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IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

Introduction

1. This document reports on the application and implementation status of the International Health Regulations (IHR or "the Regulations") and compliance therewith *(1)*. The report covers the period from 1 July 2021 to 15 July 2022, updating the information presented at the 170th session of the Executive Committee in June 2022 *(2)*. It includes issues related to the strengthening of the World Health Organization's (WHO) preparedness for and response to health emergencies, a topic addressed in Resolutions WHA75.7 *(3)*, and WHA75.12 *(4),* and Decision WHA75(9) *(5)* from the 75th World Health Assembly (WHA75), as well as Document CE170/INF/3 *(6)*. Additionally, the present report needs to be considered in the context of the ongoing COVID-19 pandemic. Hence, it is closely related to the Update on the COVID-19 pandemic in the Region of the Americas (Document CSP30/INF/1, Rev. 1) *(7)*.

2. Pursuant to IHR provisions, the current report focuses on acute public health events, States Parties' core capacities, administrative requirements, and governance. Finally, it highlights issues requiring concerted action by States Parties in the Region of the Americas and by the Pan American Sanitary Bureau (PASB) to enhance future application and implementation of the Regulations and compliance with them.

Background

3. The International Health Regulations were adopted by the 58th World Health Assembly in 2005 through Resolution WHA58.3 *(8)*. They constitute the international 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

4. The Pan American Health Organization (PAHO) serves as the World Health Organization IHR Contact Point for the Region of the Americas and facilitates the management

of public health events with the National IHR Focal Points (NFPs) through established communication channels. In 2021, the WHO Secretariat launched a secure online platform for this purpose. Between 1 January 2022 and 15 July 2022, 32 of the 35 States Parties in the Americas (91%) confirmed or updated the contact information for their NFPs, along with the updated list of national users of the secure WHO Event Information Site (EIS) for National IHR Focal Points. As of 15 July 2022, 176 users from all 35 States Parties had the credentials to access the WHO EIS portal. In 2022, routine tests of connectivity between the WHO IHR Contact Point and the NFPs in the Region were successful for 28 of the 35 States Parties (80%) by both telephone and email.

5. The analysis presented below, concerning acute public health events of potential or actual national and international concern, exclusively focuses on those events not related to the COVID-19 pandemic, which includes multisystem inflammatory syndrome in children and adolescents, the emergence of SARS-CoV-2 Variants of Concern or Variants of Interest , and adverse events following immunization with COVID-19 vaccines. From 1 July 2021 to 10 July 2022, 106 acute public health events of potential international concern were identified and assessed in the Region, representing 24% 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 77 of the 106 events (73%), national authorities (including through the NFPs on 51 events) were the initial source of information. Verification was requested for the 21events identified through media sources, and it was obtained for all of them. Monthly reports on notified events, requests for verification and responses to requests for verification are sent to all IHR NFPs in the Region of the Americas.

6. Of the 106 events assessed, 72 events (68%), affecting 27 States Parties and three territories in the Region, were of substantiated international public health concern, representing 20% of such events determined globally. Of these 72 events, 57 events (78%) were attributed to infectious hazards. The etiologies most frequently recorded for these 57 events were monkeypox (17 events), acute hepatitis of unknown origin among young children (6 events), malaria (6 events), Shigella sonnei (3 events), and influenza viruses (2 events). The remaining 15 events of substantiated international public health concern were associated with the human-animal interface (4 events), disasters (2 events), product-related hazards (8 events), and chemical-related hazards (1 event). Over the period considered, of the 63 new events unrelated to the COVID-19 pandemic that were published globally on the WHO EIS portal, 7 (11%) concerned States Parties in the Americas. In addition, between 1 July 2021 and 10 July 2022 a total of 33 Epidemiological Alerts and Updates were shared with the IHR NFPs for their awareness.

