MEMBER STATES INFORMATION SESSION ON INFECTION PREVENTION AND CONTROL (IPC)

7 March 2022
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<th>Time (CET)</th>
<th>Agenda item</th>
<th>Speaker</th>
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<tr>
<td>15.30</td>
<td>Welcome remarks</td>
<td>Dr Zsuzsanna Jakab, Deputy Director-General and ExD a.i., UHC/LC division</td>
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<tr>
<td>15.35</td>
<td>Overview of the IPC situation worldwide: highlights of achievements and gaps</td>
<td>Dr Rudi Eggers, Director, IHS department, UHC/LC division</td>
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</table>
| 15:45     | Impact of IPC – WHO areas of work and critical guidance on IPC | Dr Benedetta Allegranzi, IPC Technical Lead, IHS department, UHC/LC division  
Dr Silvia Bertagnolio, Unit Head, Surveillance, Prevention and Control department, AMR division  
Dr April Baller, IPC Focal Point, Country Readiness Strengthening department, WHE division |
| 16.00     | Country capacity building supported by regional offices | Dr Maha Talaat, IPC focal point, Eastern Mediterranean Regional Office, on behalf of all regional offices |
| 16.10     | Priorities and strategic directions for IPC | Dr Zsuzsanna Jakab, Deputy Director-General and ExD a.i., UHC/LC division |
| 16.20.    | Discussion | All participants |
| 16.55     | Closing remarks | TBD |
| 17.00     | Session closure | |
Member States Information Session on
Infection Prevention and Control

OVERVIEW OF THE IPC SITUATION WORLDWIDE:
HIGHLIGHTS OF ACHIEVEMENTS AND GAPS

Dr Rudi Eggers
Director, Integrated Health Systems department
UHC/LC WHO HQ
Health care-associated infection (HAI)
also referred to as “nosocomial” or “hospital-acquired infection”

An infection acquired by a patient
during the process of care (including preventive, diagnostic and treatment services)
in a hospital or other health-care facility,
which was not present or incubating at the time of admission;
HAIs can also appear after discharge.
HAIs may also be acquired by health workers during health care delivery,
and by visitors.

Global burden of HAIs (1)

Globally, hundreds of millions of people every year are affected by health care-associated infections (HAIs), many of which are completely avoidable.

No country or health system, even the most developed or sophisticated, can claim to be free of HAIs

- out of every 100 patients, 7 in high- and 15 in low-/middle-income countries (LMIC) will acquire at least one HAI, in acute care hospitals
- 1 in every 10 affected patients dies of HAI
- 8.9 million HAIs occur every year in acute and long-term care facilities in EU/EEA

Sources:
Global burden of HAIs (2)

Intensive care:
- High-income countries (HICs): up to **30% of patients** affected by at least one HAI in intensive care units
- Lower/middle income countries (LMICs): incidence is at least **2–3 times higher**.
- **1 in 4 cases (23.6%)** of all hospital-treated sepsis cases are health care-associated
- **48.7% of sepsis** with organ dysfunction treated in adult ICUs are hospital-acquired
- **Mortality** among patients affected by health care-associated sepsis was **24.4%**, with an increase to **52.3%** among patients treated in ICU

Neonatal care:
- Neonatal infection rates in LMICs are **3-20 times higher** than in HICs
- Incidence of health care-associated sepsis in neonates is **7.5 times higher than in adults**
- In hospital-born infants, HAIs account for estimated **4%- 56% of all deaths** in neonatal period

Surgical care:
- Most frequent type of HAI in low- and middle-income countries (LMICs), 2nd & 3rd in Europe and the USA
- Most frequent complication of surgery in Africa

WHO Global guidelines for the prevention of surgical site infection, 2018. [https://apps.who.int/iris/handle/10665/277399](https://apps.who.int/iris/handle/10665/277399)
Comparing the burden of HAIs with other infectious diseases in EU/EEA (2011-12)

HAIs account for twice the burden of 32 other infectious diseases

75% of DALYs attributable to AMR in Europe is a result of HAIs

Mortality among patients infected with MRSA is the double of those infected with MSSA

Mortality in patients infected with pathogens resistant to carbapenems is about 3-times higher

