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IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (IHR)

Introduction

1. This document reports on the application and implementation status of the International Health Regulations (hereafter referred to as “the IHR” or “the Regulations”) and compliance therewith. This report: *a*) updates the information submitted to the 162nd Session of the Executive Committee in June 2018 (*1*); *b*) reviews activities undertaken by States Parties and the Pan American Sanitary Bureau (PASB) both in response to acute public health events, including Public Health Emergencies of International Concern (PHEIC) and for the purpose of capacity building; and *c*) highlights issues requiring concerted action by States Parties in the Region of the Americas and PASB for future application and implementation of the Regulations and compliance therewith.

Background

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

Situation Analysis

Acute Public Health Events

3. The Pan American Health Organization (PAHO) serves as the World Health Organization (WHO) IHR Contact Point for the Region of the Americas and facilitates the management of public health events with the National IHR Focal Points (NFPs) through established communication channels. In 2018, 29 of the 35 States Parties in the

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

Region (83%) submitted the annual confirmation or update of contact information for their NFPs, and 26 of the 35 (74%) submitted an updated list of national users of the secure Event Information Site for National IHR Focal Points. In 2017, routine tests of connectivity between the WHO IHR Contact Point and the NFPs in the Region were successful for 30 of the 35 States Parties (86%) by e-mail and 32 of the 35 States Parties (91%) by telephone.

4. From 1 January to 30 June 2018, 55 acute public health events of potential international concern were identified and assessed in the Region, representing 22% of the events considered globally over the same period. For 31 of the 55 events (56%), national authorities (including through the NFPs on 28 occasions) were the initial source of information. It should be noted that for two of the 55 (4%) events considered, the final designation status still had to be made at the time of this writing, and verification was requested and obtained for all but one of the events identified through non-governmental sources. Therefore, of the 52 events for which the final designation status is known, 29 (56%), affecting 15 States Parties in the Region, were of substantiated international public health concern. The vast majority of these 29 events were attributed to infectious hazards (27 events, or 93%). While the etiology of two of these 27 events (7%) remained unspecified, the causative agent most frequently recorded was measles virus (7 events). The remaining two events of substantiated international public health concern were related to animal and food safety hazards.

5. In addition to the current PHEIC declared as a result of the spread of wild poliovirus and the circulating vaccine-derived poliovirus (cVDPV),² from 1 July 2017 to 30 June 2018, and to the Ebola Virus Disease outbreak in the Democratic Republic of the Congo, which has triggered the activation of the 2018 IHR Emergency Committee for Ebola virus disease,³ the significant acute public health events that affected or had public health implications for States Parties in the Americas and PASB were related mainly to vaccine-preventable diseases, which include:

- a) *Yellow fever*: The increased yellow fever virus activity in South America at the end of 2015 resulted in an exceptional upsurge in cases in the animal and human populations in Brazil in late 2016. Following the seasonal pattern observed in 2017 and 2018, the upsurge in yellow fever virus activity in Brazil has spread to areas along the southern Atlantic coast not previously deemed to be at risk for yellow fever virus transmission. This has prompted the WHO Secretariat to declare extended areas at risk for yellow fever virus transmission for international travelers to Brazil.⁴ Between 1 July 2017 and 30 June 2018, 1,266 laboratory-confirmed human cases of yellow fever, including 415 deaths (for a case fatality rate of 33%)

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

³ The web page of the 2018 IHR Emergency Committee for Ebola virus disease is available on the WHO website at: <http://www.who.int/ihr/emergency-committee-ebola-2018/en/>.

⁴ The WHO International Travel and Health web page is available on the WHO website at: <http://www.who.int/ith/en/>.

were reported in Brazil, the most affected states being Minas Gerais, Rio de Janeiro, and São Paulo. In addition to at least three cases of yellow fever detected in international travelers visiting Brazil, cases of yellow fever with a history of travel to Brazil and no history of yellow fever vaccination were detected in Argentina (7 cases), Czech Republic (1 case), France (7 cases), Germany (2 cases), the Netherlands (1 case), Romania (1 case), Switzerland (1 case), and the United Kingdom (1 case). In the context of a global shortage of yellow fever vaccine, the response interventions of the Brazilian health authorities in areas that include Bahia, Rio de Janeiro, and São Paulo states constitute the largest mass vaccination campaign ever conducted using the fractional dose of yellow fever vaccine, with a target population of 17 million individuals. During the period considered, Peruvian health authorities reported 10 laboratory-confirmed cases of yellow fever from areas known to be at risk for yellow fever virus transmission.

