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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)*. Building on and following up on the status of the Implementation on the International Health Regulations (Document CD58/INF/1) presented at the 58th Directing Council *(2),* the "Situation Analysis" section of this report covers the period from 1 July 2020 to 24 April 2021; however, in the light of the rapidly unfolding events in the leading up to the 74th World Health Assembly, the "Actions Necessary to Improve the Situation" section was drafted at the end of May 2021. 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.

2. This document needs to be considered in the context of the ongoing COVID-19 pandemic.[1] It is closely related to Document CE168/INF/1, Update on COVID-19 in the Region of the Americas *(3)*.

Background

3. The International Health Regulations were adopted by the 58th World Health Assembly in 2005 through Resolution WHA58.3 *(4)*. 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.

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* This version contains minor editorial adjustments to paragraph 7 and to the numbering of footnotes.

[1] Information about the ongoing COVID-19 pandemic is available on the WHO website at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019, and on the PAHO website at: https://www.paho.org/en/topics/coronavirus-infections/coronavirus-disease-covid-19-pandemic.

Situation Analysis

Acute Public Health Events

4. 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 with the National IHR Focal Points (NFPs) through established communication channels. In 2020, 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 for National IHR Focal Points (EIS). In 2021, the WHO Secretariat launched a secure online platform for this purpose and, between 1 January 2021 and 24 April 2021, 17 of the 35 States Parties in the Americas (49%) confirmed or updated the contact information for their NFPs, along with the updated list of EIS national users; 3 (9%) confirmed or updated only the contact information for their NFPs; and 10 (29%) updated only the list of EIS national users. As of 24 April 2021, 161 users from all 35 States Parties had the credentials to access the WHO EIS portal. In 2020, routine tests of connectivity between the WHO IHR Contact Point and the NFPs in the Region were successful on at least one occasion 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 vaccines against COVID-19). From 1 July 2020 to 24 April 2021, 60 acute public health events of potential international concern were identified and assessed in the Region, representing 29% 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 Annex A. For 40 of the 60 events (67%), national authorities (including through the NFPs on 21 occasions) were the initial source of information. Verification was requested and obtained for eight of the 12 events identified through media sources, with a verification interval ranging from 0 to 28 days and a median interval of 1.5 days.

6. Of the 50 events for which the final designation status is known, 44 (88%) events, affecting 20 States Parties and three territories in the Region, were of substantiated international public health concern, representing 26% of such events determined globally. A large majority of these 44 events were attributed to infectious hazards (30 events, or 68%). The etiologies most frequently recorded for these 30 events were *Candida auris*, dengue fever, and yellow fever—each of which were associated with five events. The remaining 14 events of substantiated international public health concern were associated with disasters (5 events), the human-animal interface (4 events), food safety (2 events), product-related hazards (1 event), and radiation-related hazards (1 event). For one event the nature of the hazard remained undetermined. Over the period considered, of the 25 new events unrelated to the COVID-19 pandemic that were published globally on the WHO EIS portal, 7 (28%) concerned States Parties in the Americas.

7. Besides the COVID-19-related public health emergency of international concern (PHEIC),[2] on 19 February 2021, following the twenty-seventh meeting of the IHR Emergency Committee, the Director-General of WHO determined that the spread of wild poliovirus and

[2] Information about the IHR Emergency Committee for the COVID-19 pandemic can be accessed on the WHO website at: https://www.who.int/ihr/procedures/ihr_committees/en/.

circulating vaccine-derived poliovirus continues to 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. In May 2018, the WHO Secretariat offered to States Parties a revised tool *(5)* to facilitate the submission of their IHR Annual Report to the World Health Assembly, as mandated by Article 54 of the Regulations, Resolution WHA61.2 *(6)*, and Decision WHA71(15) *(7)*. Like its predecessor, the revised tool exclusively focuses on States Parties' core capacities. While its use remains voluntary, it has been widely utilized by States Parties worldwide, as reflected by the information submitted to the World Health Assembly since 2019, also publicly available through the WHO e-SPAR portal.[5]

9. In 2021, 29 (83%) of the 35 States Parties in the Region of the Americas submitted their IHR Annual Report to the 74th World Health Assembly.[6] This figure corresponds to indicator 23.1.a, "Number of States Parties completing annual reporting on the International Health Regulations (2005)," included under outcome 23 and output 23.1[7] in the Program Budget of the Pan American Health Organization 2020-2021 (hereinafter the "PAHO Program Budget 2020-2021"), adopted through Resolution CD57.R5 *(8, 9)*. Antigua and Barbuda, Cuba, Dominica (for the first time since 2011), Grenada (for the fourth year in a row), Saint Vincent and the Grenadines, and Trinidad and Tobago did not comply with this obligation. Possibly due to the demands imposed on national authorities by the COVID-19 pandemic, the submission rate observed in 2021, which is the same as in 2020, is the second lowest since 2011, when the management of IHR Annual Report data was systematized by the WHO Secretariat. Since 2011, nine States Parties have consistently submitted their IHR Annual Reports to the World Health Assembly each year: Canada, Colombia, Costa Rica, 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 Annex A.

