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IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (IHR)

Introduction

1. This document reports on the application and implementation status of the International Health Regulations (IHR or "the Regulations") and compliance therewith. The report covers the period from 1 July 2018 to 30 June 2019, updating the information submitted to the 164th Session of the Executive Committee in June 2019 *(1)* and complementing the information provided in Document A72/8, presented to the 72nd World Health Assembly in May 2019 *(2)*. The current report reviews activities undertaken by States Parties and the Pan American Sanitary Bureau (PASB) in response to acute public health events, including public health emergencies of international concern (PHEIC), as well as activities for the purpose of capacity building. Finally, it highlights issues requiring concerted action by States Parties in the Region of the Americas and by PASB to enhance future application and implementation of the Regulations and compliance with them.

Background

2. The IHR were adopted by the 58th World Health Assembly in 2005 through Resolution WHA58.3.[1] They constitute the legal framework that, *inter alia*, defines national core capacities, including at points of entry, for the management of acute public health events of potential or actual national and international concern, as well as related administrative procedures.

Situation Analysis

Acute Public Health Events

3. 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

[1] The text of the International Health Regulations (Resolution WHA58.3), Third edition, is available at: http://apps.who.int/iris/bitstream/10665/246107/1/9789241580496-eng.pdf?ua=1.

management of public health events with the National IHR Focal Points (NFP) through established communication channels. In 2018, all 35 States Parties in the Region submitted the annual confirmation or update of contact information for their NFPs, along with an updated list of national users of the secure WHO Event Information Site (EIS) for National IHR Focal Points. As of 30 June 2019, 154 users from States Parties and 195 PASB staff had the credentials to access the WHO EIS portal. In 2018, routine tests of connectivity between the WHO IHR Contact Point and the NFPs in the Region were successful for 33 of the 35 States Parties (94%), by both email and telephone. To inform its efforts to support the NFPs globally, the WHO Secretariat is undertaking a two-step project aiming at assessing the NFPs' experiences and needs in fulfilling their functions detailed in Article 4 of the IHR. Of the 10 States Parties in the Americas invited, eight have agreed to participate in the first phase of the project.

4. From 1 July 2018 to 30 June 2019, 153 acute public health events of potential international concern were identified and assessed in the Region, representing 30% of the events considered globally over the same period. The number of events identified and assessed for each of the States Parties in the Americas is presented in the Annex. For 80 of the 153 events (52%), national authorities (including through the NFPs on 69 occasions) were the initial source of information.

5. It should be noted that for three of the 153 events considered (2%), the final designation status still had to be made at the time of this writing, and verification was requested and obtained for all but one of the events identified through nongovernmental sources. Of the 150 events for which the final designation status is known, 86 (57%), affecting 26 States Parties and three territories in the Region, were of substantiated international public health concern, representing 21% of such events determined globally. The vast majority of these 86 events were attributed to infectious hazards (72 events, or 84%). The etiologies most frequently recorded for these 72 events were antimicrobial-resistant agents (9 events), dengue fever (9 events), measles (9 events). The remaining 14 events of substantiated international public health concern related to the human-animal interface (7 events), food safety (1 event), chemical hazards (1 event), and product-related hazards (1 event); for four events the etiology remained undetermined. Over the period of time considered, of the 59 new events published on the WHO EIS portal, 15 (25%) concerned States Parties in the Americas.

6. Current PHEICs include those determined as a result of the spread of wild poliovirus and circulating vaccine-derived poliovirus (cVDPV),[2] as well as the Ebola virus disease outbreak in the Democratic Republic of the Congo, which in 2018 triggered the activation of the IHR Emergency Committee for Ebola virus disease.[3] Other than these,

[2] Information about ongoing events and context involving the transmission and international spread of poliovirus is available on the WHO IHR Emergency Committee web page at: http://www.who.int/ihr/ihr_ec_2014/en/.