- b) *Measles*: Since mid-2017, Venezuela has been in the throes of a nation-wide measles outbreak, with nearly 2,300 confirmed cases, including, at least, 35 deaths (for a case fatality rate of 2%), noted as of 3 June 2018 (2). While most of the cases were reported in Bolivar state and the Capital District, eleven additional states, including some bordering Brazil, Colombia, and Guyana, have also reported cases. Venezuelan health authorities are implementing the National Measles Rapid Response Plan, which includes intensified immunization interventions. As of 30 June 2018, laboratory-confirmed cases of measles imported, or related to importation, from Venezuela, were detected in Colombia (34 cases), Ecuador (17 cases) and in Brazil (465 cases, including three deaths, with nearly 1,900 suspected cases under investigation in Roraima and Amazonas states). Brazilian health authorities are conducting a vaccination campaign in all municipalities of Roraima state, that includes the immunization of immigrants from Venezuela, and in four municipalities in the Amazonas state. Preliminary laboratory confirmations of measles cases, or cases under investigations, were reported in the following states: Mato Grosso (2 cases), Rio de Janeiro (13 cases), Rio Grande do Sul (6 cases), and Rondonia (3 cases). Peruvian health authorities have reported two laboratory-confirmed cases of measles associated with a D8 genotype in patients with no history of travel outside the country. Furthermore, during the first semester of 2018, laboratory-confirmed cases of measles imported from States Parties outside the Americas, together with some resulting from related limited local transmission, were detected by health authorities in Antigua and Barbuda (1 case), Argentina (3 cases), Brazil (2 cases), Canada (16 cases), Guatemala (1 case), Mexico (5 cases), and the United States of America (90 cases).
- c) *Diphtheria*: Diphtheria outbreaks are ongoing in Haiti and Venezuela. The outbreak in Haiti began in 2014 and, as of 30 June 2018, a total of 537 confirmed and suspect cases, including 81 deaths (15% case fatality rate) were reported by the national health authorities. Cases observed during the first six months of 2018 account for 31% of the cases since the start of the outbreak. The outbreak in Venezuela began in July 2016, and, as of 22 April 2018,

approximately 1,800 confirmed and suspect cases, including 160 deaths (9% case fatality rate), were reported by the national health authorities (2). Cases during the first four months of 2018 account for 21% of the cases observed since the start of the outbreak. National health authorities are implementing a number of control measures, including immunization. Between 1 January and 30 June 2018, Brazil reported five laboratory-confirmed cases of diphtheria, including one imported from Venezuela; and Colombia reported five laboratory-confirmed cases also imported from Venezuela.

- d) *Malaria*: In the context of a significant increase in the number of malaria cases observed in several countries across the Americas since 2015, Venezuela has overtaken Brazil as the greatest contributor to the malaria burden in the Region, with a 75% increase in malaria cases observed between 2015 and 2016 (from 136,000 to 240,000) (3). A further increase in the number of malaria cases was observed in 2017, with 406,200 reported (2). Over 75% of the cases reported in 2017 are associated with *Plasmodium vivax* infection. While, in 2017, Bolivar state, bordering Brazil and Guyana, continued to account for most of malaria cases reported nationwide (64%), the malaria outbreak has spread to Sucre and Amazonas states, with the latter bordering Brazil and Colombia. The main determinants of the sustained transmission, among others, are: *a)* the high vulnerability and poor living conditions of people in mining areas, *b)* the intense mobility between endemic municipalities and other receiving areas, *c)* and hard-to-reach affected communities in Amazonas and Bolivar states. The limited availability of prompt antimalarial treatment and insecticide-impregnated nets with lasting effects, coupled with decreased indoor residual spraying capacity are hindering efforts to reduce the intensity of malaria transmission in the country.

Core Capacities of States Parties

6. In 2018, 31 (88%) of the 35 States Parties in the Region of the Americas submitted their report to the Seventy-first World Health Assembly. Belize, Grenada, Saint Lucia, and Saint Vincent and the Grenadines did not comply with this obligation. Since 2011, when the current form for the States Parties Annual Report was proposed by the WHO Secretariat for reporting to the Sixty-fourth World Health Assembly, 12 States Parties have systematically complied by submitting their report every year: Antigua and Barbuda, Barbados, Canada, Colombia, Costa Rica, Dominica, Ecuador, Guyana, Honduras, Jamaica, Mexico, and the United States of America. Information on the degree of compliance with this commitment on the part of the remaining States Parties is presented in the Annex.