10. At least 19 of the 29 States Parties (66%) that submitted their IHR Annual Report to the 74th World Health Assembly compiled the report through a multidisciplinary and/or multisectoral effort.

11. For all 13 core capacities, the average regional scores are above 60%, with the lowest average score (62%) for radiation emergencies and the highest average score (81%) for laboratory and surveillance. Apart from health service provision—with a score that is similar to the global

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

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

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

[6] Due to late submission, the information provided by Barbados in its IHR Annual Report could not be reflected in Document A74/17, presented to the 74th World Health Assembly.

[7] Outcome 23: "Health emergencies preparedness and risk reduction: Strengthened country capacity for all-hazards health emergency and disaster risk management for a disaster-resilient health sector." Output 23.1: "All-hazards emergency preparedness capacities in countries and territories assessed and reported."

average—for the remaining 12 core capacities, the average regional scores for the Americas are above the global averages.

12. Nevertheless, the status of the core capacities across subregions remains heterogeneous. As presented in Annex A, 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 10 core capacities (legislation and financing, zoonotic events and the human-animal interface, food safety, surveillance, human resources, health service provision, risk communication, points of entry, chemical events, and radiation emergencies); in Central America for one core capacity (IHR coordination and NFP functions); and in South America for three core capacities (laboratory, national health emergency framework, and health service provision). Annex A presents the core capacity scores for each State Party based on reports submitted to the 74th World Health Assembly in 2021, as well as for the overseas territories that have taken the opportunity to complete the tool and share it with PASB.

13. Historical data and trends concerning the status of core capacities from 2011 to 2018 are publicly available on the WHO Global Health Observatory web page.[8] Because of the introduction of the revised tool, comparison over time of the most current data—at regional, subregional, and national levels, including States Parties' abilities to maintain core capacities—is limited to the three-year period from 2019 to 2021, and to the 24 States Parties that have consistently submitted their IHR Annual Report over that period in a format allowing for analysis.[9]

14. Comparing the average regional scores of 2021 with those of 2019, increases were registered for all 13 core capacities, ranging from 1 to 13 percentage points for food safety. For seven of the 13 core capacities—food safety, laboratory, surveillance, national health emergency framework, health service provision, risk communication, radiation emergencies—the increases were equal to or greater than 5 percentage points. Comparing the average subregional scores of 2021 with those of 2019, in the Caribbean subregion there were increases or no changes for all core capacities except points of entry (-8%); in Central America increases were registered for all 13 core capacities; in South America, increases were registered for eight core capacities, excepting legislation and financing, IHR coordination and NFP functions, zoonotic events and the human animal interface, human resources, and chemical events; and in North America increases or no changes were registered for all core capacities apart from legislation and financing (-4%), zoonotic events and the human-animal interface (-7%), and human resources (-7%).

15. When the individual States Parties' scores of 2021 are compared with those of 2019, 22 (85%) of the 26 States Parties for which this comparison could be made[10] were able to maintain or improve their scores for at least 10 of the 13 core capacities.[11] While all 26 States Parties indicate the ability to maintain or make progress in food safety and laboratory, the lowest degrees of ability

[8] The WHO Global Health Observatory web page is available on the WHO website at: http://apps.who.int/gho/data/node.main.IHR00ALLN?lang=en.

[9] States Parties that could not be included in the analysis are Antigua and Barbuda, Barbados, Belize, Bolivia (Plurinational State of), Cuba, Dominica, Grenada, Guyana, Haiti, Saint Vincent and the Grenadines, and Trinidad and Tobago.

[10] The following States Parties could not be included in the analysis: Antigua and Barbuda, Barbados, Bolivia (Plurinational State of), Cuba, Dominica, Grenada, Guyana, Saint Vincent and the Grenadines, and Trinidad and Tobago.

[11] States Parties that, for any given core capacity and for the two years considered, have reported the lowest possible score according to the tool were not considered as having the ability to maintain that core capacity.

are reported for the following core capacities: zoonotic events and the human-animal interface, national health emergency framework, and risk communication (20 States Parties).

16. The appraisal of the status of indicator 23.2.a, "Number of countries with national action plans developed for strengthening International Health Regulations (2005) core capacities," included under outcome 23 and its output 23.2[12] in the PAHO Program Budget 2020-2021 *(8)*, was extrapolated from information provided by States Parties in their IHR Annual Reports under the legislation and financing core capacity. Of the 29 States Parties that submitted their IHR Annual Reports to the 74th World Health Assembly, 13 (45%) indicated that budgets were distributed in a timely manner and executed in a coordinated fashion. Also, 19 (66%) of the 29 States Parties indicated that an emergency public financing mechanism that allows structured reception and rapid distribution of funds for responding to public health emergencies was in place across relevant sectors.