7. Besides the COVID-19 pandemic-related public health emergency of international concern (PHEIC),[1] on 24 June 2022, following the thirty-second meeting of the Poliovirus IHR Emergency Committee, the Director-General of WHO determined that the spread of wild

[1] Information about the IHR Emergency Committee for the COVID-19 pandemic can be accessed on the WHO website at: https://www.who.int/groups/covid-19-ihr-emergency-committee.

poliovirus and circulating vaccine-derived poliovirus continues to constitute a PHEIC.[2] On 23 June 2022 the Director-General of WHO convened the IHR Emergency Committee (EC) regarding the multi-country monkeypox outbreak and concurred with the advice offered by the IHR EC that at that stage the outbreak did not constitute a PHEIC.[3] Additional information about acute public health events of significance or with implications for the Region of the Americas is published and updated on the PAHO website.[4]

Core Capacities of States Parties

8. The COVID-19 pandemic reignited the debate surrounding the objectives of each of the four components and related tools of the IHR Monitoring and Evaluation Framework (IHR MEF) *(9)*. As reported in Document CD59/INF/5 *(10)*, a consultative meeting on Joint External Evaluations (JEE) and State Party Annual Reporting (SPAR) was convened by the WHO Secretariat in March 2021. Following the meeting, a Technical Working Group for Review of the IHR MEF was established with a focus on the JEE and SPAR tools.

9. As a result of the Working Group's review, in December 2021, the WHO Secretariat shared with States Parties a revised tool[5] to facilitate the submission of their IHR Annual Reports to the World Health Assembly, as mandated by Article 54 of the Regulations, Resolution WHA61.2 *(11)*, and Decision WHA71(15) *(12)*. Like its predecessors, the revised tool focuses exclusively on the core capacities of States Parties. In December 2021 the revised tool was made available in English as both a fillable Adobe Acrobat file and an online form for submission through the WHO e-SPAR portal.[6] Translations of the tool into French and Spanish were made available for online submission through the e-SPAR portal on 24 February 2022. Preliminary versions of those translations were made available to States Parties in fillable Adobe Acrobat format on 17 March 2022, revised versions were made available on 1 April 2022, and the deadline for submission of the IHR Annual Report by States Parties to the 75th World Health Assembly was 30 April 2022.

10. The reporting on the implementation of the IHR (2005) by States Parties has evolved with the development and modification of reporting tools in 2010, 2013, 2018 and 2021. The latest SPAR tool (2021) has 15 capacities and 35 indicators, compared

[2] Information about the IHR Emergency Committee concerning ongoing events and context involving the transmission and international spread of poliovirus is available on the WHO website at: https://www.who.int/groups/poliovirus-ihr-emergency-committee.

[3] Information about the IHR Emergency Committee regarding the multi-country monkeypox outbreak is available on the WHO website at: https://www.who.int/news/item/25-06-2022-meeting-of-the-international-health-regulations-(2005)-emergency-committee--regarding-the-multi-country-monkeypox-outbreak.

[4] PAHO Epidemiological Alerts and Updates are available at: https://www.paho.org/en/epidemiological-alerts-and-updates.

[5] The Electronic State Parties Self-Assessment Annual Reporting Tool (e-SPAR) is a web-based platform available at: https://extranet.who.int/e-spar.

[6] See footnote 5.

to 13 capacities and 24 indicators in the previous version (2018). Some of the changes in the revised tool present limitations to the comparison of scores from previous years.[7]

11. In 2022, 32 (91%) of the 35 States Parties in the Region of the Americas submitted their 2021 IHR Annual Report. Barbados, Grenada (for the fifth consecutive year), and Trinidad and Tobago (for the second) had not complied with this obligation. Since 2011 when the submission of Annual Reports to the World Health Assembly by States Parties was systematized by the WHO Secretariat, 15 States Parties from the Region have submitted their report every year: Argentina, Canada, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Suriname, the United States of America, and Venezuela (Bolivarian Republic of). Information on the degree of compliance with this commitment on the part of the remaining States Parties is presented in the Annex.

12. In the Region of the Americas, the consultative process for SPAR at the country level in 2021 was conducted via face-to-face meetings (13/32), e-mail (13/32), virtual meetings (12/32) and other means (5/32). A multisectoral approach to complete the SPAR was carried out on 56% compared to 44% of the reports completed by a single government official. The main sectors reporting from the Region were those of human health (100%), food safety (81%), animal health (78%), and disaster management (78%).