7. States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2018 showed steady improvements or plateauing of all core capacities at the regional level. When the 2018⁵ Annual Reports are compared with those submitted in 2017, variations in the average regional scores for all core capacities are in the range of six percentage points. The highest average regional score obtained, 92%, continues to be for events associated with zoonotic hazards. The human resources core capacity and the core capacity to respond to events associated with chemical hazards have the lowest scores: 65% and 63%, respectively. It is worth noting that, since the introduction of this reporting form in 2011, the average regional score for the core capacity to respond to events associated with radiation-related hazards has exceeded 70%. The average regional score for all remaining core capacities is close to or above 80%. However, the status of the core capacities across the subregions remains heterogeneous, with the lowest scores reported in the Caribbean subregion. When the individual States Parties' scores from the 2018 Annual Reports are compared with those of 2017, 20 (67%) of the 30 States Parties show the ability to maintain or improve the scores for at least 10 of the 13 core capacities. The Annex also presents a summary of the States Parties Annual Reports to the Seventy-first World Health Assembly.⁶

8. Over the period from 1 July 2017 to 30 June 2018, to support efforts by the national authorities to advance in the continuous public health preparedness process, PASB conducted regional, subregional, multicountry, and country missions and workshops focusing, *inter alia*, on: *a*) the early warning function of the surveillance system; *b*) NFP functions (International Health Regulations National Focal Point Regional Meeting, held in Miami, Florida, 28-30 November 2017, including the Emergency Contact Points of the International Network of Food Safety Authorities [INFOSAN]);⁷ *c*) laboratory diagnostics and public health laboratories; *d*) infection prevention and control; *e*) risk communication; *f*) rapid response teams; *g*) points of entry; *h*) after-action reviews (Workshop for the development of a tool for conducting after-action reviews, including a web-based platform, held in Brasilia, Brazil, 29 January-2 February 2018, with the participation of the South American Institute of Governance in Health (ISAGS, Spanish acronym)); *i*) simulation exercises (Brazil and Chile); and *j*) response to chemical hazards (Caribbean sub-regional workshop on preparedness for and response to acute events related to chemical hazards, held in Port of Spain, Trinidad and Tobago, 30 October-1 November 2017, organized jointly by PASB and the WHO Collaborating Centre for the Public Health Management of Chemical Exposures, housed in Public Health England, United Kingdom). Moreover, collaboration between PASB and the International Atomic Energy Agency (IAEA) has continued within the framework of several large-scale projects focusing on the

⁵ Due to a technical information management issue, the State Party Annual Report submitted by Jamaica to the Seventy-first World Health Assembly is not accounted for in the regional and subregional analyses presented in this report.

⁶ Historical and other information on the States Parties Annual Reports submitted to the World Health Assembly is available in the WHO Global Health Observatory data repository on the WHO website at: <http://apps.who.int/gho/data/node.main.IHR?lang=en>.

⁷ The web page of the International Network of Food Safety Authorities (INFOSAN) is available on the WHO website at: http://www.who.int/foodsafety/areas_work/infosan/en/.

Caribbean subregion. As of 30 June 2018, Saint Kitts and Nevis and Suriname are the only two States Parties in the Americas that have not sought for the IAEA membership.⁸

9. Proposals to address challenges related to the establishment, maintenance, and monitoring of core capacities in Small Island Developing States (SIDS) were drafted as a result of a meeting between PASB and the WHO Regional Office for the Western Pacific held in Washington, D.C., 18-20 December 2017. Furthermore, PASB participated in a similar informal activity promoted jointly by European States Parties (France, the Netherlands, and the United Kingdom) with overseas territories in the Region of the Americas (21 March 2018).

Administrative Requirements and Governance

10. As of 30 June 2018, 487 ports in 27 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates.⁹ Nine additional ports were authorized in six overseas territories of the Netherlands and the United Kingdom. However, with respect to the voluntary certification of designated airports and ports, as of 30 June 2018, WHO had not provided Regional Offices with finalized WHO Procedures for such certification.

11. As of 30 June 2018, the IHR Roster of Experts included 481 experts, 121 of whom are from the Region of the Americas. The Roster includes experts designated by 10 of the 35 States Parties in the Region: Argentina, Barbados, Brazil, Canada, Cuba, Mexico, Nicaragua, Paraguay, the United States of America, and Venezuela.