17. The IHR Monitoring and Evaluation Framework (IHR-MEF) *(10)* 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 PAHO Program Budget 2020-2021 *(8)*. The appraisal of the status of indicator 23.3.a, "Number of countries and territories that have conducted simulation exercises or after-action review," included under outcome 23 and its output 23.3[13] in the PAHO Program Budget 2020-2021 *(8)*, was extrapolated from information provided by States Parties in their IHR Annual Reports to the 74th World Health Assembly under the national health emergency framework core capacity. Six (21%) of the 29 States Parties indicated that multisectoral all-hazard public health emergency preparedness and response plans, emergency response coordination mechanisms and incident management systems, and resource mapping and mobilization mechanisms were regularly tested and updated; one State Party indicated that testing and updating was limited to multisectoral all-hazard public health emergency preparedness and response plans, and resource mapping and mobilization mechanisms; one State Party indicated that testing and updating was limited to the emergency response coordination mechanism and incident management system, and resource mapping and mobilization mechanisms; three (10%) States Parties indicated that testing and updating was limited to the emergency response coordination mechanism and the incident management system. The remaining 18 (62%) States Parties did not report any form of testing or updating in relation to the national health emergency framework core capacity.

18. With respect to appraisal of the status of indicator 23.1.b, "Number of countries and territories that have evaluated disaster and emergency preparedness capacities in the health sector," included under outcome 23 and its output 23.1[14] in the PAHO Program Budget 2020-2021 *(8)*, no

[12] Outcome 23: "Health emergencies preparedness and risk reduction: Strengthened country capacity for all-hazards health emergency and disaster risk management for a disaster-resilient health sector." Output 23.2: "Countries and territories enabled to strengthen capacities for emergency preparedness."

[13] Outcome 23: "Health emergencies preparedness and risk reduction: Strengthened country capacity for all-hazards health emergency and disaster risk management for a disaster-resilient health sector." Output 23.3: "Countries and territories operationally ready to assess and manage identified risks and vulnerabilities."

[14] Outcome 23: "Health emergencies preparedness and risk reduction: Strengthened country capacity for all-hazards health emergency and disaster risk management for a disaster-resilient health sector." Output 23.1: "All-hazards emergency preparedness capacities in countries and territories assessed and reported."

Voluntary External Evaluations in the context of the IHR-MEF were conducted during the period covered by this report.

19. In the context of the COVID-19 pandemic, a debate has reignited surrounding the objectives of each of the four components and related tools of the IHR-MEF, driven by the following actual or apparent paradoxes: *a)* generally speaking, States Parties with "high scores" have performed poorly in responding to the COVID-19 pandemic; *b)* average regional core capacity scores, according to the IHR States Party Annual Reports to the World Health Assembly, have increased some 12 or more months into the COVID-19 pandemic. This debate is punctuated by multiform, and not necessarily compatible, issues regarding the four components: *a)* their legal weight for the purpose of mutual accountability among States Parties; *b)* expectations related to their predictive power in terms of the robustness of preparedness arrangements in place and actual capacity to mount an effective response in real life, in the absence of metrics characterizing response effectiveness; *c)* their suitability for application at the subnational level; *d)* their usefulness for ensuring mutual accountability at the international level, as well as national strategic, programmatic, and operational aspects of preparedness; and *e)* ultimately, their reliability and adequacy in capturing all elements of preparedness and response (e.g. leadership and governance). To address some of those issues, the WHO Secretariat held a consultative meeting on Joint External Evaluations and State Party Annual Reports to incorporate the lessons learned from the COVID-19 Pandemic on 9-10 March 2021, and a similar consultative meeting on action reviews and simulation exercises on 18-19 May 2021.

20. During the period covered by this report, which coincides with the rapid evolution of the COVID-19 pandemic, to support national authorities in their response efforts PASB conducted virtual regional, subregional, multi-country, and country missions, training, and workshops addressing the following pillars of the COVID-19 Strategic Preparedness and Response Plan *(11)*: 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.[15]

Administrative Requirements and Governance

21. During the period covered by this report, 492 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.[16] Nine additional ports were authorized in six overseas territories of France (1), the Netherlands (2), and the United Kingdom (6).

22. As of 24 April 2021, the IHR Roster of Experts included 423 professionals, 96 (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.

[15] Document CE168/INF/1, Update on COVID-19 in the Region of the Americas, presents an exhaustive description of capacity-building activities supported by PASB in the context of the pandemic and financial support provided by partners.

[16] 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/.

23. In 2021, 28 (80%) of the 35 States Parties in the Region responded to the global survey for updating the WHO Travel and Health web page,[17] concerning, inter alia, requirements for proof of vaccination against yellow fever as a condition for granting entry and/or exit to international travelers. At the time of writing, such requirements have not yet been published on the WHO website. 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, 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 the risk-based approach promoted by PASB *(12)* and the WHO Secretariat *(13).* As per WHO document, Interim Position Paper: Considerations Regarding Proof of COVID-19 Vaccination for International Travellers *(14)*, and the Temporary Recommendations current at the time of writing,[18] States Parties shall not require proof of vaccination against COVID-19 as a condition of entry.

