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IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (IHR)

Background

1. The International Health Regulations (“IHR” or “the Regulations”), adopted by the Fifty-eighth World Health Assembly in 2005 through Resolution WHA58.3,¹ constitute the legal framework that, among others, defines national core capacities, including at points of entry, for the management of public health events of potential or actual national and international concern and related procedures.
2. The purpose of this report is to provide an update on the status of the application and implementation of the Regulations. It updates the report presented in 2015 to the 54th Directing Council (1), focuses on activities undertaken by States Parties and the Pan American Sanitary Bureau (PASB) in response to the Public Health Emergency of International Concern (PHEIC) related to Zika virus, and highlights issues requiring concerted action by States Parties in the Region of the Americas for the future application and implementation of the Regulations.

Update on Progress Achieved

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 through established communication channels with the National IHR Focal Points (NFP). In 2015, all 35 States Parties in the Region submitted an annual confirmation or update of the contact details for their NFP. In 2015, routine connectivity tests performed between the WHO IHR Contact Point and the NFP in the Region were successful for 30 of the 35 States Parties (86%) by e-mail and for all 35 States Parties by telephone.
4. In the period from 1 January to 31 December 2015, a total of 99 public health events of potential international concern were identified and assessed in the Region. For

¹ The text of the International Health Regulations (Resolution WHA58.3) is available at: http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.

59 of the 99 events (60%), national authorities, including through the NFP on 44 occasions, were the initial source of information. Verification was requested and obtained for 25 events identified through informal or unofficial sources. Of the 99 events considered, 45 (45%), affecting 22 countries and territories in the Region, were of substantiated international public health concern. The largest proportion of these 45 events was attributed to infectious hazards (34 events; 76%), and the etiology most frequently recorded was Zika virus (15 events). The remaining 11 events of substantiated international public health concern were attributed to the following hazard categories: zoonosis related (5), food safety (2), product related (2), chemical (1), and radiation related (1).

5. Significant public health events that affected, or had public health implications for, States Parties in the Americas from 1 January 2015 to 8 April 2016 are highlighted below:

- a) Since the IHR Emergency Committee Concerning the International Spread of Wild Poliovirus (Polio IHR EC) first met in April 2014, with subsequent determination by the Director-General of WHO that the international spread of **wild poliovirus** constituted a PHEIC, the Polio IHR EC has met on seven additional occasions. During its most recent meeting in February 2016, the committee concluded that the spread of wild poliovirus, together with the circulating vaccine-derived poliovirus (cVDPV), still constitutes a PHEIC, and temporary recommendations were refined and extended for a further three months with a focus on specific subsets of countries, none of which are in the Americas. PAHO continues to advise that States Parties in the Americas apply the recommendations of the Technical Advisory Group on Vaccine-preventable Diseases to maintain the Americas free of wild poliovirus.
- b) The **Middle East respiratory syndrome coronavirus (MERS-CoV)** began to spread in 2012, and as of 20 March 2016 nearly 1,700 laboratory-confirmed cases, including over 600 fatalities, had been reported to WHO. Confirmed cases of MERS-CoV infection have been reported by 26 States Parties worldwide, including 13 with documented local transmission and with the Kingdom of Saudi Arabia accounting for approximately 80% of the cases. In response to the spread of MERS-CoV, the Director-General convened the IHR Emergency Committee concerning Middle East respiratory syndrome coronavirus (MERS-CoV IHR EC), and the committee met 10 times between July 2013 and September 2015. The advice provided by the MERS-CoV IHR EC, disseminated to all States Parties, did not lead to the determination of a PHEIC by the Director-General.
- c) Following the notification to WHO of the first **Ebola virus disease (EVD)** cases in Guinea in March 2014, the outbreak rapidly spread to the neighboring countries of Liberia and Sierra Leone. The spiraling out of control of the outbreak led to the convening, on 6 August 2014, of the IHR Emergency Committee regarding the Ebola outbreak in West Africa (EVD IHR EC) and, upon its advice, to the determination by the Director-General of the EVD outbreak in West Africa as a PHEIC. As of 8 April 2016, there have been over 28,600 cases and more than