12. Following the survey launched by PASB in 2017 to gather information on the requirements for the International Certificate of Vaccination or Prophylaxis, with proof of vaccination against yellow fever as a condition for international travelers to enter and/or exit any specific country in the Region, the WHO Secretariat modified the questionnaire for updating the WHO publication *International Travel and Health* for 2018. Twenty-one (60%) of the 35 States Parties in the Region responded to the global survey.¹⁰

13. Pursuant to Resolution WHA68.4 (4), aimed at guaranteeing the participatory process in mapping areas at risk for yellow fever transmission, the Scientific and Technical Advisory Group on Geographical Yellow Fever Risk Mapping (GRYF) was created in December 2015. This group includes experts from five countries in the Region: Argentina, Brazil, Panama, Trinidad and Tobago, and the United States of America.¹¹ Since its

⁸ The list of IAEA member States is available on the IAEA website at: <https://www.iaea.org/about/governance/list-of-member-states>.

⁹ The list of ports authorized to issue the Ship Sanitation Certificate is available on the WHO website at: http://www.who.int/ihr/ports_airports/ihr_authorized_ports_list.pdf.

¹⁰ The updated requirements for the International Certificate of Vaccination or Prophylaxis, as determined by States Parties, is available on the International Travel and Health of the WHO website at: <http://www.who.int/ith/en/>.

¹¹ The web page of the Scientific and Technical Advisory Group on Geographical Yellow Fever Risk Mapping (GRYF) is available on the WHO website at: <http://www.who.int/ith/yellow-fever-risk>.

creation, the GRYF has held seven virtual meetings. Further to the Technical consultation on harmonizing the methodology for yellow fever risk assessment and risk mapping, held in Geneva, Switzerland, 14-15 December 2017, PASB was tasked with leading the work for yellow fever-related mapping at the global level.

14. One of the critical issues for governance of the IHR is the monitoring of their application, implementation, and compliance therewith. Based on the Information Document *Development of a draft five-year global strategic plan to improve public health preparedness and response-Consultation with Member States*, prepared by the WHO Secretariat pursuant to Decision WHA70(11) (5) and presented in Annex B to Document CSP29/INF/6 (6), a three-step global consultation was conducted with Member States. This included: *a)* the 2017 sessions of the six WHO Regional Committees; *b)* a web-based consultation from 19 September to 13 October 2017, with 11 (31%) of the 35 States Parties in the Region providing feedback; and *c)* a face-to-face Member States consultation, attended by representatives of Permanent Missions to the United Nations in Geneva, held in Geneva, Switzerland, on 8 December 2017.

15. Further to the global consultative process, the *Draft five-year global strategic plan to improve public health preparedness and response, 2018-2023* (hereafter “the Draft Plan”) was submitted to the 142nd session of the WHO Executive Board, held in January 2018, as Annex I of Document EB142/10 (7). The position on the development of the Draft Plan expressed by States Parties of the Americas during the 29th Pan American Sanitary Conference was accurately captured in paragraph 7 of Document EB142/34¹² (8). Nevertheless, without explicitly referring to the IHR Monitoring and Evaluation Framework (9, 10) as a whole, the Draft Plan presented in Document EB142/10 embedded the four components of the Framework: one mandatory (State Party Annual Reporting), and three voluntary (After-Action Review of Public Health Events, Simulation Exercises, and Joint External Evaluations).

16. With no changes in the text proposed in Annex 2 of Document EB142/10, the 142nd session of the WHO Executive Board adopted Decision EB142(1) (11), supporting the endorsement of the Draft Plan by the Seventy-first World Health Assembly in May 2018. The Draft Plan, also incorporating modified indicators and deliverables, was presented to the World Health Assembly as Annex of Document A71/8 (12). As a result of an intense debate, the World Health Assembly adopted Decision WHA71(15) (13), which significantly differs from the text of Decision EB142(1). The World Health Assembly decided to “welcome with appreciation” the Draft Plan, and not to “endorse” it, also stressing that the Draft Plan “does not create any legally binding obligations for Member

[mapping/en/](#).

