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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 16 July 2022 to 15 July 2023, updating the information presented at the 172nd Session of the Executive Committee in June 2023 *(2)* and complementing the information provided in Document A76/9 Rev. 1 presented to the 76th World Health Assembly in May 2023 *(3)*. It includes issues related to the governance of the World Health Organization (WHO) in preparing for and responding to health emergencies, a topic addressed in various WHO documents *(4–8)* and in the Report on Strategic Issues between PAHO and WHO (Document CD60/INF/2) *(9)*.

2. Pursuant to IHR provisions, the current report discusses 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 *(10)*. 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 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.

Between 1 January and 31 July 2023, all 35 States Parties in the Americas 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 NFPs. The 2023 results showed improvement compared to the results for the same period in 2022 (32/35 States Parties) and in 2021 (25/35 States Parties) *(11, 12)*. Regular follow-up and support from PAHO/WHO Representative (PWR) Offices has helped ensure full compliance (35/35) and will continue to be utilized in future years. In late 2022, routine tests of connectivity between the WHO IHR Contact Point and the NFPs in the Region were successful for 29 of the 35 States Parties (83%) by both telephone and email. Results from these tests have continued to improve since 2021. Regarding the WHO EIS, as of 15 July 2023, 184 users from all 35 States Parties had the credentials to access the portal.

5. The analysis presented below, concerning acute public health events of potential or actual national and international concern, exclusively focuses on events not related to the COVID-19 pandemic (therefore, excluding 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 16 July 2022 to 15 July 2023, a total of 173 acute public health events of potential international concern were identified and assessed in the Region, representing 36% of the 482 events considered globally over the same period.[1] This higher proportion may be due to the different sensitivity of the surveillance systems among regions. The number of events identified and assessed for each of the States Parties in the Americas is presented in Table 1 of the Annex. For 116 of the 173 events (67%), national authorities (including through the NFPs for 67 events) were the initial source of information. Verification was requested from States Parties for 40 signals identified through event-based surveillance activity conducted by PASB, and it was obtained for 33 of them.

6. Of the 173 events assessed, 106 events (61%), affecting 24 States Parties and eight territories in the Region, were considered of substantiated international public health concern, representing 27% of 387 such events determined globally. Of those 106 substantiated events, 88 events (83%) were attributed to infectious hazards. The etiologies most frequently recorded for over 50% of those 88 infectious hazard events were mpox (12 events), malaria (7), dengue (7), cholera (6), yellow fever (5), influenza due to identified avian or animal influenza virus (4), and measles (4). The remaining 18 substantiated events were attributed to non-infectious hazards and were associated with product-related hazards (14), non-communicable diseases (2), a stolen radionuclear source (1), and a chemical hazard (1). Over the period considered, of the 67 new events that were published globally on the WHO EIS portal, 12 (18%) concerned States Parties in the Americas. In addition, between 16 July 2022 and 15 July 2023, a total of 46 Epidemiological Alerts and Updates, seven Regional Risk Assessments, and four

[1] Additional public health events are being detected within each of the WHO regions. The Event Management System (EMS) is not intended to be the sole repository for all public health events, but only for those assessed and reported under the IHR framework. Factors such as differing protocols contribute to the varying number of events recorded in the EMS for each WHO region. Additional information is available at: https://www.paho.org/en/dva-annual-report.

Briefing Notes were disseminated through the PAHO website.[2] Information regarding acute public health events identified and assessed in the Region and recorded in the Event Management System (EMS) is updated weekly on the PAHO website.[3]

7. From 16 July 2022 to 15 July 2023, approximately 2.21 million articles were screened using the Epidemic Intelligence from Open Sources (EIOS) system.[4] A total of 3,280 signals were detected by PASB, and actions were taken as appropriate to monitor, discard, or verify the signals. PASB provided training for 10 Member States (Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, Guyana, Honduras, Paraguay, and Peru) in using EIOS to strengthen capacity building for event-based surveillance and early detection of acute public health events.

8. As of May 2023, the WHO Director-General determined that the COVID-19 pandemic and the multi-country outbreak of mpox no longer constituted a public health emergency of international concern (PHEIC), issuing Temporary Recommendations for both events that were valid until August 2023.[5] Standing recommendations were then issued by the WHO Director-General and have been in effect for all States Parties since August 2023, in accordance with provisions of Articles 16 to 18, and 50 to 53 of the IHR for COVID-19 and mpox.[6] On 12 May, the WHO Director-General determined that the risk of international spread of poliovirus continues to constitute a PHEIC.[7]

9. As of 15 July 2023, the multi-region cholera event remains designated by WHO as a global grade 3 emergency, the highest grade.[8] Additional information about acute public health events of significance or with implications for the Region is published and updated on the PAHO website.[9]

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

[3] Information is available at: https://shiny.pahobra.org/ems/.