- 11,300 deaths in the three West African countries. With the recognition that new EVD clusters will continue to occur in these West African countries due to the reintroduction of the virus from survivors, as of January 2016 they were declared Ebola free by WHO. Based on the advice formulated by the EVD IHR EC at its ninth meeting on 29 March 2016, the Director-General terminated the PHEIC, also implying the termination of related temporary recommendations, including those applying to States Parties in the Americas.
- d) Following the reemergence of **Zika virus**—a vector-borne virus transmitted, similar to the dengue and chikungunya viruses, by *Aedes aegypti* and *Aedes albopictus* mosquitoes—in the Western Pacific Region in 2007, a case of autochthonous transmission of the virus was confirmed in Easter Island, Chile, in 2014. In February 2015, health authorities in Brazil began investigating cases of rash illness in the country’s northeastern states, which, by the end of April 2015, approached nearly 7,000. The investigation led to the laboratory confirmation of autochthonous transmission of Zika virus in May 2015, representing the first documented transmission on the continental platform of the Americas. Reports by Brazilian health authorities concerning the unusual increase in cases of Guillain-Barré syndrome (GBS) in adults and microcephaly in newborns in the areas where autochthonous transmission of Zika virus was established were shared with the international community through the secure Event Information Site for NFP (EIS) in July 2015 and October 2015, respectively.
- The rapid spread of Zika virus in the Americas and beyond, accompanied by growing evidence of a spatial-temporal association with increases in the number of cases of GBS and microcephaly in newborns, led to the convening, on 1 February 2016, of the IHR Emergency Committee on Zika Virus and Observed Increase in Neurological Disorders and Neonatal Malformations (Zika IHR EC). Upon its advice, the Director-General determined the event to be a PHEIC. Temporary Recommendations issued, including recommendations following the second meeting of the Zika IHR EC on 8 March 2016, focused on:
 - i. The intensification of concerted international research efforts to further corroborate the now widespread scientific consensus that Zika virus is a cause of microcephaly and GBS. The need for rapid and transparent sharing of the outcomes of research efforts was emphasized.
 - ii. The implementation of control measures comprising surveillance, which also includes the development of a case definition for “congenital Zika infection” and rapid and transparent information sharing; vector control measures; risk communication targeting women of childbearing age and pregnant women, along with dissemination of information on the risk of sexual transmission; preparedness of health services for antenatal counseling, management of pregnancies at risk for Zika virus infection and related birth outcomes, and, in the longer term, management of the consequences; and travel advice focusing on pregnant women and safe sexual practices (no travel or trade restrictions with countries and

territories experiencing Zika virus transmission were deemed to be warranted).

- As of 8 April 2016, 34 countries and territories in the Americas had confirmed autochthonous vector-borne transmission of Zika virus. Brazil, Colombia, Martinique, and Panama have reported evidence of congenital Zika virus infection with fetal central nervous system malformations. Brazil accounts for the vast majority of these cases, with over 1,000 confirmed cases (93% clustered in the country's northeastern states) and more than 4,000 cases under investigation (75% in the northeastern states). Less than 50 cases have been confirmed or are under investigation in Colombia, Martinique, and Panama. Twelve countries and territories in the Region have confirmed Zika virus infection in at least one GBS case, and five of them have also reported increases in GBS cases.

6. At the end of 2015, PASB substantially intensified activities to support States Parties in responding to the introduction of Zika virus in the Region, which culminated in December 2015 with the activation of an Organization-wide Incident Management Structure (IMS) including the release of funds from the PAHO Epidemic Emergency Fund. During the following months, the PASB IMS, in close coordination with the equivalent structure established at WHO headquarters in February 2016, triggered the release WHO Contingency Fund for Emergencies, and the roll out of activities outlined in the Strategy for Enhancing National Capacity to Respond to Zika Virus Epidemic in the Americas (2). The strategic framework revolves around the following elements: *a*) timely monitoring of the evolution of the epidemic in its multifaceted aspects; *b*) risk reduction through vector control; *c*) enhancement of response capacity with a focus on health services (including blood safety), risk communication, and mass gatherings; and *d*) development of a regional research agenda on Zika virus to address the growing gaps in knowledge.