[3] The web page of the 2018 IHR Emergency Committee for Ebola virus disease is available on the WHO website at: http://www.who.int/ihr/emergency-committee-ebola-2018/en/. The statement on the third meeting of this committee is available at: https://www.who.int/ihr/procedures/statement-emergency-committee-ebola-drc-july-2019.pdf.

from 1 July 2018 to 30 June 2019, the significant acute public health events that affected or had public health implications for States Parties in the Americas and PASB related mainly to vaccine-preventable diseases, as detailed below.

a) *Measles:*[4] Since mid-2017, Venezuela has been in the throes of a nationwide measles outbreak. As of 18 June 2019, the country had accumulated over 6,700 confirmed cases, including 79 deaths, none of which was observed in 2019 (case fatality rate of 1%). During the same period, confirmed cases of measles imported, or related to importation, from Venezuela were detected in six countries in the Region: Argentina (9 cases); Brazil (over 10,400 cases, including 12 deaths, none of which was observed in 2019, case fatality rate of 0.1%); Chile (25 cases); Colombia (333 cases); Ecuador (16 cases); and Peru (38 cases). In the countries experiencing the largest outbreaks, the number of cases reported has shown a steady decrease since the beginning of July 2018. During the period of this report, confirmed cases of measles imported, or related to importation, from States Parties other than Venezuela, both within and outside the Americas, were detected by health authorities in 11 countries of the Region: Argentina (5 cases), the Bahamas (1 case), Brazil (25 cases), Canada (76 cases), Chile (2 cases), Costa Rica (10 cases), Cuba (1 case), Mexico (6 cases), Peru (4 cases), the United States of America (nearly 1,300 cases), and Uruguay (9 cases). One additional confirmed case of measles was reported onboard a cruise ship sailing in the Caribbean.

b) *Yellow fever:*[5] The increased yellow fever virus activity in South America at the end of 2015 resulted in an exceptional upsurge in cases in the animal and human populations of Brazil in late 2016. Following the seasonal pattern observed in 2017 and 2018, the upsurge in yellow fever virus activity in Brazil has spread to areas along the country's southern Atlantic coast not previously deemed to be at risk for yellow fever virus transmission. This has prompted the WHO Secretariat to designate extended areas as being at risk for yellow fever virus transmission in its advice for international travelers to Brazil.[6] During the period of this report, 81 laboratory-confirmed human cases of yellow fever, including 15 deaths (case fatality rate of 18%), were reported in Brazil; the most affected states are Paraná, Santa Catarina, and São Paulo. Additional cases, all related to areas known to be at risk for yellow fever transmission, were reported by the authorities of Bolivia (1 case), Colombia (1 fatal case), French Guiana (1 case), and Peru (12 cases, including 8 deaths).

[4] Information about measles outbreaks and spread in the Americas is available on the PAHO website at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=10302:2014-archive-by-disease-measles&Itemid=41205&lang=en.

[5] Information about yellow fever outbreaks and spread in the Americas is available on the PAHO website at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=10319:2014-archive-by-disease-yellow-fever&Itemid=41222&lang=en.

[6] Information about the extension of areas determined to be at risk for yellow fever transmission is available on the WHO website at: https://www.who.int/ith/updates/20180503/en/.

c) *Diphtheria:*[7] Diphtheria outbreaks are ongoing in Haiti and Venezuela. The outbreak in Haiti began in 2014; as of 1 June 2019, a total of 1,128 confirmed and probable cases were reported by the national health authorities, including 52 deaths among confirmed cases (5% case fatality rate). The 480 cases observed in 2018 account for 43% of cases since the beginning of the outbreak. The outbreak in Venezuela began in July 2016, and as of 22 June 2019, nearly 2,900 confirmed and suspect cases were reported by the national health authorities, including 286 deaths (10% case fatality rate). The 1,208 cases observed in 2018 account for 42% of the cases observed since the beginning of the outbreak. During the period covered by this account, Colombia reported eight laboratory-confirmed cases including three deaths, also imported from Venezuela.

d) *Malaria:*[8] In Venezuela, over the eight-year period 2010-2018, the number of malaria cases increased by 800%, and autochthonous transmission spread from 12 to 17 federal entities and from 60 to 125 municipalities. This upward trend corresponds to a tenfold increase in the national incidence rate over the same period. In 2017, Venezuela accounted for 84% of the increase in cases in the Region *(3)*, with over 411,000 confirmed cases reported, including 333 deaths. In 2018, nearly 405,000 confirmed cases were observed in Venezuela, including 257 deaths; and between 1 January and 25 May 2019, nearly 177,000 confirmed cases, including 59 deaths possibly attributable to malaria, were noted nationally.