Actions Necessary to Improve the Situation

24. For global health governance, as anticipated in Document CD58/INF/1 *(2)*, the future application and implementation of and compliance with the IHR is linked to the implementation of Resolution WHA73.1, COVID-19 Response *(15, 16)*, and, implicitly, the evolving COVID-19 pandemic. Since the adoption of that Resolution by the 73rd World Health Assembly in May 2020, additional related actions have been taken by WHO Member States and the WHO Secretariat. The following paragraphs summarize the status of relevant processes and initiatives, which are also taking place in the context of ongoing WHO reform processes, including the WHO Transformation Agenda.

a) *Concerted actions by WHO Member States which have triggered actions by the WHO Secretariat*

   i. Adoption of Decision WHA69(9), 2016 *(17)*, establishing the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC), [19] which presented its report to the 74th World Health Assembly in Document A74/16 *(18)*, closely related to its appraisal in the Interim Report on WHO's Response to COVID-19: January-April 2020 *(19)* and Document A73/10 *(20)*. In its most recent deliberations *(18)*, the IOAC offered 11 recommendations on the topic of the "WHO ongoing response to the COVID-19 pandemic," and 21 additional recommendations, grouped under four programmatic areas;

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

[18] 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/19-04-2021-statement-on-the-seventh-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic.

[19] Information about the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme is available, in English only, at: https://www.who.int/groups/independent-oversight-and-advisory-committee.

ii. Adoption of Resolution WHA73.1, 2020 *(15)*, which led to the convening by the Director-General of WHO of the:

a) IHR Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response (COVID-19 IHR RC),[20] which presented its Final Report to the 74th World Health Assembly in Document A74/9 Add.1 *(21)*. Its Interim Progress Report was presented in Document EB148/19 *(22)*. In its Final Report *(21)*, the COVID-19 IHR RC offered 40 recommendations, grouped under 10 thematic areas;

b) Independent Panel for Pandemic Preparedness and Response (IPPPR), [21] which presented its Final Report to the 74th World Health Assembly through Document A74/INF./2 *(23)*.[22] Its first and second Progress Reports were presented in Document A73/INF./4 *(24)* and through Document EB148/INF./4 *(25)*, respectively.[23] In its Final Report *(23)*, the IPPPR made six recommendations for "immediate actions to end the COVID-19 pandemic," and 28 additional recommendations, grouped under seven strategic or programmatic areas, to "ensure that any future infectious disease outbreak does not become a catastrophic pandemic";

iii. Adoption of Resolution WHA73.8, Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005), 2020 *(26)*;

iv. Adoption of Decision EB148(12) on sustainable financing *(27)*, which led to the establishment of the Working Group on Sustainable Financing, which presented the reports of its first two meetings to the 74th World Health Assembly in Document A74/6 *(28)*.[24]

b) *Concerted actions by WHO Member States*

Adoption of Decision EB148(2), Strengthening WHO's Global Health Emergency Preparedness and Response, 2021 *(29)*, through which: "The Executive Board … [d]ecided to call for the development of a resolution … to address the recommendations of the Independent Panel [IPPPR] and the two committees mentioned above [COVID-19 IHR RC and IOAC]." At the global level, negotiations to develop the prospective resolution have been ongoing since February 2021, under the leadership of the European Union, and were triggered by the formulation during the COVID-19 pandemic of eight proposals by

[20] Information about the IHR Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response is available, in English only, at: https://www.who.int/teams/ihr/ihr-review-committees/covid-19.

[21] Information about the Independent Panel for Pandemic Preparedness and Response (IPPPR) is available, in English only, at: https://theindependentpanel.org/.

[22] The full text of the Main Report of the IPPPR, COVID-19: Make it the Last Pandemic, and background documents are available at: https://theindependentpanel.org/mainreport/#download-main-report.

[23] The full text of the Second Progress Report of the IPPPR is available, in English only, at: https://test-the-independent-panel.pantheonsite.io/wp-content/uploads/2021/01/Independent-Panel_Second-Report-on-Progress_Final-15-Jan-2021.pdf.

[24] Information about the Working Group on Sustainable Financing is available at: https://apps.who.int/gb/wgsf/index.html.

individual or groups of WHO Member States,[25] broadly aimed at strengthening the global emergency preparedness and response architecture. On 5 February 2021, PASB shared with PAHO Member States, and presented to the Ministers of Health in the Americas, an analysis of those proposals, framed in accordance with the "Key Areas for Action for Consideration" section of Document EB148/18, WHO's Work in Health Emergencies: Strengthening WHO's Global Emergency Preparedness and Response; Report by the Director-General, 2021 *(30)*. A summary of that analysis is presented in Annex B. Between February and May 2021, PASB offered six virtual sessions to facilitate dialogue on the prospective resolution among Member States in the WHO Region of the Americas. The coordination of the Group of the Americas (GRUA) has kept PASB abreast of the progress of the prospective resolution.

c) *Actions by the Director-General of WHO and selected WHO Member States*

Further to the presentation of Document EB148/18 *(30)*—which states that, "Now may be the time for the world to renew its political commitment to the spirit of the Regulations, and enshrine it in an international treaty as proposed by the President of the European Council"—on 30 March 2021, the Director-General of WHO and 25 Heads of Governments issued the statement "Global leaders unite in urgent call for international pandemic treaty."[26] [27] From the Region of the Americas, the statement was signed by the Heads of Governments of Chile, Costa Rica, and Trinidad and Tobago.