DALYs: disability-adjusted life years, i.e. years of life lost to due to premature mortality and years lived with a disability due to HAIs


- **High-risk exposures** (e.g. involvement in intubations, more direct or intense patient contact, or contact with bodily secretions)
- Not wearing **masks or respirators** appropriately
- **Black and Asian race and Hispanic ethnicity** relative to White race
- Contact with an infected household member or in a private setting

**Interim findings of WHO case control study in 97 health facilities in 19 countries**

**Risk factors** for COVID-19 in HCWs

- Prolonged **close contact** (>15min within 1 meter)
- Inconsistently wearing a respirator or a surgical mask or both compared to consistently wearing a respirator during aerosol-generating procedures
- Not always appropriately performing **hand hygiene** during prolonged patient contact

**Global number of deaths among HWs with COVID-19** (Jan 2020-May 2021)

115,500 (80,000-180,000)
Global pulse survey on continuity of essential health services during the COVID-19 pandemic

Critical shortages were reported in availability of essential COVID-19 tools in hospitals across 11 countries.

Major gaps in availability were most frequently reported in PPE, diagnostics and biomedical equipment.

<p>| Percentage of hospitals with availability of essential COVID-19 tools (n=387 hospitals in 11 countries) |
|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|</p>
<table>
<thead>
<tr>
<th>Vaccines</th>
<th>PPE for all staff</th>
<th>Diagnostics</th>
<th>Therapeutics</th>
<th>Biomedical equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon (n=60)</td>
<td>Data not available</td>
<td>15</td>
<td>62</td>
<td>92</td>
</tr>
<tr>
<td>Congo (n=33)</td>
<td>91</td>
<td>18</td>
<td>100</td>
<td>73</td>
</tr>
<tr>
<td>Ghana (n=35)</td>
<td>35</td>
<td>17</td>
<td>40</td>
<td>89</td>
</tr>
<tr>
<td>Kenya (n=68)</td>
<td>93</td>
<td>18</td>
<td>53</td>
<td>87</td>
</tr>
<tr>
<td>Mali (n=14)</td>
<td>Data not available</td>
<td>29</td>
<td>0</td>
<td>86</td>
</tr>
<tr>
<td>Namibia (n=43)</td>
<td>97</td>
<td>56</td>
<td>58</td>
<td>74</td>
</tr>
<tr>
<td>Paraguay (n=20)</td>
<td>100</td>
<td>90</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Peru (n=36)</td>
<td>100</td>
<td>58</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Senegal (n=14)</td>
<td>33</td>
<td>36</td>
<td>100</td>
<td>86</td>
</tr>
<tr>
<td>Suriname (n=9)</td>
<td>100</td>
<td>11</td>
<td>100</td>
<td>56</td>
</tr>
<tr>
<td>Zambia (n=55)</td>
<td>Data not available</td>
<td>100</td>
<td>91</td>
<td>33</td>
</tr>
</tbody>
</table>

Tracer items:

PPE for all staff: medical/surgical mask, examination gloves, respirators, goggles, and protective apron available for all staff
Diagnostics: functioning equipment for onsite PCR/RTD
Therapeutics: Dexamethasone (injectable)/ corticosteroids
Biomedical equipment: Invasive and non-invasive ventilators, oxygen available, oxygen pulsometer

Source: Round 3 Global pulse survey on continuity of essential health services, Nov-Dec 2021 (reflecting situation during previous 6 months)
Infection prevention and control (IPC) is an evidence-based approach and practical solution designed to prevent harm to patients and health workers at every single health care encounter across the whole health system by stopping the spread of infection and antimicrobial resistance (AMR)

http://www.who.int/infection-prevention/en/
• **33%**: no national IPC programme (A) or not implemented (B) (LICs 8.3 times more likely)
• **35%**: IPC programmes properly implemented in healthcare facilities **nationwide** (D) and monitored (E)
• **32%**: IPC programme implemented in **selected** health-care facilities (C)
2021 WHO global survey on IPC minimum requirements at the national level – preliminary results