7. In addition to the above, several events have required closer monitoring and field responses by PASB during the period covered by this account. They include the following: between 1 January and 30 June 2019, over 1.5 million dengue fever cases were reported in the Americas, including over 8,000 cases of severe dengue (0.6%) and 604 deaths (0.04% case fatality rate).[9,10] With respect to the same period of 2018, a nearly three-fold increase in the number of dengue fever cases and nearly double the number of deaths were observed. The simultaneous circulation of two or more dengue virus serotypes, which increases the risk for outbreaks and/or severe dengue fever cases, was reported in 15 countries and territories in the Region. There was an outbreak of hantavirus pulmonary syndrome in Argentina, with 34 laboratory-confirmed cases, including 11 deaths (case fatality rate 32%); as the outbreak was sustained by airborne human-to-human transmission, its control required the implementation of strict selective respiratory isolation measures. In Guyana, a cluster of histoplasmosis cases was linked to a mining exploitation

[7] Information about diphtheria outbreaks and spread in the Americas is available on the PAHO website at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=12840:archive-by-disease-diphtheria&Itemid=42228&lang=en.

[8] Information about malaria outbreaks and spread in the Americas is available on the PAHO website at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=8630:2013-publication-management-of-severe-malaria-handbook&Itemid=41199&lang=en.

[9] Historical and current information on dengue fever epidemiology in the Americas can be consulted on the interactive PLISA Health Information Platform for the Americas at: http://www.paho.org/data/index.php/en/.

[10] Information about dengue fever outbreaks and spread in the Americas is available on the PAHO website at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=6306:2011-archive-diseases-dengue&Itemid=41184&lang=en.

site, affecting 14 workers, two of whom died. Finally, in Bolivia, a cluster of heamorrhagic fever syndrome, including five cases, two of which were fatal, was determined to be caused by a Chapare-like Arenavirus by laboratory tests performed on samples obtained from three of the patients. Three of the cases were health care workers, infected while performing medical procedures with no personal protective equipment.

Core Capacities of States Parties

8. Following the 142nd Session of the WHO Executive Board in 2018, the WHO Secretariat launched a formal global consultative process to revise the tool offered to countries for submission of their States Parties Annual Reports to the World Health Assembly. The "State Party self-assessment annual reporting tool," hereafter referred to as "the revised tool" *(4)*, together with the related guidance document *(5)*, was published on the WHO website in May 2018. It should be noted that use of the revised tool, still exclusively focusing on core capacities, remains entirely voluntary. The only legal requirement for States Parties, pursuant to Article 54.1 of the Regulations, Resolution WHA61.2 *(6)*, and Decision WHA71(15) *(7)*, is the yearly submission of the State Party Annual Report to the World Health Assembly.

9. In 2019, 33 (94%) of the 35 States Parties in the Region of the Americas submitted their annual reports to the 72nd World Health Assembly. At the time of elaboration of this report, Barbados and Grenada had not complied with this obligation. Since 2011, when data management related to the submission of the States Parties Annual Reports to the World Health Assembly was systematized by the WHO Secretariat, 11 States Parties have systematically complied by submitting their report every year: Antigua and Barbuda, Canada, Colombia, Costa Rica, Dominica, Ecuador, Guyana, Honduras, Jamaica, Mexico, and the United States of America. Information on the degree of compliance with this commitment on the part of the remaining States Parties is presented in the Annex. Due to a technical information management issue, the State Party Annual Report submitted by Bolivia to the 72nd World Health Assembly could not be accounted for in the regional and subregional analyses presented in this report. Guyana opted to submit its annual report to the 72nd World Health Assembly in a different format. Therefore, the information submitted by Guyana could not be meaningfully included in the Annex to this report, which presents a summary of the States Parties Annual Reports to the 72nd World Health Assembly.[11]

10. States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2018 showed steady improvements or plateauing of the average regional scores for all core capacities. However, because of the introduction of the revised tool—which entails a partial redefinition of the 13 core capacities previously considered, a different set of indicators, a five-point scale for measuring each indicator, and a focus on "access" to core capacities as opposed to developing and maintaining core capacities in each country—

[11] Historical information on the States Parties Annual Reports submitted to the World Health Assembly in 2011-2018 is available in the WHO Global Health Observatory data repository on the WHO website at: http://apps.who.int/gho/data/node.main.IHR00ALLN?lang=en.

it is not possible at this stage to analyze trends in core capacities scores at regional, subregional, and national levels, including States Parties' abilities to maintain core capacities.