d) *Actions by the Director-General of WHO*

i. On 18 January 2021, in his opening remarks at the 148th session of the Executive Board, and as reflected in Document EB148/18 *(30)*, the Director-General formally launched the Universal Health and Preparedness Review (UHPR), which "is based on a voluntary mechanism of peer-to-peer review, led by Member States, to promote greater, more effective international cooperation by bringing nations and stakeholders together in a spirit of solidarity."[28]

ii. In Document EB148/18 *(30)*, the Director-General of WHO formally launched the Biohub initiative, which "aims to build a global repository linked to a sustainable pathogen-sharing mechanism for the standardized collection, characterization and archiving of viruses, other pathogens and specimens to facilitate and accelerate the development of diagnostic tests and their evaluation for diseases of epidemic potential." The Biohub facility, to be based in Spiez, Switzerland, was jointly

[25] The proposals were made by following individual or groups of WHO Member States: *i)* Botswana, Nepal, Oman, Switzerland; *ii)* Brazil and the United States of America; *iii)* Chile, Ecuador, Guatemala, Peru, Uruguay; *iv)* France and Germany; *v)* India; *vi)* Japan; *vii)* Republic of Korea; and *viii)* the United Kingdom.

[26] The statement is available on the WHO website, in English only, at: https://www.who.int/news/item/30 03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty.

[27] Article 2 of the WHO Constitution, which is available on the WHO website at: https://www.who.int/governance/eb/who_constitution_en.pdf, stipulates that: "In order to achieve its objective, the functions of the Organization shall be: … (k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective" and, in Article 19, that "The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization."

[28] The WHO Director-General's opening remarks at 148th session of the Executive Board are available at: https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th-session-of-the-executive-board.

launched by the WHO Secretariat and the Government of Switzerland on 24 May 2021.[29]

iii. On 29 March 2021, the WHO Secretariat, together with the Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE), and the United Nations Environment Programme (UNEP) (collectively, the "Partners") launched a joint call for experts to serve on the One Health High-Level Expert Panel (OHHLEP) "to assist them in their support to Governments in the framework of the Partners' One Health collaboration."[30] The OHHLEP was launched by the four above-mentioned agencies on 20 May 2021.[31]

iv. On 5 May 2021, WHO and the Government of Germany launched the WHO Hub for Epidemic and Pandemic Intelligence: "The Hub, based in Berlin and working with partners around the world, will lead innovations in data analytics across the largest network of global data to predict, prevent, detect, prepare for and respond to pandemic and epidemic risks worldwide."[32]

25. Pursuant to Resolution WHA73.1 *(15)*, since September 2020, the application and implementation of and compliance with the IHR have been the subject of specific scrutiny by the COVID-19 IHR RC *(21)*, and, more tangentially, the IOAC *(18)* and the IPPPR *(23)*. It is noted that, despite the current absence of metrics to assess the effectiveness of a response, these three bodies have regarded the response to the COVID-19 pandemic as globally suboptimal, although their standpoints vis-à-vis the relevance and adequacy of the Regulations as a tool for global health governance are not entirely consistent.

26. The report of the COVID-19 IHR RC to the 74th World Health Assembly *(21)* implicitly recognizes the relevance and adequacy of the Regulations by stating that: "As we reviewed the IHR article by article, we found that much of what is in the Regulations is well considered, appropriate and meaningful in any public health emergency of international concern. However, it was clear to us that in the context of a pandemic, countries that in 2005 approved the IHR, in 2020 only applied the Regulations in part, were not sufficiently aware of them, or deliberately ignored them." It also concluded that: "The Regulations are a pillar of global health security: the foundations of the global architecture for monitoring and responding to public health risks and emergencies, involving countries, institutions and networks coordinated by WHO." At the same time, in recommending that "WHO and States Parties should consider the benefits of developing a global convention on pandemic preparedness and response in support of IHR implementation. Such a convention may include provisions for preparedness, readiness and response during a pandemic that are not addressed by the IHR," it seems to contradict its own appraisal, without recommending how to

[29] The joint press release by the Government of Switzerland and WHO is available, in English only, at: https://www.who.int/news/item/24-05-2021-who-and-switzerland-launch-global-biohub-for-pathogen-storage-sharing-and-analysis.

[30] The joint call for experts by the FAO, the OIE, UNEP, and WHO is available at: https://www.who.int/news-room/articles-detail/call-for-experts-one-health-high-level-expert-panel-(ohhlep).

[31] The joint press release by the FAO, the OIE, UNEP, and WHO launching the OHHLEP is available, in English only, at: https://www.who.int/news/item/20-05-2021-new-international-expert-panel-to-address-the-emergence-and-spread-of-zoonotic-diseases.