7. Within the framework outlined above, activities undertaken by PASB as of 8 April 2016 include:

- a) The intensification of resource mobilization and coordination efforts with international partner organizations and agencies, including multiple United Nations agencies,² the Inter-American Development Bank, the World Bank, and WHO headquarters.

² International Atomic Energy Agency (IAEA); International Civil Aviation Organization (ICAO); Joint United Nations Program on HIV/AIDS (UNAIDS) Office for the Coordination of Humanitarian Affairs (OCHA); UN-HABITAT (United Nations Centre for Human Settlements); United Nations Children's Fund (UNICEF); United Nations Development Group for Latin America and the Caribbean (UNDG-LAC); United Nations Development Program (UNDP); United Nations Educational, Scientific and Cultural Organization (UNESCO); United Nations High Commissioner for Refugees (UNHCR); United Nations Population Fund (UNFPA); UN Women; and World Food Program (WFP).

- b) The development and dissemination of PAHO technical guidelines and epidemiological updates providing inputs to documents developed by WHO headquarters.
- c) The organization of virtual meetings with national competent authorities and professionals from different disciplines to address continuously emerging new technical facets related to the spread of Zika virus.
- d) The provision of face-to-face training on laboratory services, entomological surveillance and vector control, monitoring of pregnant women, and risk communication at the national, subregional, and regional levels.
- e) The deployment of multidisciplinary technical field missions to 22 countries and territories, in some cases on multiple occasions, involving the mobilization of over 70 staff and experts, including through the Global Outbreak Alert and Response Network (GOARN). The expertise represented in the in-country mission teams spanned several technical areas: antenatal care, clinical management, entomology and vector control, epidemiology, health and laboratory services, neonatology, neurology, public health, risk communication, and radiology. A mission related to preparations for the XXXI Summer Olympics and Paralympics Games, to be held in Rio de Janeiro, Brazil, 5 August-21 September 2016, was also conducted.
- f) The distribution of reagents to 20 countries for detection of Zika virus by polymerase chain reaction (PCR), including an instrumental partnership with the United States Centers for Disease Control and Prevention.
- g) The organization of expert consultations on laboratory services, vector control, clinical surveillance, health services, and ethics.
- h) The coordination of research efforts, including the organization of the meeting, Towards the development of a Research Agenda for Characterizing the Zika Virus Outbreak and its Public Health Implications in the Americas, held in Washington, D.C., 1-2 March 2016.
- i) The development of a dedicated Zika virus PAHO portal presenting information tailored to a variety of audiences.³

8. While the introduction of Zika virus in the Americas is enabling a better understanding of the full spectrum of disease caused by this virus, over 600 million people in the Americas are living in areas at risk for transmission of the virus, and its spread could pose a significant burden to public health and to health systems as a whole. Although sexual transmission of Zika virus might eventually assume a more prominent role in shaping the evolution of the Zika epidemic, integrated vector control remains the cornerstone for mitigating the impact of vector-borne diseases.

³ The Zika virus PAHO portal is available at:
http://www.paho.org/hq/index.php?option=com_content&view=article&id=11585&Itemid=41688&lang=en.

Reports on States Parties Core Capacities

9. States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2016 showed steady improvements at the regional level in all core capacities. However, the status of the core capacities across the subregions continues to be heterogeneous, with the lowest scores consistently registered in the Caribbean subregion. Since the States Parties Annual Reports in their current format were instituted for reporting to the Sixty-fourth World Health Assembly in 2011, when the response rate was 51% (18 of 35 States Parties), for the first time all 35 States Parties in the Americas reported to the Sixty-ninth World Health Assembly (2016). This should be regarded as an achievement, one that signals an increased sense of ownership of the Regulations by States Parties as well as their willingness to be mutually accountable. Over this six-year period, 12 States Parties systematically complied with respect to annual submission of reports: Antigua and Barbuda, Barbados, Canada, Colombia, Costa Rica, Dominica, Ecuador, Guyana, Honduras, Jamaica, Mexico, and the United States. Information on the degree of compliance with this commitment among the remaining States Parties is presented in the Annex.