¹² “The Regional Committee for the Americas emphasized that strategic pillar 1 should link the core capacities required by the International Health Regulations (IHR) (2005) with essential public health functions and should reflect the variation across States Parties with respect to both the maturity of their health systems and the status of their implementation of the Regulations. There was broad agreement that the IHR (2005) Monitoring and Evaluation Framework should be presented as a stand-alone document, separate from the draft global strategic plan, for consideration and adoption by the Seventy-first World Health Assembly in May 2018.” (Document EB142/34, paragraph 7)

States”. However, the implementation of all the components of the Draft Plan is already captured in existing Resolutions adopted by PAHO and WHO Governing Bodies (14-17).

17. During the 142nd session of the WHO Executive Board, the WHO Secretariat proposed that, together with the Draft Plan, the revised tool for States Parties to submit their annual report to the World Health Assembly be presented to the Seventy-first World Health Assembly. To that end, the WHO Secretariat launched a two-step consultation with States Parties that included: a) an email consultation with States Parties during the first two weeks of March 2018, with 9 (26%) of the 35 States Parties in the Region providing feedback; and b) a face-to-face meeting, which took place with representatives of selected States Parties from each of the six WHO Regions in order to have a Technical consultation on the revised State Party self-assessment annual reporting tool under the International Health Regulations (2005), was held in Geneva, Switzerland, 7-8 March 2018. While representatives from States Parties in the Americas (Argentina, Brazil, Mexico, Peru, the United States of America, and Uruguay) participated in the meeting, all States Parties in the Region were provided with the information needed to take part in the discussion remotely. Trinidad and Tobago contributed to the meeting through remote connection. The revised tool for States Parties to submit their annual report to the World Health Assembly, starting from the Seventy-second World Health Assembly in May 2019, was published on the WHO website in May 2018.¹³ It should be noted that, while, pursuant to Article 54.1 and Resolution WHA61.2 (18), the annual submission of the State Party Report to the World Health Assembly remains the only legal requirement, the use of the revised tool remains entirely voluntary.

18. Following the Joint External Evaluations conducted in the Americas in 2015 and 2016 (10), Canada hosted a Joint External Evaluation in June 2018. Five States Parties included Joint External Evaluations in their Biennial Workplan 2018-2019 developed with PASB, and four additional ones expressed their intention to host a Joint External Evaluation over the 2018-2019 biennium.

Action Necessary to Improve the Situation

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

¹³ The revised tool, “State Party self-assessment annual reporting tool - International Health Regulations (2005)” is available on the WHO website at:
<http://www.who.int/iris/bitstream/10665/272432/1/WHO-WHE-CPI-2018.16-eng.pdf?ua=1>.

20. In light of this, the actions needed to improve the situation outlined in Document CSP29/INF/6 (6) submitted to the 29th Pan American Sanitary Conference still apply. They include:

- a) Advocacy at different levels to harmonize the understandings and aspirations of States Parties to overcome misconceptions that might be hampering the application, implementation, and compliance with the IHR. Such interventions should particularly focus on establishing communication bridges between technical and decision-making levels in country.
- b) The IHR are increasingly understood as a tool to strengthen and increase the sustainability of *a)* national essential public health functions, including planning and financing, that largely exist already and are operational to different degrees, and *b)* national intersectoral mechanisms. However, the Regulations, especially at the political level, often continue to be viewed as a new technical discipline whose requirements and implications are confined to the health sector and are mainly related to public health “crises” and obligations—with somewhat punitive connotations. In alignment with the scope and purpose of the IHR, this warrants interventions at the national level to demonstrate the cost-effectiveness of sustained resource allocation for strengthening essential public health functions, as opposed to merely responding to acute public health events as they happen, a strategy with high costs and economic consequences.
- c) While the IHR provide for mechanisms to ensure mutual accountability, along with requirements for monitoring implementation and compliance by the Parties, application of the four components of the IHR Monitoring and Evaluation Framework should be tailored to the needs of States Parties in the Region (e.g., Small Island Developing States).