[4] The EIOS system is a fit-for-purpose, constantly evolving web-based system designed to augment and accelerate global public health intelligence activities. It is built on a longstanding collaboration between WHO and the Joint Research Centre of the European Commission. Information available at: https://www.who.int/initiatives/eios.

[5] Statement on the fifteenth meeting of the IHR (2005) Emergency Committee on the COVID-19 pandemic: https://www.who.int/news/item/05-05-2023-statement-on-the-fifteenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic.

[6] Fifth Meeting of the IHR (2005) Emergency Committee on the Multi-Country Outbreak of mpox (monkeypox): https://www.who.int/news/item/11-05-2023-fifth-meeting-of-the-international-health-regulations-(2005)-(ihr)-emergency-committee-on-the-multi-country-outbreak-of-monkeypox-(mpox).

[7] 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/news/item/12-05-2023-statement-of-the-thirty-fifth-polio-ihr-emergency-committee.

[8] Information about the global cholera situation is available on the WHO website at: https://www.who.int/emergencies/disease-outbreak-news/item/2023-DON437.

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

Core Capacities of States Parties

10. In October 2022, the WHO Secretariat informed States Parties of the IHR that the e-SPAR platform was available for their State Party Self-Assessment Annual Reporting (SPAR) submission for 2022 *(13)*. PASB held a training session on the e-SPAR process for States Parties through the NFPs in January 2023. The deadline for States Parties to submit their IHR Annual Reports to the 76th World Health Assembly was extended to 31 March 2023. All 35 States Parties of the Americas complied with this provision.

11. In 2022, the regional average for core capacities remained the same as in 2021 for all capacities (67%). Surveillance (85%) achieved the highest regional average in 2022, while the lowest average was reported for policy, legal and normative instruments to implement IHR (55%) and for response to radiation emergencies (55%).

12. In 2022, capacities across the subregions remained heterogeneous. The North America subregion presented the highest average for all 15 capacities in the Region (87%), however, the average for the same capacities between 2021 and 2022 decreased 3% in the subregion. The lowest average was reported for policy, legal and normative instruments to implement IHR (63%). The Caribbean subregion reported the lowest average scores (61%), showing a 1% decrease compared to the average for the 15 capacities in 2021. In the Caribbean, the six capacities with average scores below 60% were radiation emergencies (36%), chemical events (40%), policy, legal and normative instruments to implement IHR (51%), infection prevention and control (57%), financing (59%), and human resources (59%). Similarly, the Central America subregion reported a decrease of 1% in the average scores for all capacities from 2021 to 2022 (68%). The infection prevention and control capacity received the lowest average (55%). The South America subregion was the only one that increased its core capacities average by 2% from 2021 to 2022 (67%). The human resources capacity had the lowest average score in the subregion (55%). Table 2 of the Annex presents the core capacities by country in the Americas.

13. As requested by the Small Island Developing States (SIDS) of the Region during the informal IHR meeting held in Chile in December 2022, a follow-up meeting took place in Jamaica (2–4 May 2023) to analyze the 35 indicators of the 15 core capacities currently represented in the SPAR and determine whether they should be adapted to the context of the SIDS, including overseas entities. Participants in the meeting concluded that 32/35 (92%) of the SPAR indicators were applicable to SIDS in their current form and 3/33 (8%) needed deeper consideration. These indicators were C1.2 Gender equality in health emergencies, C3.2 Financing for public health emergency response, and C8.2 Utilization of health services. The meeting's report is under review and will soon be available on the PAHO website.

14. The PAHO Program Budget 2022–2023, adopted through Resolution CD59.R8 *(14)*, includes four indicators related to the IHR core capacities reported in the SPAR, which are summarized in Tables 3 and 4 of the Annex. They are Outcome (OCM) indicator 23.b and Output (OPT) indicators 23.1.a, 23.2.a, and 23.3.a. For OCM indicator 23.b, 57% of 35 States Parties have maintained or improved scores for at least 12 of the 15 core capacities.