11. The majority of the 31 States Parties that opted to use the revised tool to submit their State Party Annual Report to the 72nd World Health Assembly compiled the report through a multidisciplinary and multisectoral effort, including face-to-face meetings in 24 States Parties (77%).

12. For all 13 core capacities, the average regional scores are close to or above 60%, with the lowest average scores (54%) for radiation emergencies, and the highest average score (76%) for IHR coordination and National IHR Focal Point functions. Except for the health service provision core capacity, the average regional scores for the Americas related to the remaining 12 core capacities are above the global averages.[12]

13. Nevertheless, the status of the core capacities across subregions remains heterogeneous. As presented in the Annex, the highest average subregional scores for all 13 core capacities are consistently observed for North America, while the lowest average scores are registered in the Caribbean subregion for eight core capacities (legislation and financing, zoonotic events and the human-animal interface, surveillance, human resources, risk communication, points of entry, chemical events, radiation emergencies); in Central America for four core capacities (IHR coordination and National IHR Focal Point functions, food safety, National Health Emergency Framework, and health service provision); and in South America for one core capacity (laboratory).

14. The PAHO Program and Budget 2018-2019 *(8)*, adopted through Resolution CSP29.R6 *(9)*, includes outcome 5.2, "Countries have an all-hazards health emergency risk management program for a disaster-resilient health sector, with emphasis on vulnerable populations." This outcome includes output 5.2.1, "Countries enabled to monitor and evaluate their capacities for health emergency preparedness and IHR," along with output indicator 5.2.1.c, "Number of countries with national action plans developed for strengthening capacities." In relation to these, it should be emphasized that, as indicated in Document CSP29/INF/6 (2017) on the Implementation of the International Health Regulations (IHR) *(10)*, the wide variation across States Parties with respect to both the maturity of their health systems and the status of their application and implementation of the IHR makes it necessary to overcome the one-size-fits-all concept of a "dedicated national IHR plan".

15. Of the 31 States Parties that have submitted their annual reports using the revised tool, 11 States Parties (35%) indicated that budgets are distributed in a timely manner and executed in a coordinated fashion. Also, 19 (61%) of the 31 States Parties indicated that an emergency public financing mechanism that allows structured reception and rapid

[12] Historical information on the States Parties Annual Reports submitted to the World Health Assembly using the revised tool is available on the WHO website at: https://extranet.who.int/e-spar.

distribution of funds for responding to public health emergencies is in place across relevant sectors.

16. The IHR Monitoring and Evaluation Framework (IHR-MEF) *(11)* includes one mandatory component, namely the State Party Annual Report, and three voluntary ones: After-Action Review of Public Health Events, Simulation Exercises, and Voluntary External Evaluations. The voluntary components are embedded in the WHO Programme Budget 2018-2019 *(12)*, adopted through Resolution WHA70.5 *(13)*, and the PAHO Program and Budget 2018-2019 *(8)*, adopted through Resolution CSP29.R6 *(9)*. Over the period covered by this report, PASB has facilitated the translations from English to Spanish of the tools proposed for implementation of some of the voluntary components of the IHR-MEF.

