The International Health Regulations (2005) in Malawi: Assessment of the status of implementation in 2015

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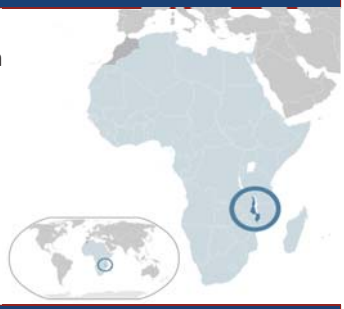
Introduction: International Health Regulations (2005)

- International Health Regulations (IHR) 2005 requires countries to develop, strengthen and maintain the capacities to detect, assess, notify and report public health events
- Deadline for implementation was June 2012
- Malawi has not previously conducted a national assessment of the status of implementation
- **Objective: To determine the status of implementation and establish a baseline for measuring progress towards full IHR implementation**



Methods: mixed-methods cross-sectional assessment

Study period: March to August 2015

Data sources:

- 75 semi-structured interviews with purposively-selected informants (including 17 districts, 20 health facilities and 18 laboratories)
- National tabletop exercise
- Two stakeholder meetings

IHR (2005) Core Capacity Areas:

1. National legislation, policy and financing
2. Coordination and national focal point (NFP) Communication
3. Surveillance
4. Response
5. Preparedness
6. Risk communication
7. Human Resources
8. Laboratory

Data analysis

- Descriptive analysis of quantitative data from questionnaires.
- Qualitative analysis of strengths, weaknesses, opportunities and threats (SWOT).
- Existing capacities and gaps documented by IHR (2005) Core Capacities, Points of Entry and four Hazard areas (food safety, animal health, chemical events and radiological events).

Results

- Malawi does not yet have the core capacities to fulfill the IHR requirements.
- Structures, guidelines and protocols in existence provide good foundation, although many not fully implemented or operational (*Table 1 – Example from Core Capacity 3: Surveillance*).
- Multi-sectoral collaboration and adoption of all-hazards approach to event preparedness and response not formalized.
- Examples of essential system improvements required for full IHR implementation:
  - Operationalization of existing structures, guidelines and protocols for surveillance, preparedness and response,
  - Reinforcement of the Integrated Disease Surveillance and Response (IDSR) strategy,
  - Increased national and district laboratory capacity,
  - Formalization of multi-sectoral collaboration.

Table 1. Selected existing capacities and weaknesses for Core Capacity 3: Surveillance, Malawi, 2015

Existing capacities	Weaknesses
• Integrated Disease Surveillance and Response has been updated to include 41 priority conditions and is aligned with the requirements of the IHR (2005). • Reporting structures at the community, health facility, district and central levels are in place. • Electronic reporting mechanisms are being implemented from the district to central level.	• Revised Integrated Disease Surveillance and Response technical guidelines are not yet implemented. • Lack of integration between vertical surveillance programs and national surveillance system. • Inadequate equipment for data capturing, storage, investigation and reporting. • No formalized early warning system in place.

Discussion and limitations

- IHR (2005) implementation must be considered a continuous process.
- Implementation of the IHR (2005) requires multi-sectoral commitment to prioritize health security activities.
- Self-reported data may lead to inaccurately reported levels of core capacity implementation.
- Operational status of structures, procedures and guidelines difficult to document, partially improved by tabletop exercise.

Conclusion and recommendations

- IHR assessment serves as a reminder that countries must intensify activities to meet the requirements of the IHR (2005), irrespective 2012 implementation deadline.
- A prioritized action plan must be developed to address gaps.
- Multi-sectoral collaboration and support from partners is essential for strengthening existing structures and fostering support for implementing the IHR.

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