[32] The joint press release by the Government of Germany and WHO is available, in English only, at: https://www.who.int/news/item/05-05-2021-who-germany-launch-new-global-hub-for-pandemic-and-epidemic-intelligence.

make the IHR continuously fit for purpose or proposing more expedited amendments of the Regulations with respect to that which is stipulated in the IHR Article 55 Amendments.

27. The IOAC *(18)* affirms its alignment with the recommendations of the COVID-19 IHR RC and, like the latter, states that "[t]he COVID-19 pandemic has highlighted the importance of the International Health Regulations (2005) … in preparing for, and responding to, outbreaks and emergencies," while pointing out that "[t]he [COVID-19] crisis has also highlighted shortcomings in the International Health Regulations (2005) and their application by Member States and the WHO Secretariat," and that "a new international treaty for pandemic preparedness and response … should support Member States to comply with International Health Regulations (2005) provisions. … The Committee considers that stricter compliance with the provisions of the International Health Regulations (2005), coupled with stronger international solidarity, is of the utmost importance in facing future pandemic threats."

28. The IPPPR *(23)* states that the IHR "did not lead to an urgent, coordinated, worldwide response," and that the Regulations are not "enabling WHO to act immediately and independently." Much like the COVID-19 IHR RC and the IOAC, the IPPPR recommends the adoption of "a Pandemic Framework Convention within the next 6 months … complementary to the IHR, to be facilitated by WHO and with the clear involvement of the highest levels of government, scientific experts and civil society."

29. With respect to whether, when, and how to move forward with the proposal of developing a WHO convention, agreement or other international instrument on pandemic preparedness and response, a draft decision was presented to the 74th World Health Assembly,[33] with a focus on holding a special session of the World Health Assembly in November 2021 to consider the benefits of developing such an instrument through an intergovernmental process. Statements of support or concern have been expressed about the necessity, timing, and time frame required to undertake such an endeavor while the COVID-19 pandemic is still ongoing.

30. With respect to the proposed resolution on strengthening the global health emergency preparedness and response of WHO *(29)*, and which, pursuant to Decision EB148(2), "address[es] the recommendations of the Independent Panel [IPPPR] and the two committees mentioned above [COVID-19 IHR RC and IOAC]," the draft presented to the 74th World Health Assembly[34] provides for the establishment of a Member States Working Group on strengthening WHO preparedness and response to health emergencies. A thorough and critical analysis by Member States of the recommendations by the three above-mentioned bodies may provide clarity regarding *a)* consistency—internally for each specific set, across the three sets, and vis-à-vis the IHR—relevance, and feasibility; *b)* recommended actions to which WHO Member States may already have committed through the above-mentioned prospective resolution and/or existing ones; *c)* the need for revisions of the text of the Regulations—considering that the draft resolution presented in Document A74/A/CONF./2 contains the statement, "Reaffirming resolution WHA58.3 (2005)"; focusing on Article 55 to expedite any amendments that may be warranted; and considering the

[33] The text of the draft decision is presented in Document A74/A/CONF./7, Special Session of the World Health Assembly to Consider Developing a WHO Convention, Agreement or Other International Instrument on Pandemic Preparedness and Response, and, as of 25 May 2021, is available on the WHO website at: https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_ACONF7-en.pdf.

[34] The text of the draft resolution is presented in Document A74/A/CONF./2, Strengthening WHO Preparedness for and Response to Health Emergencies, and, as of 25 May 2021, is available on the WHO website at: https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_ACONF2-en.pdf.

possible scope of an additional international instrument to be negotiated among Member States; *d)* recommended actions that may prolong existing strategic and cooperative approaches to strengthen preparedness and response and which may ultimately have resulted in a suboptimal global response to the COVID-19 pandemic; and *e)* the mandates of and articulation between existing, newly created, and proposed high-level, governance, and advisory bodies.

31. Annex B contains an overview of the non-COVID-19-related recommendations made by the IOAC *(18)*, the COVID-19 IHR RC *(21)*, and the IPPPR *(23)* concerning areas for improvement according, inter alia, to the "Key Areas for Action for Consideration" presented in Document EB148/18 (30). Of the 89 recommendations put forward, 64 relate to three areas for improvement: *i)* strengthening WHO governance, accountability, and oversight during and in relation to health emergencies (23 recommendations); *ii)* ensuring coordinated and monitored national health emergency preparedness and response by virtue of the IHR (18 recommendations); and *iii)* providing for an enhanced global early warning, alert, and emergency response system under WHO leadership (23 recommendations). Of the 89 recommendations, a total of 38—concerning different topics—are either virtually identical or overlap significantly.

32. Recommendations by the COVID-19 IHR RC and the IPPPR which are either completely or partially aligned with suggestions made in paragraphs 36 to 46 of Document CD58/INF/1 *(2)* to address issues that have repeatedly been pinpointed as undermining the relevance of the IHR as a tool for global governance relate to the following: *a)* complete alignment: information sharing by States Parties with the WHO Secretariat during acute public health events; no need for a formal "intermediate level of alert"; procedures related to the IHR Emergency Committees; temporary recommendations concomitantly issued with the determination of a PHEIC; additional health measures; and *b)* partial alignment: national IHR Focal Points; essential public health functions; IHR monitoring and evaluation.

