2012 March 25]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf.
4. World Health Organization. IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties [Internet]. Geneva: WHO; 2011 [cited 2012 March 25]. Available from: http://whqlibdoc.who.int/hq/2011/WHO_HSE_IHR_2011.6_eng.pdf.
5. World Health Organization. Implementation of the International Health Regulations (2005) – Report by the Director-General [Internet]. 65th World Health Assembly; 2012 May21-26; Geneva (Switzerland). Geneva: WHO; 2012 (Document A65/17) [cited 2012 April 5]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_17-en.pdf.
6. World Health Organization. International Travel and Health [Internet]. Geneva: WHO; 2012 [cited 2012 May 18]. Available from: <http://www.who.int/ith/en/index.html>.

Annex

**CORE CAPACITIES
AVERAGE SCORE (%) BY SUBREGION**

Capacity	Subregion				Americas ⁵
	<i>North America</i> ¹	<i>Caribbean</i> ²	<i>Central America</i> ³	<i>South America</i> ⁴	
National legislation, policy, and financing	92%	36%	80%	84%	65%
Coordination and communications with NFPs	82%	62%	90%	73%	74%
Surveillance	90%	77%	76%	73%	77%
Response	88%	73%	72%	80%	75%
Preparedness	68%	49%	53%	63%	58%
Risk communication	76%	71%	68%	69%	72%
Human resources	100%	39%	50%	66%	57%
Laboratory	80%	63%	76%	86%	73%
Points of entry	85%	50%	58%	48%	51%
Zoonotic events	81%	74%	73%	80%	77%
Food Safety	91%	64%	56%	71%	69%
Chemical events	75%	29%	23%	59%	41%
Radiation emergencies	86%	15%	46%	40%	35%

¹ The subregion of North America includes Canada, Mexico, and the United States; the response rate was 3 out of 3 States Parties (3/3, or 100%). The table reflects information provided by 3 States Parties.

² The Caribbean subregion includes Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Haiti, Jamaica, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago; the response rate was 13 out of 13 States Parties (13/13, or 100%). The table reflects information provided by 11 States Parties.

³ The Central American subregion includes Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama; the response rate was 6 out of 7 States Parties (6/7, or 86%). The table reflects information provided by 6 States Parties.

⁴ The South American subregion includes Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, and Venezuela; the response rate was 9 out of 12 States Parties (9/12, or 75%). The table reflects information provided by 8 States Parties.

⁵ For the Region of the Americas, the response rate was 31 out of 35 States Parties (31/35, or 89%). The table reflects information provided by 28 States Parties.