17. In the context of the IHR-MEF *(11)*, as well as of the Biennial Work Plans 2018-2019 jointly developed by the PAHO/WHO Representative Offices and national authorities, PASB has supported Grenada in hosting, and Haiti in re-hosting, a Voluntary External Evaluation, based on the Joint External Evaluation (JEE) tool, during the period covered by this report *(14)*. Toward this end, PASB worked in close collaboration with the International Atomic Energy Agency (IAEA), the World Organisation for Animal Health (OIE), and the WHO Collaborating Centre for the Public Health Management of Chemical Exposures (WHO CC UNK-179), hosted by Public Health England, United Kingdom (PHE/UK). PASB is also supporting Argentina and the Dominican Republic in their preparations to host Voluntary External Evaluations, based on the JEE tool, during the second semester of 2019. Four States Parties included Voluntary External Evaluations in their Biennial Work Plan 2018-2019, and four additional ones expressed their interest in hosting a Voluntary External Evaluation. All States Parties that have hosted Voluntary External Evaluations are listed in the Annex.

18. According to the States Parties Annual Reports submitted to the 72nd World Health Assembly using the revised tool, 17 of 31 States Parties (55%) have tested, reviewed, and updated at least one of the instruments constituting their National Health Emergency Framework. PASB supported Simulation Exercises in Bolivia, Brazil, and the Dominican Republic and, jointly with PHE/UK, organized a virtual simulation exercise for countries and territories in the Caribbean subregion, focusing on the international reporting of a chemical event occurring in a port. PASB supported After-Action Reviews of public health events in Brazil and the Dominican Republic. PASB also participated in the After-Action Review related to the case of measles reported onboard a cruise ship sailing in the Caribbean, which was organized by the National Institute for Public Health and the Environment (RIVM) of the Netherlands.

19. Over the period from 1 July 2018 to 30 June 2019, to support efforts by the national authorities to advance in the continuous process of enhancing public health preparedness, PASB conducted regional, subregional, multicountry, and country missions and workshops. These focused on, among other topics: *a)* the early warning function of the surveillance system; *b)* NFP functions; *c)* laboratory diagnostics and public health

laboratories; *d)* infection prevention and control; *e)* risk communication; *f)* rapid response teams; *g)* points of entry; *h)* response to chemical hazards; and *i)* all-hazard response functions. Several capacity-building activities were carried out thanks to the financial support provided to PASB by the governments of Brazil and the United States of America. Moreover, collaboration between PASB and IAEA is continuing within the framework of several large-scale projects focusing on the Caribbean subregion. As of 30 June 2019, Saint Kitts and Nevis and Suriname are the only two States Parties in the Americas that have not sought IAEA membership.[13]

20. Proposals to address challenges related to the establishment, maintenance, and monitoring of core capacities in Small Island Developing States (SIDS) were drafted as a result of meetings between PASB, WHO Headquarters, the WHO Regional Office for the Western Pacific, PHE/UK, and RIVM, held in Washington, DC, on 16-19 July 2018, and in London, United Kingdom, on 17-19 July 2019. National authorities from the Caribbean subregion and PASB staff have participated in Voluntary External Evaluations in SIDS of the WHO Western Pacific Region. There has been increasingly close collaboration between PHE and PASB, especially in organizing two workshops for the Caribbean subregion: "National Port Health Strategy and Points of Entry-Related IHR Provisions" and "Preparedness for and Response to Acute Events Related to Chemicals" in Miami (Florida), Unites States of America, 30 January-6 February 2019. Additionally, the government of the Netherlands has allocated funds to PASB to support IHR-related activities in the Caribbean subregion.

Administrative Requirements and Governance

21. During the period of this report, 484 ports in 26 States Parties in the Region of the Americas, including one landlocked State Party (Paraguay), were authorized to issue the Ship Sanitation Certificate.[14] Ten additional ports were authorized in seven overseas territories of France, the Netherlands, and the United Kingdom. As highlighted in Document A72/8 *(2)*, presented to the 72nd World Health Assembly, States Parties face persistent challenges in implementing the issuance of the Ship Sanitation Certificate according to the intended rationale. As the application and implementation of the IHR requires a dynamic and collective learning process, some States Parties in the Americas are currently considering a reduction in their number of authorized ports in light of cost-effectiveness reviews. With respect to the voluntary certification of designated airports and ports, at the time of elaboration of this report, procedures for such certification were not yet available.

22. As of 30 June 2019, the IHR Roster of Experts included 444 professionals, 102 of whom are from the Region of the Americas. They include experts designated by

[13] The list of IAEA member States is available on the IAEA website at: https://www.iaea.org/about/governance/list-of-member-states.