33. The proposals to reshape the global health architecture have, by definition, global breadth and implications, and, in the regional space, may lead to useful forward actions ensuing from the 74th World Health Assembly and making the cooperation that PASB can deliver to PAHO Member States more effective.

Action by the Executive Committee

34. The Executive Committee is invited to take note of this report and provide any comments it deems pertinent.

Annexes

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Annex A

Summary Table 1: States Parties Annual Reports to the 74th World Health Assembly, Voluntary Components of the IHR Monitoring and Evaluation Framework, and Public Health Events of Potential International Concern[1]

(core capacity scores in percentages)

	Mandatory State Party Annual Report															
State Party	**Number of Annual Reports submitted from 2011 to 2021** (11-year period)	**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**	**Voluntary External Evaluation (year conducted)**	**Number of acute public health events of potential international concern assessed** (1 July 2020-24 April 2021)[2]
Antigua and Barbuda	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Argentina	10	67	80	80	80	67	80	60	40	53	40	70	60	60	Yes (2019)	0
Bahamas	9	60	80	80	80	87	60	80	73	40	80	60	40	20	-	1
Barbados	9	33	40	40	80	73	80	40	80	60	60	60	40	40	-	0
Belize	7	47	50	40	80	73	40	40	80	47	20	70	20	20	Yes (2016)	0
Bolivia (Plurinational State of)	9	87	50	80	20	73	60	80	80	40	40	40	80	20	-	3

[1] Acute public health events of potential international concern assessed in the overseas territories in the Americas of France, the Netherlands, and the United Kingdom are not reflected in Table 1.

[2] 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 Table 1.

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 2020-24 April 2021)[2]
	Number of Annual Reports submitted from 2011 to 2021 (11-year period)	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		
Brazil	10	100	100	100	100	100	100	100	93	67	80	60	100	100	-	3
Canada	11	100	100	100	100	100	100	100	100	100	100	100	100	100	Yes (2018)	2
Chile	10	80	80	80	100	80	80	60	67	67	60	80	80	80	-	2
Colombia	11	73	70	80	80	80	70	60	67	73	80	100	60	80	-	3
Costa Rica	11	93	80	80	80	93	70	80	67	73	80	60	80	60	-	1
Cuba	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Dominica	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Dominican Republic	10	47	60	60	80	53	80	40	60	40	80	60	40	80	Yes (2019)	2
Ecuador	11	87	90	80	80	80	80	80	73	60	60	0	80	60	-	1
El Salvador	10	100	100	100	100	100	100	100	100	100	100	100	100	100	-	2
Grenada	5	-	-	-	-	-	-	-	-	-	-	-	-	-	Yes (2018)	1
Guatemala	10	73	40	40	60	80	80	60	100	47	40	60	40	40	-	1
Guyana	11	100	100	100	100	100	100	100	100	100	100	100	100	100	-	0
Haiti	8	27	60	60	20	60	90	40	53	27	20	20	40	0	Yes (2016, 2019)	1
Honduras	11	40	80	80	80	87	80	60	60	13	60	60	40	40	-	0

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 2020-24 April 2021)[2]
	Number of Annual Reports submitted from 2011 to 2021 (11-year period)	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		
Jamaica	11	93	100	100	80	87	80	80	80	73	100	100	80	80	-	0
Mexico	11	80	100	60	80	87	100	80	87	87	80	80	80	80	-	8
Nicaragua	10	100	40	80	80	87	80	80	100	73	80	100	80	100	-	4
Panama	10	93	80	80	80	93	90	80	80	73	80	60	80	60	-	1
Paraguay	9	47	100	20	80	67	100	40	73	53	60	80	60	60	-	0
Peru	9	67	50	80	80	47	80	40	67	40	40	40	40	100	Yes (2015)	3
Saint Kitts and Nevis	9	33	80	60	80	67	60	40	47	60	40	40	40	20	-	0
Saint Lucia	9	60	90	80	80	87	70	80	80	60	60	90	40	20	-	1
Saint Vincent and the Grenadines	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Suriname	10	73	70	60	80	80	60	80	60	60	80	10	40	20	-	0
Trinidad and Tobago	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
United States of America	11	100	100	80	100	100	100	60	100	100	100	100	80	80	Yes (2016)	4
Uruguay	7	73	50	80	80	87	90	80	87	73	100	100	60	80	-	0
Venezuela (Bolivarian Republic of)	10	73	90	80	80	67	90	80	67	60	40	100	40	100	-	5

Summary Table 2: Overseas Territories in the Region of the Americas which have completed and shared with PASB the IHR State Party Annual Report tool on the occasion of the 74th World Health Assembly, and Public Health Events of Potential International Concern
(core capacity scores in percentages)

	Mandatory State Party Annual Report														
Overseas territory	**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**	**Voluntary External Evaluation (year conducted)**	**Number of acute public health events of potential international concern assessed** (1 July 2019-30 June 2020)[1]
Bermuda (Overseas territory of the United Kingdom)	73	70	80	60	73	80	60	60	67	80	40	40	20	-	0
Cayman Islands (Overseas territory of the United Kingdom)	73	50	60	20	80	60	80	80	33	100	n/a	20	20	-	0

[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 Table 2.