10. When the most recent reports are compared with the States Parties Annual Reports submitted to the Sixty-eighth World Health Assembly (2015), variations in regional average scores are in the range of 10 percentage points in the case of all capacities other than points of entry, for which a 15% improvement was registered. With the exception of the capacities to respond to events associated with chemical (57%) and radiation-related (55%) hazards, the regional average score for all remaining capacities is close to or above 75%; the highest score is for surveillance (92%). The Annex also presents a summary of the States Parties Annual Reports to the Sixty-ninth World Health Assembly.

11. PAHO conducted ad hoc missions to review the IHR implementation status in two of the United Kingdom Overseas Territories in the Americas: the Cayman Islands and the Turks and Caicos Islands. In the overseas territories of the Kingdom of the Netherlands, the progress made is noteworthy in terms of legal and operational arrangements for the application and implementation of the IHR, as crystallized in a mutual agreement among the Netherlands, Aruba, Curaçao, and Sint Maarten.

12. To support institutional and intersectoral strengthening efforts in States Parties in the Region, PAHO has continued its joint activities with other international specialized agencies and organizations. Regional initiatives were conducted with the International Civil Aviation Organization (ICAO), within the framework of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA), at the Sixth Americas Meeting held in Panama in September 2015; the International Air Transport Association (IATA), with activities focusing on certification and re-certification of national professionals with respect to international shipments of samples; and the Food and Agriculture Organization (FAO) at the annual regional meeting of the Food Safety Authorities Network (INFOSAN), held in Mexico in October 2015. Subregional activities were conducted with the International Atomic

Energy Agency (IAEA); for example, the first coordination meeting of the “Strengthening Cradle-to-Grave Control of Radioactive Sources” project in IAEA Member States in the Caribbean subregion was held in Jamaica in April 2016. Activities at the national level were conducted with ICAO within the framework of the CAPSCA project, including visits to the major international airports of Bolivia, Colombia, Panama, and Paraguay, and with the World Organization for Animal Health (OIE) intersectoral workshop in Costa Rica.

13. As of 8 April 2016, 484 ports in 27 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates (3). Ten additional ports were authorized in eight overseas territories of France, the Netherlands, and the United Kingdom. As of the same date, no information had been provided to the WHO Regional Offices regarding the status of the WHO Procedures for voluntary certification of designated airports and ports already submitted to the States Parties on two occasions.

14. In the absence of rejections and/or reservations notified by States Parties to the Director-General by the set deadline (11 January 2016), the amendment of Annex 7 of the Regulations—recognizing that one single dose of yellow fever vaccine is sufficient to confer lifelong protection—will enter into force in July 2016 (4). As per Resolution WHA68.4 (5), aimed at guaranteeing a 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 established in December 2015 and consists of experts from five countries in the Region: Argentina, Brazil, Panama, Trinidad and Tobago, and the United States. As of 8 April 2016, 19 of the 35 States Parties (54%) had provided contributions to the 2016 update of the WHO publication *International Travel and Health* (6).

15. As of 8 April 2016, the IHR Roster of Experts included 435 experts, 123 of whom are from the Region of the Americas, including eight designated by the respective State Party (Barbados, Brazil, Mexico, Nicaragua, Paraguay, Peru, United States of America, Venezuela).

16. The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation (7), adopted by the Sixty-eighth World Health Assembly through Resolution WHA68.5 (8), mandate that “the Secretariat should develop [...] a new monitoring and evaluation scheme with the active involvement of WHO regional offices [that will be] subsequently proposed to all States Parties through the WHO governing bodies’ process” and that “the implementation of the IHR should now advance [...] to a more action-oriented approach to periodic evaluation of functional capacities.”