[14] The list of ports authorized to issue the Ship Sanitation Certificate is available on the WHO website at: https://www.who.int/ihr/ports_airports/IHR-list-of-Authorized-ports-to-issue-Ship-Sanitation-Certificates.pdf?ua=1.

10 of the 35 States Parties in the Region: Argentina, Barbados, Brazil, Canada, Cuba, Mexico, Nicaragua, Paraguay, Peru, and the United States of America.

23. In 2019, 21 (60%) of the 35 States Parties in the Region responded to the global survey for updating the WHO publication International Travel and Health.[15] It is worth noting that in January 2019, Brazil introduced the electronically-issued International Certificate of Vaccination or Prophylaxis (ICVP).[16] Also in 2019, the WHO Secretariat established a guideline development group for the revision of WHO International Travel and Health[17], and launched the process for the development of guidelines to assess the effectiveness and impact of travel and trade restrictions to prevent, delay, or reduce international spread of diseases during outbreaks.

Actions Necessary to Improve the Situation

24. The IHR constitute a tool for seamlessly supporting the continuous and intersectoral public health preparedness process, from the national to the international level, and collectively responding to acute public health events. Since the Regulations' entry into force in 2007, the status of national core capacities, the frequency and volume of interactions related to acute public health events between States Parties and the WHO IHR Contact Point, and the level of engagement of States Parties in the governance processes observed in the Americas all seem to signal a slowly evolving cultural shift among Parties to the IHR in terms of transparency and mutual accountability, underscoring the relevance of the Regulations as a global governance tool.

25. In light of this, the actions needed to improve the situation outlined in the documents to the 29th Pan American Sanitary Conference in 2017 *(10)*, to the 56th Directing Council in 2018 *(15)*, and to the 164th Session of the Executive Committee in June 2019 *(1)*, still apply. In particular:

a) Advocacy is needed at different levels to harmonize the understandings and aspirations of States Parties in order to overcome misconceptions that might be hampering the application and implementation of the Regulations and continuing compliance. Such interventions should focus particularly on establishing communication bridges between technical and decision-making levels in the States Parties.

[15] The updated requirements for the International Certificate of Vaccination or Prophylaxis, as determined by States Parties, are available on the International Travel and Health page of the WHO website at: http://www.who.int/ith/en/.

[16] Information about the introduction of the electronically-issued ICVP is available on the PAHO website at: https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=guidelines-5053&alias=47732-international-certificate-of-vaccination-or-prophylaxis-icvp-2019&Itemid=270&lang=en.

[17] Information about the guideline development group for the revision of WHO International Travel and Health is available on the WHO website at: https://www.who.int/ith/guideline-development-group-ith-revision/en/.

b) The IHR are increasingly understood as a tool to strengthen and increase the sustainability of *a)* national essential public health functions, including planning and financing, that largely exist already and are operational to different degrees, and *b)* national intersectoral mechanisms. However, the Regulations, especially at the political level, often continue to be viewed as a new technical discipline whose requirements and implications are confined to the health sector and are mainly related to public health "crises" and obligations—with somewhat punitive connotations. In alignment with the scope and purpose of the IHR, this warrants interventions at the national level to demonstrate the cost-effectiveness of sustained resource allocation for strengthening essential public health functions, as opposed to merely responding to acute public health events as they happen, a strategy with high costs and economic consequences.

c) The increased measles activity in the Region has spotlighted challenges faced by national authorities in the management of acute public health events involving conveyances and/or travelers, as defined in Article 1 of the IHR. International contact tracing operations remain complex because of the number of channels that may need to be activated to obtain and exchange the required information. Moreover, the management of events on conveyances, vessels in particular, at times has been limited to the physical segregation of the conveyance, without concurrent epidemiological investigations and public health interventions on board. Therefore, further action by PASB is warranted in order to clarify the implementation of procedures related to the granting of *free pratique*, or lack thereof, and to the *quarantine* of conveyances, as defined in Article 1 of the IHR, since these measures are not intended to prevent epidemiological investigation and application of public health measures on board, or to put at risk the safety of health care workers.