OPT indicator 23.1.a was achieved in 2022, as all 35 States Parties in the Region complied with the submission of the Annual Report.[10] OPT indicator 23.2.a represents the institutionalisation and sustainability of the core capacities registered by indicator C3.1 Financing for IHR implementation.[11] In 2022 it scored 55% below the target for 2023 (80%). For OPT indicator 23.3.a, 13/35 (37%) of the States Parties scored 100% in at least one of the following SPAR indicators: C7.1, C7.2, C7.3, or C8.3.[12]

15. As part of the voluntary component of the IHR Monitoring and Evaluation Framework, PASB compiled a summary of some actions developed by States Parties and confirmed with national authorities through PWR Offices. Table 5 in the Annex reports on the Joint External Evaluations, Voluntary External Evaluations, and After and Intra action reviews and Simulation exercises to test different contingency plans and operational protocols conducted in the Region.

Administrative Requirements and Governance

16. As of 15 July 2023, 533 ports in 28 States Parties in the Region, including one landlocked State Party (Paraguay), were authorized to issue the Ship Sanitation Certificate. A total of 12 ports were authorized in seven overseas territories of France (2 ports), the Netherlands (3 ports), and the United Kingdom (7 ports). The WHO Secretariat established an online portal to allow States Parties to update their list of authorized ports.[13]

17. As of 15 July 2023, the IHR Roster of Experts included 450 professionals, 103 (23%) of whom were from the Region. They comprised experts designated by 11 of the 35 States Parties in the Region: Argentina, Barbados, Brazil, Canada, Cuba, Jamaica, Mexico, Nicaragua, Paraguay, Peru, and United States of America.

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[10] Output indicator 23.1.a: Number of States Parties completing annual reporting on the International Health Regulations (2005). The indicator is calculated by counting the number of States Parties that have submitted the State Party Annual Report (SPAR) to the World Health Assembly.

[11] Output indicator 23.2.a: Number of States Parties with national action plans developed for strengthening International Health Regulations (2005) core capacities. The indicator is calculated by counting the number of States Parties for which the score registered for C3.1 Financing for IHR implementation, included in the State Party Annual Report (SPAR) submitted to the 76th World Health Assembly in 2023, is equal to or above 80%.

[12] Output indicator 23.3.a: Number of countries and territories that have conducted simulation exercises or after-action review. The indicator is calculated by counting the number of States Parties for which the score registered is 100% for at least one of the following indicators: C8.1 Planning for emergency preparedness and response mechanism, C8.2 Management of health emergency response operations, or C8.3 Emergency resource mobilization, included in the State Party Annual Report (SPAR) submitted to the World Health Assembly. The PAHO Program Budget 2022–2023 was linked to the SPAR's first edition. Currently, the indicators for SPAR's second edition are related to those from the previous edition as follows: C8.1 changed to C7.1 Planning for health emergencies; C8.2 changed to C7.2 Management of health emergency response; C8.3 changed to C7.3. Emergency logistic and supply chain management, and C8.3 Continuity of essential health services was included.

[13] The list of ports authorized to issue the Ship Sanitation Certificate is available on the WHO website at: https://extranet.who.int/ihr/poedata/public/en.

18. The global survey[14] for updating the WHO Travel and Health web page[15] included, inter alia, requirements for proof of vaccination against yellow fever as a condition for granting entry and exit to international travelers.[16, 17] The latest data remains the same as that reported in 2022 *(2)*.

19. 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 entry and exit. During the COVID-19 pandemic, States Parties in the Americas adopted different measures regarding international travel, including requirements for granting entry and exit, 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 *(15, 16)*. According to a WHO interim position paper, Considerations Regarding Proof of COVID-19 Vaccination for International Travelers *(17)*, and the Temporary Recommendations, States Parties shall not require proof of vaccination against COVID-19 as sole condition of entry. As of 15 July 2023, two of the 35 States Parties in the Region[18] request a vaccination certificate to enter the country. Most of the travel measures have been lifted by 33 of the 35 States Parties in the Region.

Action Needed to Improve the Situation

20. The IHR (2005) are a legally binding instrument for health emergencies, and their future governance and implementation are related to ongoing processes led by Member States through the Working Group on Amendments to the IHR (2005) (WGIHR) [19] and the Intergovernmental Negotiating Body (INB). [20] The INB was established to draft and negotiate a WHO convention, agreement, or other international instrument on pandemic prevention, preparedness, and response, referred to as the WHO CA+, as explained in Document CD60/INF/2 *(9)*.