Summary Table 3: States Parties Annual Reports to the 74th World Health Assembly: Regional and Subregional Averages (core capacity 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* = 9)	58	74	69	76	79	71	64	73	59	62	61	49	36
Central America** (*n* = 7)	78	69	74	80	85	83	71	81	60	74	71	66	69
South America*** (*n* = 10)	75	76	76	78	75	83	68	71	59	60	67	66	74
North America**** (*n* = 3)	93	100	80	93	96	100	80	96	96	93	93	87	87
Region of the Americas (*n* = 29)	**73**	**76**	**74**	**79**	**81**	**81**	**69**	**77**	**63**	**68**	**69**	**63**	**62**

* Caribbean subregion includes: Bahamas, Barbados, Belize, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, and Suriname.
** Central America subregion includes: Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
*** South America subregion includes: Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela (Bolivarian Republic of).
**** North America subregion includes: Canada, Mexico, and United States of America.

Annex B

Summary Table: Implementation of Decision EB148(2), Strengthening WHO's Global Health Emergency Preparedness and Response (2021)

Proposals by WHO Member States to the WHO Secretariat, and Non-COVID-19-related recommendations by the IOAC, the COVID-19 IHR RC and the IPPPR by area for improvement

Areas for improvement	**Number of communications from Member States which included proposals for improvements** (*n* = 8)	**Number of recommendations from the IOAC**[1]	**Number of recommendations from the COVID-19 IHR RC**[2]	**Number of recommendations from the IPPPR**[3]	**Total number of recommendations**
Not reflected in Document EB148/18 *(30)*					
(i) Strengthening WHO governance, accountability, and oversight during and in relation to health emergencies	5/8	14	2	7	**23**
▪ *High level – United Nations*	-	-	-	*2*	*2*
▪ *High level – WHO*	-	-	*1*	*3*	*4*
▪ *Organizational WHO*	-	*14*	*1*	*2*	*17*
(ii) Improving coordination between WHO and the UN System during and in relation to health emergencies	4/8	-	1	-	**1**

[1] IOAC: Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme.
[2] COVID-19 IHR RC: IHR Review Committee on the Functioning of the IHR during the COVID-19 Response.
[3] IPPPR: Independent Panel for Pandemic Preparedness and Response.

Areas for improvement	**Number of communications from Member States which included proposals for improvements** (*n* = 8)	**Number of recommendations from the IOAC**[1]	**Number of recommendations from the COVID-19 IHR RC**[2]	**Number of recommendations from the IPPPR**[3]	**Total number of recommendations**
"Key Areas for Action for Consideration" as per Document EB148/18 *(30)*					
(a) Coordinated and monitored national health emergency preparedness and response by virtue of the IHR	-	-	11	7	**18**
▪ *Improving mechanisms to monitor status of preparedness, including IHR*	8/8	-	*4*	*4*	*8*
▪ *Strengthening Member States' capacities*	5/8	-	*7*	*3*	*10*
(b) Sustained, predictable funding for health emergency preparedness and response, including from domestic budgets		6	1	3	**10**
▪ *Funding for WHO*	5/8	*6*	-	*1*	*7*
▪ *Funding for Member States*	2/8	-	*1*	*2*	*3*
(c) An enhanced global early warning, alert, and emergency response system under WHO leadership	-	-	19	4	**23**
▪ *More transparent, timely, and broader information sharing*	7/8	-	*7*	*2*	*9*
▪ *Improve mechanism related to the determination of a PHEIC*	8/8	-	*2*	*1*	*3*
▪ *Improve the functioning of IHR Emergency Committees*	5/8	-	*3*		*3*
▪ *Need for WHO to lead on and carry out field missions*	2/8	-	*1*	*1*	*2*
▪ *Improve WHO guidance and response mechanisms in relation to transport sector*	5/8	-	*6*	-	*6*

Areas for improvement	**Number of communications from Member States which included proposals for improvements** (*n* = 8)	**Number of recommendations from the IOAC**[1]	**Number of recommendations from the COVID-19 IHR RC**[2]	**Number of recommendations from the IPPPR**[3]	**Total number of recommendations**
(d) A global health emergency end-to-end supply chain and logistics system	1/8	-	-	1	**1**
(e) Mobilizing a global health emergency workforce	1/8	1	3		**4**
(f) Managing misinformation and disinformation that cause harm and undermine public health	None	-	1	2	**3**
(g) Harnessing global knowledge to translate evidence into effective health emergency policy	4/8	-	1	1	**2**
(h) Enhancing and expanding networks, mechanisms, and incentives for the sharing of samples and genomic data	3/8	-	1	-	**1**
(i) Accelerating research and innovation for epidemics	2/8	-	-	1	**1**
(j) Coordinating a global platform to ensure rapid, equitable access to the fruits of research	3/8	-	-	2	**2**
Total recommendations	Not Applicable	**21**	**40**	**28**	**89**

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