17. In compliance with these recommendations, the WHO Secretariat developed a Concept Note (9) outlining a proposed post-2016 IHR monitoring and evaluation framework revolving around four components: self-assessment, after-action review of public health events, simulation exercises, and external evaluations. The Concept Note was submitted to the scrutiny of Member States in the six WHO Regions at the Regional

Committee meetings in 2015. As noted in the Final Report to the 54th Directing Council (10), as well as in the report by the regional committees to the 138th Executive Board (11), the proposed IHR monitoring and evaluation framework was regarded by Member States as a solid basis to build upon and be finalized for consideration and approval by the Sixty-ninth World Health Assembly, per the timeline presented in the Concept Note itself and in compliance with Article 54 of the Regulations.

18. To facilitate the revision and finalization of the IHR monitoring and evaluation framework, the WHO Secretariat organized the Technical Consultation on Monitoring and Evaluation of Functional Core Capacity to Implement the International Health Regulations (2005) in Lyon, France, on 20-22 October 2015 (12), with the participation of experts from Barbados, Brazil, and the United States. Subsequently, there has been relatively limited progress in terms of finalizing the IHR monitoring and evaluation framework to be presented to the Sixty-ninth World Health Assembly. However, the WHO Secretariat has devoted extraordinary resources to coordinating with partners (e.g., the Global Health Security Agenda) in the development of a tool related to one of the four components: the Joint External Evaluation tool. As of 8 April 2016, no information had been provided to the WHO Regional Offices about the possible presentation of the IHR monitoring and evaluation framework to the Sixty-ninth World Health Assembly in May 2016.

Action Necessary to Improve the Situation

19. As the spread of Zika virus is progressively unfolding, it is simultaneously unveiling its multifaceted public health and ethical implications and challenges, in the short and long term, at both national and regional levels, and spanning disciplines and sectors. Similar to the EVD outbreak in West Africa, the spread of Zika virus is testing the application of the IHR and, once again, emphasizing that countries' ability to respond to rapidly emerging and evolving risks requires resilient health systems wherein essential public health functions—the core capacities detailed in Annex 1 of the Regulations—should represent an intrinsic and sustainable component. Action is being taken by PASB across its departments to conceptually frame and operationally translate the application and implementation of IHR provisions in the context of health systems. The document Resilient Health Systems (Item 4.4 of the provisional agenda of the 158th Session of the Executive Committee) constitutes a first step.

20. Similarly, as with the dengue epidemics in the Region over the past 30 years and the establishment of chikungunya virus transmission in all countries and territories in the Americas where *Aedes aegypti* is present over a 12-month period, the Zika virus epidemic is offering the opportunity to revive vector control efforts outlined in the Strategy for Arboviral Disease Prevention and Control (Item 4.10 of the provisional agenda of the 158th Session of the Executive Committee).

21. Especially in the context of the reform of WHO's work in outbreaks and emergencies, the work of the IHR Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response (EVD IHR RC) might

have a substantial impact with respect to both States Parties and the WHO Secretariat in determining whether the IHR are to gain relevance as a tool to support the continuous public health preparedness process as part of a holistic health systems strengthening approach. The EVD IHR RC also includes members from Canada and Jamaica, and its report should be presented to the Sixty-ninth World Health Assembly. As of 8 April 2016, no preview of the report had been made available to Member States or the Regional Offices.

Action by the Executive Committee

22. The Executive Committee is invited to take note of this report and provide any recommendations it may have.

Annex

References

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Annex

Summary Table: States Parties Annual Reports to the 69th World Health Assembly (Core Capacities Scores in Percentages)