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

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

[16] 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).

[17] Country vaccination requirements and WHO recommendations for international travelers 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.

[18] Plurinational State of Bolivia and Nicaragua.

[19] The WGIHR web page is available at: https://apps.who.int/gb/wgihr/.

[20] The INB web page is available at: https://apps.who.int/gb/inb/.

21. The Review Committee regarding amendments to the International Health Regulations (2005) was convened by the Director-General in compliance with Decision WHA75(9), adopted by the 75th World Health Assembly in 2022, and Decision EB150(3), adopted by the150th session of the Executive Board in 2022 *(18, 19)*, and in accordance with Article 50 of the IHR. The Review Committee submitted its report in mid-January 2023, pursuant to Article 55 of the Regulations, and the Director-General transmitted the report to the WGIHR.

22. The Review Committee examined 307 proposed amendments to the IHR submitted by State Parties,[21] including Brazil, United States of America, and Uruguay (the latter on behalf of the Member States of the Southern Common Market).

23. As of 28 July 2023, the WGIHR has held four meetings, and two more are planned before final proposed amendments are presented for consideration by the 77th World Health Assembly in 2024. Since November 2022, the WGIHR and INB Bureaus held various joint meetings and participated in a joint briefing session with the Review Committee, however substantive conversations started in both Bureaus in April and May 2023 that challenge the timeline of May 2024. From the joint discussions in July 2023, the approach to the issues that appear in the Bureaus' text for the Pandemic Accord and in the compilation of proposed amendments to the IHR (2005) remains unclear. It also remains unclear whether, for instance, provisions of the IHR, such as the declaration of a PHEIC, will trigger actions from the Pandemic Accord.

24. Member States and both Bureaus are set to discuss the synergies and complementarity between the WHO CA+, the IHR, and other relevant mechanisms and instruments to ensure alignment and consistency and to avoid inappropriate duplication and overlap. As the WGIHR will present its final report and recommendations to the World Health Assembly in 2024, it is essential that Member States continue to engage actively in the deliberations.

25. In December 2022 and April 2023, two informative sessions for States Parties were organized by PASB on the process for the amendments to the IHR. For the INB process, the following were held: *a)* a regional consultation in September 2022, *b)* a regional information session in February 2023, and *c)* a face-to-face regional meeting in March 2023. A face-to-face regional INB and WGIHR meeting was also held in July 2023. PASB will continue to support Member States in strengthening their core capacities and will continue to facilitate discussions among Member States.

[21] States Parties that submitted amendments to the IHR include Armenia, Bangladesh, Brazil, Czech Republic (on behalf of the Member States of the European Union), Eswatini (on behalf of the Member States of the WHO Africa Region), India, Indonesia, Japan, Malaysia, Namibia, New Zealand, Republic of Korea, Russian Federation (on behalf of the Member States of the Eurasian Economic Union), Switzerland, United States of America, and Uruguay (on behalf of the Member States of the Southern Common Market). Information is available at: https://apps.who.int/gb/wgihr/pdf_files/wgihr2/A_WGIHR2_5-en.pdf.

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

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Annex

Table 1. Public Health Events of Potential International Concern, 16 July 2022 – 15 July 2023

State Party	Number of acute public health events of potential international concern[a] for which verification was requested/obtained[b]
Antigua and Barbuda	0 (N/A)
Argentina	9 (1 request/1 response)
Bahamas	4 (N/A)
Barbados	1 (1 request/1 response)
Belize	0 (N/A)
Bolivia (Plurinational State of)	5 (3 requests/2 responses)
Brazil	11 (3 requests/3 responses)
Canada	8 (N/A)
Chile	6 (1 request/0 responses)
Colombia	17 (5 requests/5 responses)
Costa Rica	2 (N/A)
Cuba	3 (1 request/1 response))
Dominica	0 (N/A)
Dominican Republic	2 (2 requests/2 responses)
Ecuador	7 (N/A)
El Salvador	3 (2 requests/2 responses)
Grenada	1 (N/A)
Guatemala	3 (N/A)

Table 1. Public Health Events of Potential International Concern, 16 July 2022 – 15 July 2023 *(cont.)*

State Party	Number of acute public health events of potential international concern[a] for which verification was requested/obtained[b]
Guyana	1 (N/A)
Haiti	1 (1 request/1 response)
Honduras	4 (1 request/1 response)
Jamaica	2 (N/A)
Mexico	15 (7 requests/7 responses)
Nicaragua	2 (2 requests/1 response)
Panama	2 (N/A)
Paraguay	7 (2 requests/2 responses)
Peru	10 (2 requests/2 responses)
Saint Kitts and Nevis	0 (N/A)
Saint Lucia	0 (N/A)
Saint Vincent and the Grenadines	0 (N/A)
Suriname	0 (N/A)
Trinidad and Tobago	1 (N/A)
United States of America	25 (1 request/1 response)
Uruguay	7 (N/A)
Venezuela (Bolivarian Republic of)	5 (5 requests/1 response)

[a] 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.