d) While the IHR provide for mechanisms to ensure mutual accountability, along with requirements for monitoring implementation and compliance by the Parties, application of the four components of the IHR-MEF should be tailored to the contexts and needs of States Parties in the Region (e.g., SIDS). In particular:

   i. The Regulations constitute a tool to support the continuous, and intrinsically dynamic, intersectoral public health preparedness process. Given the introduction of the revised tool for submission of the State Party Annual Report to the World Health Assembly, caution is needed in interpreting the scores of individual States Parties, since the first submission using the revised tool does not allow for appraisal of the States Parties' abilities to further build or maintain core capacities. Moreover, considering the overall advanced status of core capacities in the Region, substantial further progress is unlikely to be observed in coming years, and in some cases this might be explained on the basis of the specific risk profile of individual States Parties.

   ii. While voluntary After-Action Review of Public Health Events and Simulation Exercises are being conducted across the Region, in most States Parties these activities still need to become systematically embedded in the public health preparedness process in order to drive changes, to be supported by sustainable

institutional and administrative arrangements, and to be systematically documented.

iii. Hosting a Voluntary External Evaluation, which requires a significant investment of financial and human resources by both the State Party and PASB, signals the commitment of the State Party's government to take subsequent action in the short and medium terms. Accordingly, the in-country preparatory phase, which precedes the visit of the external mission team, is critical to set realistic expectations as well as the scope of subsequent institutional actions aiming at strengthening existing governance, planning, and financing mechanisms. The Voluntary External Evaluations conducted in the Region have also made clear that finalization of the report of the external mission team constitutes a rather lengthy process.

Action by the Directing Council

26. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

Annex

References

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Annex

Summary Table 1: States Parties Annual Reports to the 72nd World Health Assembly, Voluntary Components of the IHR Monitoring and Evaluation Framework, and Public Health Events of Potential International Concern

(core capacities scores in percentages)

	Mandatory State Party Annual Report														Voluntary External Evaluation (year conducted)	Number of acute public health events of potential international concern assessed (1 July 2018-30 April 2019)
State Party	Number of Annual Reports submitted from 2011 to 2019 (9-year period)	Legislation and financing	IHR coordination and National IHR Focal Point	Zoonotic events and the human-animal interface	Food safety	Laboratory	Surveillance	Human resources	National Health Emergency Framework	Health service provision	Risk communication	Points of entry	Chemical events	Radiation emergencies		
Antigua and Barbuda	9	27	30	20	80	47	60	60	60	40	40	20	20	40	No	0
Argentina	8	80	80	60	80	67	80	60	40	60	40	70	60	60	No	6
Bahamas	7	60	80	0	80	73	40	60	73	40	60	40	20	20	No	1
Barbados	8	-	-	-	-	-	-	-	-	-	-	-	-	-	No	1
Belize	6	20	20	20	40	67	30	40	67	47	60	20	0	0	Yes (2016)	1
Bolivia (Plurinational State of) [1]	8	-	-	-	-	-	-	-	-	-	-	-	-	-	No	7
Brazil	8	93	100	80	80	100	100	100	87	47	80	60	100	100	No	15
Canada	9	93	100	100	100	100	100	100	100	100	100	100	100	100	Yes (2018)	2
Chile	8	73	80	100	100	80	80	60	73	47	20	70	100	80	No	9
Colombia	9	80	70	80	80	73	60	60	73	47	60	80	60	40	No	9
Costa Rica	9	93	70	60	80	93	70	80	27	73	80	60	100	20	No	8

[1] Due to a technical information management issue, the State Party Annual Report submitted by Bolivia to the 72nd World Health Assembly is not accounted for in the regional and subregional analyses presented in this report.