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total N</th>
<th>%</th>
<th>Low income</th>
<th>%</th>
<th>Lower-middle income</th>
<th>%</th>
<th>Upper-middle income</th>
<th>%</th>
<th>High income</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total countries participating (interim analysis)</td>
<td>65</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>14</td>
<td>-</td>
<td>24</td>
<td>-</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Met 100% of national IPC programme minimum requirements</td>
<td>2</td>
<td>3%</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Met 75% of national IPC programme minimum requirements</td>
<td>32</td>
<td>49%</td>
<td>6</td>
<td>67%</td>
<td>6</td>
<td>43%</td>
<td>11</td>
<td>46%</td>
<td>9</td>
<td>50%</td>
</tr>
<tr>
<td>Met 50% of national IPC programme minimum requirements</td>
<td>52</td>
<td>80%</td>
<td>7</td>
<td>78%</td>
<td>11</td>
<td>79%</td>
<td>17</td>
<td>71%</td>
<td>17</td>
<td>94%</td>
</tr>
</tbody>
</table>

WHO confidential unpublished data

In 2020, 44% of countries indicated lack of IPC supplies and best practices as a major reason for essential health services disruption (e.g., interruption of routine vaccination programmes) in the context of the COVID-19 pandemic.

2019 WHO global survey on IPC in health care facilities: 4440 facilities, 81 countries

Overall implementation of IPC

- advanced: 50.7%
- Intermediate or basic: 47.3%
- Inadequate: 2%

- Only 16% of HCFs met ALL WHO IPC minimum requirements (MR),
  - 0% in LICs
  - 27% of primary & 11% of secondary/tertiary HCFs in HICs

- 69% met 75% of IPC MR
- 93% met 50% of IPC MR

Source: Tomczyk S, et al. The Lancet Infectious Diseases 2022

https://doi.org/10.1016/S1473-3099(21)00809-4
1.8 billion people are using health care facilities that lack basic water services.

800 million people are using facilities with no toilets.

1 in 4 health care facilities lack basic water.

1 in 3 health care facilities lack hand hygiene facilities at the point of care.

17% of facilities have continuous availability of alcohol-based hand rub supplies in low-income countries (75% in HICs).

https://www.who.int/publications/i/item/9789240017542
https://www.who.int/publications/i/item/9789240011618
2021 global survey on IPC minimum requirements at the national level – comparison with 2018 in 35 countries

- Same proportion of countries having a national IPC programme: 62.9% in 2018 and 2021

- **Significant increases of key indicators**, i.e. proportion of countries:
  - that appointed a trained IPC focal point (25.7% vs 68.6%, \( p=0.004 \)).
  - having a dedicated budget (22.9% vs 48.6%, \( p=0.05 \))
  - having an in-service IPC curriculum (60% vs 85.7%, \( p=0.04 \)). But in 2021 only 36.9% of countries are able to provide training materials and support for these training activities.
  - promoting multimodal strategies for IPC interventions (54.3% vs 88.6%, \( p=0.006 \))

WHO confidential unpublished data
Key messages

- Patients affected by HAI and sepsis have prolonged hospital stay, excess mortality, complications and long-term disabilities
- HAIs also add a significant burden to health systems, including increased workloads and costs
- HAI morbidity and mortality due to HAIs is 2-20 times higher in low- and middle-income countries
- Health care facilities can be amplifiers of outbreaks, involving both patients & health workers
- Antibiotic-resistant microorganisms are responsible for most of HAIs
- There is strong evidence on effectiveness and cost-effectiveness of IPC interventions
- While national IPC programmes may exist, they are often poorly funded & implemented (even in high-income countries), with much lower implementation in low- and middle-income countries
- In 2021, some significant progress has been made on a number of IPC indicators but shocking gaps still exist and sustainability should be ensured
IMPACT OF IPC - WHO AREAS OF WORK AND CRITICAL GUIDANCE

Dr Benedetta Allegranzi, IHS department, UHC/LC, WHO HQ
Dr Silvia Bertagnolio, SPC department, AMR, WHO HQ
Dr April Baller, CRS department, WHE, WHO HQ
IPC work at WHO