[b] Verification requests for territories (n=3) were not included.

Table 2. Core Capacity Scores in Percentages by State Party – Annual Report 2022

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 (PoE) and border health	Zoonotic diseases	Food safety	Chemical events	Radiation emergencies
Antigua and Barbuda	10	30	47	50	68	90	50	60	67	47	33	73	60	80	20	40
Argentina	12	70	53	80	72	80	50	47	67	60	67	73	80	80	60	60
Bahamas	9	20	80	50	84	90	50	73	73	20	60	80	20	80	40	20
Barbados	9	70	80	70	52	100	70	80	87	67	73	80	60	80	40	40
Belize	8	20	33	40	52	60	30	73	40	80	20	60	20	80	40	40
Bolivia (Plurinational State of)	11	40	60	70	88	80	70	80	87	40	60	53	80	80	80	80
Brazil	11	50	80	80	80	80	50	87	47	80	80	67	20	100	60	80
Canada	12	70	100	100	100	100	80	93	100	100	100	100	100	100	100	100
Chile	12	60	80	80	80	80	100	87	80	100	87	80	60	40	80	80
Colombia	12	60	80	50	84	100	40	73	87	73	53	93	80	80	80	60
Costa Rica	12	20	60	60	80	80	70	53	80	60	60	67	80	80	80	40
Cuba	11	100	100	90	100	100	100	100	100	100	100	100	100	100	100	100
Dominica	11	40	73	50	60	30	60	80	80	60	67	80	80	80	40	40
Dominican Republic	11	50	73	40	60	90	60	60	80	40	73	27	80	80	80	40
Ecuador	12	80	53	30	72	80	50	73	53	27	40	67	60	80	80	60
El Salvador	12	80	93	90	88	100	90	100	100	80	80	100	80	100	100	100
Grenada	6	30	47	30	48	70	30	33	47	27	40	27	20	40	20	20

Table 2. Core Capacity Scores in Percentages by State Party – Annual Report 2022 *(cont.)*

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 (PoE) and border health	Zoonotic diseases	Food safety	Chemical events	Radiation emergencies
Guatemala	12	50	27	20	44	70	30	67	73	33	47	20	20	20	60	40
Guyana	11	40	47	70	76	60	60	73	80	40	60	40	40	40	40	40
Haiti	9	40	53	50	96	100	90	80	73	40	60	33	80	40	0	0
Honduras	12	50	80	40	80	80	50	60	60	33	47	40	80	80	60	40
Jamaica	11	90	93	100	92	100	70	93	80	67	87	93	80	100	80	80
Mexico	12	40	87	70	96	100	50	87	93	53	80	87	60	80	60	80
Nicaragua	12	90	93	70	72	100	90	100	100	60	100	100	80	80	40	100
Panama	12	50	60	70	96	100	90	87	73	80	80	80	80	80	40	60
Paraguay	11	30	53	20	60	100	60	67	73	53	60	80	60	80	80	60
Peru	11	20	33	40	52	80	30	67	33	40	33	33	20	40	60	100
Saint Kitts and Nevis	9	70	80	70	56	80	60	80	87	93	87	87	80	80	40	20
Saint Lucia	10	60	67	30	68	80	50	80	60	33	53	100	80	80	40	20
Saint Vincent and the Grenadines	9	30	47	90	76	80	40	100	60	53	80	33	80	40	40	40
Suriname	12	60	40	50	76	70	60	60	67	73	33	20	20	20	20	20
Trinidad and Tobago	9	60	73	40	72	80	60	73	73	60	80	80	80	80	40	20
United States of America	12	80	93	100	92	100	80	100	93	100	87	93	80	100	80	80
Uruguay	9	70	67	80	64	90	60	80	73	73	100	80	80	40	60	40
Venezuela (Bolivarian Republic of)	12	90	80	40	76	80	40	80	87	80	73	93	80	80	80	100