State Party	Mandatory State Party Annual Report														Voluntary External Evaluation (year conducted)	Number of acute public health events of potential international concern assessed (1 July 2018-30 April 2019)
	Number of Annual Reports submitted from 2011 to 2019 (9-year period)	Legislation and financing	IHR coordination and National IHR Focal Point	Zoonotic events and the human-animal interface	Food safety	Laboratory	Surveillance	Human resources	National Health Emergency Framework	Health service provision	Risk communication	Points of entry	Chemical events	Radiation emergencies		
Cuba	8	100	100	100	100	100	100	100	100	100	100	100	100	100	No	3
Dominica	9	80	90	80	100	73	60	60	80	60	80	90	20	40	No	0
Dominican Republic	8	40	40	20	20	53	60	40	53	33	100	40	40	80	No	6
Ecuador	9	87	80	80	60	73	80	80	80	47	60	80	80	60	No	10
El Salvador	8	100	100	100	20	100	100	100	60	60	40	100	40	60	No	2
Grenada	5	-	-	-	-	-	-	-	-	-	-	-	-	-	Yes (2018)	0
Guatemala	8	67	30	60	20	80	70	80	80	33	60	60	60	100	No	3
Guyana[2]	9	-	-	-	-	-	-	-	-	-	-	-	-	-	No	2
Haiti	7	27	60	60	20	60	90	40	47	27	20	10	40	0	Yes (2016, 2019)	2
Honduras	9	7	80	80	20	60	80	20	20	0	40	40	0	0	No	3
Jamaica	9	80	90	80	80	80	80	60	80	73	80	90	40	80	No	1
Mexico	9	100	100	80	80	80	100	100	87	87	60	80	80	80	No	16
Nicaragua	8	100	30	60	80	87	60	60	73	73	80	80	60	100	No	1
Panama	8	53	80	80	80	73	80	80	80	73	40	60	80	60	No	7
Paraguay	7	40	90	80	80	53	80	80	40	47	80	60	60	20	No	4

[2] The State Party Annual Report submitted by Guyana to the 72nd World Health Assembly was presented in a different format. Therefore, the information is not accounted for in the regional and subregional analyses presented in this report.

State Party	Mandatory State Party Annual Report														Voluntary External Evaluation (year conducted)	Number of acute public health events of potential international concern assessed (1 July 2018-30 April 2019)
	Number of Annual Reports submitted from 2011 to 2019 (9-year period)	Legislation and financing	IHR coordination and National IHR Focal Point	Zoonotic events and the human-animal interface	Food safety	Laboratory	Surveillance	Human resources	National Health Emergency Framework	Health service provision	Risk communication	Points of entry	Chemical events	Radiation emergencies		
Peru	7	53	50	60	40	47	70	40	60	33	40	40	80	100	Yes (2015)	4
Saint Kitts and Nevis	7	7	70	60	80	67	60	40	47	60	40	30	40	20	No	0
Saint Lucia	7	47	90	80	80	87	40	80	47	47	60	80	40	0	No	1
Saint Vincent and the Grenadines	7	40	70	20	80	73	60	80	20	47	20	30	20	20	No	0
Suriname	8	80	90	80	80	73	90	80	87	53	80	100	40	20	No	1
Trinidad and Tobago	8	53	100	20	40	80	40	20	40	80	40	40	60	20	No	0
United States of America	9	100	100	80	100	93	100	60	100	100	100	90	80	80	Yes (2016)	7
Uruguay	5	100	90	80	80	87	90	80	93	80	100	80	60	80	No	2
Venezuela (Bolivarian Republic of)	8	73	90	80	80	53	80	80	73	60	80	90	40	80	No	15

Summary Table 2: States Parties Annual Reports to the 72nd World Health Assembly: Regional and Subregional Averages (core capacities scores in percentages)

Subregion	Legislation and financing	IHR coordination and National IHR Focal Point functions	Zoonotic events and the human-animal interface	Food safety	Laboratory	Surveillance	Human resources	National Health Emergency Framework	Health service provision	Risk communication	Points of entry	Chemical events	Radiation emergencies
Caribbean* (*n*=12)	52	74	52	72	73	63	60	62	56	57	54	37	30
Central America (*n*=7)**	66	61	66	46	78	74	66	56	50	63	63	54	60
South America* (*n*=9)**	76	81	78	76	70	80	71	69	52	62	70	71	69
North America** (*n*=3)**	98	100	87	93	91	100	87	96	96	87	90	87	87
Region of the Americas (n=31)	66	76	66	69	75	74	67	66	57	63	64	55	54

* 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, and Trinidad and Tobago.

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

*** South America subregion includes: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.

**** North America subregion includes: Canada, Mexico, and United States of America.

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