13. For all capacities, the average regional in 2021 was 67% compared to the global average of 65%. For all 15 core capacities, the average regional scores are close to or above 60%, with the lowest average scores (50%) for policy, legal, and normative instruments to implement IHR and, the highest average score (81%) for surveillance. Among the 15 core capacities for 2021, the strengths in the Region are in surveillance (83%), laboratory (75%) and health emergency management (75%), while the challenges are policy, legal and normative instruments to implement IHR (50%), chemical events (58%) and radiation emergencies (58%).

14. For 2021 the challenges by indicators were gender equality in health emergencies (44%), workforce surge during a public health event (54%), policy, legal and normative instruments (57%), financing for IHR implementation (58%), safe environment in health facilities (58%), resources for detection and alert (58%), and capacity and resources (58%).

15. The overall status of the core capacities across subregions in the Americas remains heterogeneous. As presented in the Annex, the highest average subregional scores for all 15 core capacities are consistently observed for North America, while the lowest average scores are registered in the Caribbean subregion for nine core capacities (financing, laboratory, surveillance, zoonotic diseases, chemical events, radiation emergencies, IHR coordination and NFP functions and advocacy, health services provision, and risk communication and community engagement). In Central America the lowest scores are for three core capacities (health emergency management, infection prevention and control, and

[7] Ibid.

points of entry and border health); and in South America for six core capacities (policy, legal, and normative instruments to implement IHR, human resources, food safety, IHR coordination and NFP functions and advocacy, health services provision, and risk communication and community engagement).

16. As presented in the Annex, no Voluntary External Evaluations in the context of the IHR MEF were conducted during the period covered by this report *(7)*. COVID-19 pandemic-related action reviews were conducted in Argentina, Belize, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Panama, and Uruguay, and possibly others. Pursuant to Resolution WHA74.7 *(13)*, the WHO Secretariat presented a detailed concept note to the 75th World Health Assembly on the voluntary pilot phase of the Universal Health and Preparedness Review mechanism and how it relates to the existing IHR MEF *(14)*.

17. The period covered by this report coincides with the rapid evolution of the COVID-19 pandemic. During this time, to support national authorities in their response efforts, PASB conducted regional, subregional, multi-country, and country missions, training, and workshops on a virtual basis. They addressed the following pillars of the WHO COVID-19 Strategic Preparedness and Response Plan of 2021 *(15)*: risk communication, community engagement, and infodemic management; surveillance, epidemiological investigation, contact tracing, and adjustment of public health and social measures; points of entry, international travel and transport, and mass gatherings; laboratories and diagnostics; infection prevention and control, and protection of the health workforce; case management, clinical operations, and therapeutics; maintaining essential health services and systems; and vaccination.[8]

Administrative Requirements and Governance

18. As of 15 July 2022, 533 ports in 28 States Parties in the Region of the Americas, including one landlocked State Party (Paraguay), were authorized to issue the Ship Sanitation Certificate.[9] Ten additional ports were authorized in seven overseas territories of France (2), the Netherlands (2), and the United Kingdom (6). The WHO Secretariat established an online portal to allow States Parties to update the list of their authorized ports, and States Parties were informed accordingly on 18 March 2022.

19. As of 15 July 2022, the IHR Roster of Experts included 436 professionals, 100 (23%) of whom are from the Region of the Americas. They include experts designated by 11 of the 35 States Parties in the Region: Argentina, Barbados, Brazil, Canada, Cuba, Jamaica, Mexico, Nicaragua, Paraguay, Peru, and the United States of America.

[8] Document CSP30/INF/1, Rev. 1, Update on COVID-19 in the Region of the Americas *(7)*, presents an exhaustive description of capacity-building activities supported by PASB in the context of the pandemic and financial support provided by partners.

[9] 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/portslanding/en/.