Table 3. Outcome (OCM) and Output (OPT) 23 Indicators from the Program Budget of the Pan American Health Organization 2022–2023 by Subregional Averages, 2022
(core capacity scores in percentages)

	OCM Indicator 23.b	OPT Indicator 23.1.a	OPT Indicator 23.2.a	Core capacities related to OPT Indicator 23.3.a			
Subregions	**SP meeting and sustaining IHR requirement for core capacities 12 of 15 capacities maintained or improved**	**SPAR compliance**	**C3.1 Financing for IHR implementation >=80**	**C7.1 Planning for health emergencies**	**C7.2 Management of health emergency response**	**C7.3 Emergency logistic and supply chain management**	**C8.3 Continuity of essential health services (EHS)**
Caribbean[a]	8/15	100	46	67	85	80	74
Central America[b]	3/7	100	53	74	81	76	65
North America[c]	2/3	100	87	69	80	76	68
South America[d]	7/10	100	54	73	82	79	72
AMRO Average	20/35 (57%)	100	55	71	82	78	69

[a] 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.

[b] Central America subregion: Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

[c] North America subregion: Canada, Mexico, and United States of America.

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

See footnotes 10–12 for further information.

Table 4. Core Capacities by State Party for which scores were maintained or improved in 2022 compared to 2021

State Party	Number of core capacities for which scores were maintained or improved in 2022 compared to 2021
Antigua and Barbuda	14/15
Argentina	12/15
Bahamas	10/15
Barbados	*
Belize	10/15
Bolivia (Plurinational State of)	12/15
Brazil	6/15
Canada	13/15
Chile	13/15
Colombia	14/15
Costa Rica	9/15
Cuba	14/15
Dominica	13/15
Dominican Republic	13/15
Ecuador	7/15
El Salvador	11/15
Grenada	*
Guatemala	9/15
Guyana	0/15
Haiti	13/15
Honduras	10/15
Jamaica	10/15

Table 4. Core Capacities by State Party for which scores were maintained or improved in 2022 compared to 2021 *(cont.)*

State Party	Number of core capacities for which scores were maintained or improved in 2022 compared to 2021
Mexico	8/15
Nicaragua	15/15
Panama	14/15
Paraguay	12/15
Peru	15/15
Saint Kitts and Nevis	13/15
Saint Lucia	15/15
Saint Vincent and the Grenadines	15/15
Suriname	14/15
Trinidad and Tobago	*
United States of America	15/15
Uruguay	15/15
Venezuela (Bolivarian Republic of)	11/15

* SPAR not submitted in 2021, therefore comparison is not possible.

Table 5. Summary of the IHR Monitoring and Evaluation Framework Voluntary Components, 1 January 2016 – 15 July 2023[a]

State Party	After Action Reviews	Intra Action Reviews	Simulation Exercises	Joint External Evaluations / Voluntary External Evaluation
Antigua and Barbuda			(2021)	
Argentina		(2022)		(2019)
Bahamas	(2020)		(2023)	
Barbados				
Belize			(2023)	(2016)
Bolivia (Plurinational State of)		(2016, 2021)	(2023)	
Brazil		(2018, 8 in 2020, 7 in 2021, 2023)		
Canada				(2018)
Chile			(2022)	
Colombia				
Costa Rica	(2022)	(2021)	(2021, 2022)	
Dominica		(2021)		
Dominican Republic			(2023)	(2019)
Ecuador		(2017)		
El Salvador			(2022)	
Grenada				(2018)
Guatemala			(2021, 2022)	Ongoing in 2023
Guyana				Ongoing in 2023
Haiti	(2023)	(2018)	(2022)	(2016, 2019)
Honduras			(2023)	
Jamaica			(2021)	

Table 5. Summary of the IHR Monitoring and Evaluation Framework Voluntary Components, 1 January 2016 – 15 July 2023[a] *(cont.)*

State Party	After Action Reviews	Intra Action Reviews	Simulation Exercises	Joint External Evaluations / Voluntary External Evaluation
Mexico			(2022)	
Panama			(2023)	
Peru	(2019)		(3 in 2021, 2 in 2022)	(2015)[b]
Saint Kitts and Nevis		(2022)		
Suriname		(2023)		
Trinidad and Tobago			(2021)	
United States of America			(2022)	(2016)

[a] Reported to PASB and through the SPAR in 2022.

[b] Pilot of the Global Health Security Agenda tool.

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