State Party	Requested and Obtained 2012-2014 Extension	Requested and Obtained 2014-2016 Extension	Number of Annual Reports Submitted from 2011 to 2016 (6-year-period)	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	yes	6	100	100	100	82	73	86	100	100	97	100	100	85	23
Argentina	yes	no	5	50	73	80	100	100	86	100	90	83	100	80	69	62
Bahamas	yes	yes	4	75	83	100	70	0	71	40	96	97	67	27	54	8
Barbados	yes	yes	6	100	90	95	82	100	100	80	96	100	100	80	77	69
Belize	yes	yes	5	25	63	75	88	52	57	40	45	83	89	53	38	8
Bolivia (Plurinational State of)	yes	yes	5	100	90	75	76	53	57	40	91	91	89	67	23	77
Brazil	no	no	5	100	100	100	100	100	100	100	96	100	100	100	92	100
Canada	no	no	6	100	100	95	100	100	100	100	100	100	100	93	100	100
Chile	no	no	5	75	83	90	94	61	100	40	66	97	100	93	54	77
Colombia	no	no	6	100	90	85	81	100	100	60	80	97	89	80	77	77
Costa Rica	no	no	6	100	100	100	69	71	100	80	86	97	100	100	46	54
Cuba	yes	no	5	100	100	100	100	100	100	100	100	100	100	100	100	100
Dominica	yes	yes	6	50	100	80	78	60	100	40	43	80	100	100	15	15
Dominican Republic	yes	yes	5	75	90	75	58	81	71	40	80	88	100	47	38	77
Ecuador	yes	yes	6	100	100	95	83	91	86	80	86	94	100	93	62	100
El Salvador	yes	no	5	100	100	100	100	90	86	100	100	100	100	100	54	85
Grenada	yes	yes	4	100	83	95	69	33	86	60	49	49	100	67	46	15
Guatemala	yes	no	5	50	83	100	94	80	100	100	100	88	100	87	77	69
Guyana	yes	yes	6	100	100	95	100	100	100	100	100	94	100	53	62	0

Summary Table: States Parties Annual Reports to the 69th World Health Assembly (Core Capacities Scores in Percentages) (cont.)

State Party	Requested and Obtained 2012-2014 Extension	Requested and Obtained 2014-2016 Extension	Number of Annual Reports Submitted from 2011 to 2016 (6-year-period)	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	yes	4	0	46	100	70	26	100	40	96	17	67	27	38	0
Honduras	yes	yes	6	100	80	95	76	50	57	60	81	88	100	87	38	62
Jamaica	yes	yes	6	50	90	90	100	92	71	60	86	88	78	87	77	85
Mexico	yes	no	6	100	70	95	94	100	100	100	100	100	100	100	100	100
Nicaragua	yes	no	5	100	83	100	87	100	100	100	86	100	100	60	0	0
Panama	yes	yes	5	75	100	95	88	60	71	40	96	94	89	60	15	31
Paraguay	yes	yes	4	100	100	95	94	43	100	80	76	91	89	47	69	92
Peru	yes	yes	4	100	100	100	94	90	100	80	100	24	100	100	69	100
Saint Kitts and Nevis	yes	yes	4	100	100	80	58	33	86	20	87	71	67	80	0	0
Saint Lucia	yes	yes	5	75	56	70	69	25	86	40	83	74	89	60	23	0
Saint Vincent and the Grenadines	yes	yes	5	75	63	80	66	53	43	80	0	0	0	0	0	0
Suriname	yes	yes	5	50	83	90	100	100	71	40	86	97	67	87	62	0
Trinidad and Tobago	yes	yes	5	50	56	95	76	71	71	20	81	83	89	87	62	77
United States	no	no	6	100	100	100	100	100	100	100	60	24	100	100	100	100
Uruguay	yes	no	2	100	100	95	94	90	100	20	56	100	100	100	69	62
Venezuela (Bolivarian Republic of)	yes	yes	4	100	90	95	100	100	86	100	90	97	100	93	100	85

Summary Table: States Parties Annual Reports to the 69th World Health Assembly (Core Capacities Scores in Percentages) (cont.)

Caribbean* (n=15)	70	81	90	81	61	82	57	77	75	81	67	49	27
Central America** (n=7)	86	91	95	82	76	84	74	90	94	98	77	38	54
South America*** (n=10)	93	93	91	92	83	91	70	83	87	97	85	68	83
North America**** (n=3)	100	90	97	98	100	100	100	87	75	100	98	100	100

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

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

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

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

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