20. In 2022, 19 (54%) of the 35 States Parties in the Region responded to the global survey[10] for updating the WHO Travel and Health web page.[11] The 2022 survey concerned, inter alia, requirements for proof of vaccination against yellow fever as a condition for granting entry and/or exit to international travelers.[12, 13] In the context of the COVID-19 pandemic, it is worth noting that, pursuant to Articles 35 and 36 and Annexes 6 and 7 of the Regulations, no health documents other than the International Certificate of Vaccination or Prophylaxis (ICVP), with proof of vaccination against yellow fever, can be required by States Parties as conditions for granting travelers exit and/or entry. During the COVID-19 pandemic, States Parties in the Americas have adopted different international travel-related measures, including requirements for granting exit and/or entry, to mitigate the risk of exportation, importation, and onward local transmission of the SARS-CoV-2 virus. In some cases, these were consistent with IHR provisions, beyond Article 43, and with the risk-based approach promoted by the WHO Secretariat *(16, 17)*. As per the WHO interim position paper, Considerations Regarding Proof of COVID-19 Vaccination for International Travellers *(18)*, and the Temporary Recommendations current at the time of this writing,[14] States Parties shall not require proof of vaccination against COVID-19 as sole condition of entry. As of 15 July 2022, seven States Parties in the Region—Argentina, Costa Rica, Cuba, El Salvador, Grenada, Jamaica and Mexico—are not applying any COVID-19-related requirement for granting entry to their territory.

Action Needed to Improve the Situation

21. For global health governance, as anticipated in Documents CD58/INF/1 *(15)*, CE170/INF/3 *(6)*, and CE170/INF/4 *(2)*, the future application and implementation of and compliance with the IHR is linked to the implementation of various documents discussed during the WHA75. They include: *a)* Resolution WHA75.7 urging Member States to strengthen health emergency preparedness and response in cities and urban settings *(3)*; *b)* Resolution WHA75.12 *(4)* that, in accordance with paragraph 3 of Article 55 of the IHR, adopted the amendments to Article 59, and the subsequent updates to Articles 55, 61, 62, and 63 of the Regulations; and *c)* Decision WHA75(9) *(5)*, which establishes that the

[10] Countries that responded to the International Travel and Health 2022 Survey: Bahamas, Belize, Brazil, Chile, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Haiti, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Suriname and Uruguay.

[11] The WHO Travel and Health web page is available at: https://www.who.int/health-topics/travel-and-health#tab=tab_1.

[12] The list of countries with Risk of Yellow Fever Transmission and Countries Requiring Yellow Fever Vaccination (updated to May 2021) is available at: https://www.who.int/publications/m/item/countries-with-risk-of-yellow-fever-transmission-and-countries-requiring-yellow-fever-vaccination-(may-2021).

[13] Country Vaccination Requirements and WHO Recommendations for International Travellers and Malaria Prophylaxis per Country, updated to May 2021, is available at: https://www.who.int/publications/m/item/vaccination-requirements-and-recommendations-for-international-travellers-and-malaria-situation-per-country-2021-edition.

[14] The current Temporary Recommendations, issued by the Director-General of WHO in response to the COVID-19 PHEIC, are available on the WHO website at: https://www.who.int/news/item/12-07-2022-statement-on-the-twelfth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic.

Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR) continue with a revised name (the "Working Group on Amendments to the IHR," WGIHR) and mandate, —to work exclusively on the proposed amendments to the International Health Regulations (2005) for consideration by the 77th World Health Assembly in 2024.

22. Additionally, the WHA75 noted the report presented by the Director-General of WHO containing 10 proposals to strengthen the global architecture for health emergency preparedness, response and resilience. In this context, the term "architecture" refers to all the systems and capacities—including mechanisms for financing and governance—at national, regional, and global levels that are crucial to the world's collective ability to prepare for and respond to health emergencies *(19)*, considering the work of the established Intergovernmental Negotiating Body[15] to draft and negotiate a WHO convention, agreement, or other international instrument on pandemic prevention, preparedness, and response *(20)*.

23. This ongoing work to reshape the global health architecture is led primarily by Member States and has, by definition, global breadth and implications. In the Region of the Americas, it may lead to useful actions ensuing from the 75th World Health Assembly and making the cooperation that PASB can deliver to PAHO Member States more effective.

Action by the Pan American Sanitary Conference

24. The Conference is invited to take note of this report and provide any comments it deems pertinent.

Annex

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Annex

Summary Table 1. Public Health Events of Potential International Concern and Voluntary External Evaluations in the Context of the IHR Monitoring and Evaluation Framework