Action by the Directing Council

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

Annex

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Annex

**Summary Table: States Parties Annual Reports to the Seventy-first World Health Assembly
(Core Capacities Scores in Percentages)**

State Party	2014-2016 Extension Requested and Obtained	Number of Annual Reports Submitted from 2011 to 2018 (8-year period)	Number of core capacities for which scores were maintained or improved with respect to 2017	Legislation Policy Financing	Coordination and NFP Communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Antigua and Barbuda	yes	8	5/13	75	40	90	77	55	71	80	88	86	89	100	46	23
Argentina	no	7	8/13	50	57	80	49	55	57	40	96	97	78	93	85	77
Bahamas	yes	6	13/13	75	83	100	76	62	100	40	96	78	78	93	77	54
Barbados	yes	8	10/13	100	100	95	94	100	100	80	92	100	100	73	85	77
Belize	yes	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bolivia (Plurinational State of)	yes	7	6/13	100	63	100	81	80	43	40	90	88	100	100	15	92
Brazil	no	7	8/13	100	90	90	100	100	100	100	92	97	89	100	92	100
Canada	no	8	13/13	100	100	100	100	100	100	100	100	100	100	100	100	100
Chile	no	7	11/13	100	100	90	100	90	71	60	70	83	100	100	54	69
Colombia	no	8	10/13	100	100	95	81	100	100	60	80	92	89	80	85	85
Costa Rica	no	8	8/13	75	100	95	83	82	100	80	76	88	100	100	77	77
Cuba	no	7	12/13	100	100	100	100	100	100	100	100	91	100	100	100	100
Dominica	yes	8	10/13	50	100	65	83	60	100	40	58	30	100	100	8	8
Dominican Republic	yes	7	5/13	75	47	90	45	55	100	40	62	63	22	53	0	62
Ecuador	yes	8	10/13	100	100	90	58	53	100	40	83	86	100	73	69	100
El Salvador	no	7	11/13	100	100	100	100	72	57	100	100	97	100	100	92	85
Grenada	yes	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Guatemala	no	7	8/13	0	37	90	82	72	14	60	66	41	100	60	38	92
Guyana	yes	8	12/13	100	100	95	100	100	100	100	100	46	100	80	77	54

**Summary Table: States Parties Annual Reports to the Seventy-first World Health Assembly
(Core Capacities Scores in Percentages) (cont.)**

State Party	2014-2016 Extension Requested and Obtained	Number of Annual Reports Submitted from 2011 to 2018 (8-year period)	Number of core capacities for which scores were maintained or improved with respect to 2017	Legislation Policy Financing	Coordination and NFP Communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Haiti	yes	6	13/13	50	63	85	64	73	71	40	80	9	100	40	69	54
Honduras	yes	8	5/13	50	73	90	94	43	71	60	68	29	89	67	77	100
Jamaica ¹	yes	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mexico	no	8	10/13	100	70	95	94	100	100	100	96	88	100	100	85	100
Nicaragua	no	7	12/13	75	83	100	88	100	100	100	90	75	100	80	92	100
Panama	yes	7	13/13	100	100	100	88	60	71	60	96	72	100	60	15	62
Paraguay	yes	6	11/13	100	100	85	89	43	100	60	76	100	78	67	38	69
Peru	yes	6	6/13	50	100	100	77	35	71	60	100	9	100	53	8	92
Saint Kitts and Nevis	yes	5	13/13	0	20	45	94	92	100	0	92	43	67	80	15	23
Saint Lucia	yes	6	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saint Vincent and the Grenadines	yes	6	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Suriname	yes	7	10/13	50	83	90	94	70	86	40	86	83	100	93	54	0
Trinidad and Tobago	yes	7	8/13	50	63	70	77	100	86	0	78	88	78	80	69	92
United States of America	no	8	13/13	100	100	100	100	100	100	100	100	100	100	100	100	100
Uruguay	no	4	12/13	100	100	95	94	100	100	60	56	91	100	100	77	62
Venezuela (Bolivarian Republic of)	yes	7	13/13	100	90	95	100	100	86	100	90	94	100	87	100	85

¹ Due to a technical information management issue, the State Party Annual Report submitted by Jamaica to the Seventy-first World Health Assembly is not accounted for in the regional and subregional analyses presented in this report.

**Summary Table: States Parties Annual Reports to the Seventy-first World Health Assembly
(Core Capacities Scores in Percentages) (cont.)**

Subregion	Legislation Policy Financing	Coordination and NFP Communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Caribbean* (n=10)	65	73	79	77	72	81	52	78	61	84	76	58	46
Central America** (n=7)	68	77	95	83	69	73	71	80	66	87	74	56	82
South America*** (n=10)	90	90	92	83	76	83	62	83	84	93	85	62	83
North America**** (n=3)	100	90	98	98	100	100	100	99	96	100	100	95	100
Region of the Americas (n=30)	78	82	91	85	78	85	65	85	75	92	84	63	73

* Caribbean subregion includes: Antigua and Barbuda, The Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

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

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

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

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