State Party	**Number of acute public health events of potential international concern assessed,[1] 1 July 2021-10 July 2022** (number of events for which verification was requested/obtained)	**Voluntary External Evaluation** (year conducted)
Antigua and Barbuda	0 (N/A)	-
Argentina	3 (N/A)	Yes (2019)
Bahamas	1 (N/A)	-
Barbados	1 (N/A)	-
Belize	0 (N/A)	Yes (2016)
Bolivia (Plurinational State of)	3 (2/2)	-
Brazil	22 (4N/4A)	-
Canada	4 (2/2)	Yes (2018)
Chile	3 (1/1)	-
Colombia	13 (33)	-
Costa Rica	2 (N/A)	-
Cuba	1 (N/A)	-
Dominica	0 (N/A)	-
Dominican Republic	1 (N/A)	Yes (2019)
Ecuador	4 (N/A)	-
El Salvador	0 (N/A)	-

[1] Events related to the COVID-19 pandemic, including multisystem inflammatory syndrome in children and adolescents, the emergence of SARS-CoV-2 Variants of Concern or Variants of Interest, and adverse events following immunization with vaccines against COVID-19, are not reflected in the Annex.

State Party	**Number of acute public health events of potential international concern assessed,[1] 1 July 2021-10 July 2022** (number of events for which verification was requested/obtained)	**Voluntary External Evaluation** (year conducted)
Grenada	0 (N/A)	Yes (2018)
Guatemala	0 (N/A)	-
Guyana	0 (N/A)	-
Haiti	2 (2/2)	Yes (2016, 2019)
Honduras	1 (N/A)	-
Jamaica	1 (N/A)	-
Mexico	13 (1/1)	-
Nicaragua	0 (N/A)	-
Panama	3 (N/A)	-
Paraguay	5 (2/2)	-
Peru	3 (1/1)	Yes (2015)
Saint Kitts and Nevis	0 (N/A)	-
Saint Lucia	1 (N/A)	-
Saint Vincent and the Grenadines	0 (N/A)	-
Suriname	1 (N/A)	-
Trinidad and Tobago	0 (N/A)	-
United States of America	10 (4/4)	Yes (2016)
Uruguay	3 (1/1)	-
Venezuela (Bolivarian Republic of)	8 (6/6)	-

Summary Table 2. States Parties Annual Reports: Global, Regional and Subregional Averages, 2021

(core capacity scores in percentages)

Subregion	C.1 Policy, legal and normative instruments to implement IHR	C.2 IHR Coordination and NFP functions and advocacy	C.3 Financing	C.4 Laboratory	C.5 Surveillance	C.6 Human resources	C.7 Health emergency	C.8 Health services provision	C.9 Infection prevention and control (IPC)	C.10 Risk communication and community engagement (RCCE)	C.11 Points of entry (PoEs) and border health	C.12 Zoonotic diseases	C.13 Food safety	C.14 Chemical events	C.15 Radiation emergencies
Global Average (n=177)	52	66	62	72	81	59	70	72	60	67	61	65	63	55	56
Region of the Americas (n=32)	50	69	63	75	83	62	75	73	61	66	71	69	71	58	58
Caribbean (n=12)*	52	64	56	69	78	59	74	68	60	60	67	67	67	42	38
Central America (n=7)**	54	71	57	78	87	70	72	80	53	73	67	69	77	66	60
North America (n=3)***	67	93	97	96	100	87	96	93	91	91	93	87	93	87	87
South America (n=10)****	41	64	64	74	82	53	73	68	59	60	71	68	64	64	72

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

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

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

Summary Table 3. States Parties Annual Reports, 2021
(core capacity scores in percentages by country)

State Party of IHR	Number of Annual Reports submitted from 2011 to 2021 (11 years)	Policy, legal and normative instruments to implement IHR	IHR Coordination and NFP functions and advocacy	Financing	Laboratory	Surveillance	Human resources	Health emergency management	Health services provision	Infection prevention and control (IPC)	Risk communication and community engagement (RCCE)	Points of entry (PoEs) and border health	Zoonotic diseases	Food safety	Chemical events	Radiation emergencies
Antigua and Barbuda	9	40	40	40	64	80	50	60	60	40	33	73	60	80	20	40
Argentina	11	50	40	80	72	70	50	60	67	67	60	80	80	80	60	60
Bahamas	8	30	80	50	64	70	50	80	47	53	47	93	60	60	20	20
Barbados	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Belize	7	20	33	30	40	70	30	80	40	60	27	80	40	80	20	40
Bolivia (Plurinational State of)	10	20	47	60	52	80	50	87	80	47	73	40	80	20	40	60
Brazil	10	90	87	80	96	100	90	80	80	80	80	67	80	100	100	100
Canada	11	60	100	100	100	100	90	100	100	100	100	100	100	100	100	100
Chile	11	50	80	80	80	80	50	80	80	80	40	80	80	80	80	80
Colombia	11	60	80	50	84	80	40	73	93	67	33	93	80	80	60	60
Costa Rica	11	20	80	50	88	80	80	67	67	53	67	67	80	80	60	60
Cuba	10	70	100	100	100	100	100	100	100	100	100	100	100	100	100	60
Dominica	10	40	73	50	76	60	60	80	80	60	67	80	80	80	40	20
Dominican Republic	10	50	73	40	60	90	60	60	80	40	73	53	80	80	100	40
Ecuador	11	30	73	50	80	80	50	80	53	47	67	80	80	80	80	60
El Salvador	11	80	87	100	100	100	100	100	100	67	100	100	80	100	100	100
Grenada	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

State Party of IHR	Number of Annual Reports submitted from 2011 to 2021 (11 years)	Policy, legal and normative instruments to implement IHR	IHR Coordination and NFP functions and advocacy	Financing	Laboratory	Surveillance	Human resources	Health emergency management	Health services provision	Infection prevention and control (IPC)	Risk communication and community engagement (RCCE)	Points of entry (PoEs) and border health	Zoonotic diseases	Food safety	Chemical events	Radiation emergencies
Guatemala	11	50	33	20	48	80	30	33	93	27	20	80	20	40	60	40
Guyana	10	100	87	100	88	100	80	100	100	93	100	100	100	80	80	80
Haiti	8	40	53	50	72	100	90	60	73	33	47	33	80	40	20	20
Honduras	11	40	73	70	84	70	40	60	47	47	73	60	80	80	20	20
Jamaica	10	100	100	100	92	100	80	93	80	73	100	87	80	80	80	80
Mexico	11	60	87	90	96	100	90	87	87	73	87	87	80	80	80	80
Nicaragua	11	90	93	60	72	100	90	100	100	60	100	27	60	80	40	100
Panama	11	50	60	60	96	90	90	87	73	80	80	80	80	80	80	60
Paraguay	10	40	53	40	72	70	50	60	67	33	60	80	20	80	60	60
Peru	10	20	33	30	48	80	30	47	20	40	20	33	20	20	40	100
Saint Kitts and Nevis	8	40	73	50	56	90	40	80	80	80	87	27	80	80	40	40
Saint Lucia	9	60	67	30	64	80	50	80	60	33	53	93	80	80	40	20
Saint Vincent and the Grenadines	8	20	20	20	36	20	20	20	33	20	20	20	20	20	20	20
Suriname	11	60	47	50	76	70	60	60	67	73	33	20	20	20	20	20
Trinidad and Tobago	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
United States of America	11	80	93	100	92	100	80	100	93	100	87	93	80	100	80	80
Uruguay	8	20	67	80	60	90	60	80	73	73	100	67	80	20	60	40
Venezuela (Bolivarian Republic of)	11	30	80	90	100	90	60	80	67	53	67	87	80	80	60	100

Summary Table 4. New Indicators from States Parties Annual Reports(n=11): Global, Regional and Subregional Averages (core capacities scores in percentages), 2021

Subregions	C.1.2 Gender Equality in health emergencies	C.6.2 Workforce surge during a public health event	C.9.3 Safe environment in health facilities	C.2.3 Advocacy for IHR implementation	C.9.1 IPC programmes	C.10.3 Community engagement	C.9.2 Health care-associated infections (HCAI) surveillance	C.4.3 Laboratory quality system	C.10.2 Risk communication	C.11.3 Risk-based approach to international travel-related measures	C.4.5 Effective national diagnostic network
Caribbean*	52	47	60	57	62	50	58	57	68	75	72
Central America**	51	69	49	69	57	80	54	69	69	77	83
North America***	47	93	100	87	87	80	87	93	100	87	93
South America****	28	40	50	54	54	56	72	70	66	68	82
AMR Average	44	54	58	61	61	61	64	67	71	74	79
Global Average	45	54	61	62	63	65	56	69	69	64	75

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

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

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

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