Global IPC Network

IPC GUIDELINES & DEVELOPMENT RESEARCH GROUPS

HQ Sepsis Coordination Group

Private Organizations for Patient Safety
- Hand Hygiene
- Injection Safety

Private Organizations for Patient Safety
- Hand Hygiene
- Injection Safety

HQ IPC Task Force

IPC Hub

AMR

Emergencies

Quality

Sepsis

Patient safety

Special programmes (e.g. TB, HIV, and Malaria)

WASH
IPC decreases risk of SARS-CoV-2 infection among health workers

**Decreased risk** significantly associated with:

- **training** in IPC*
- adequacy and appropriate **use of PPE***
- **hand hygiene***
- **universal masking** in health care facilities*

**Chou R et al & WHO multi-center case-control study
IPC is cost-effective in response to outbreaks
OECD/WHO Joint Project on the COVID-19 pandemic

• Cost-effectiveness model used with data regarding the first 180 days of the pandemic

• **Combining increased access to PPE with IPC training** yields the greatest global health and economic gains

  ➢ >50% of new infections among HCWs in South-East Asia, Europe and the Americas, and approximately **one third of new infections** in other regions, **could have been averted**

  ➢ $7.2 billion USD net savings globally
  ➢ **Hand hygiene also cost-effective** in most regions
### Evidence about IPC impact on infections and AMR as patient outcomes

<table>
<thead>
<tr>
<th>IPC Impact</th>
<th>Percentage</th>
<th>Patient Outcomes</th>
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<tbody>
<tr>
<td>HAI reduction</td>
<td>35-70%</td>
<td>Implementing IPC programmes and interventions</td>
</tr>
<tr>
<td>HAI reduction</td>
<td>50%</td>
<td>Improving hand hygiene compliance</td>
</tr>
<tr>
<td>MRSA reduction</td>
<td>56%</td>
<td>In England according to a national target over 4 years</td>
</tr>
<tr>
<td>SSI reduction</td>
<td>44%</td>
<td>In African countries, implementing a prevention programme combined with safety climate improvement</td>
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- Single-bed rooms
- ABHR at the point of care
- Multiple AMR patterns in healthcare
IPC is cost-saving: proper IPC saves lives and allows facilities to make money

- HAI extra costs: US $1,000-12,000, depending on the country
- US $7.2-14.9 billion spent on HAIs in the USA, in 2016

When IPC and hand hygiene are implemented in combination with antibiotic stewardship programmes

| 2/3 Reduction in Frequency of AMR Infections | 27,000 Deaths avoided in Europe | 85% Reduction in Health Burden | 3€ Per capita saved every year |

Ensure the WHO core components for effective IPC are in place!!

- OECD (2018), Stemming the Superbug Tide: Just a Few Dollars More. Available at oe.cd/amr-2018

https://www.who.int/teams/integrated-health-services/infection-prevention-control/ipc-and-antimicrobial-resistance
WHO core components for effective IPC programmes

- Zingg W et al. TLID 2015
- Storr J et al. ARIC 2017
- Price L et al. TLID 2017
WHO IPC global guidelines

https://www.who.int/teams/integrated-health-services/infection-prevention-control
Translating guidelines to action
Implementation manuals and resources
IPC national & facility level assessment tools

https://www.who.int/teams/integrated-health-services/infection-prevention-control/core-components
Welcome to the WHO Global IPC Portal

The WHO Global IPC Portal is a resource and tool to help healthcare and other professionals working in the field of IPC, from facility through to national and international level. It is:

- Anonymous – we do not verify your identity unless you want to share your data
- Safe – you can learn from the resources and interact freely with the tools without fear of tracking
- Private – your data can be discarded or, if you store it, kept confidential
- Useful – there are tools, resources and data to help you improve your IPC program performance
- Easy to use – the tool is accessible via mobile or desktop app with a simple and clear layout and intuitive navigation logic
- Evolving – new tools and features will be added as they become available
- User-moulded – well-used features will be enhanced, unused features will be dropped

https://ipcportal.who.int/

Please contact your national IPC focal point and encourage your country’s participation!
IPC and WASH

Hand Hygiene for All
A whole of society approach to achieving universal hand hygiene and stopping the spread of COVID-19

https://washinhcf.org/
IPC & quality of care, patient safety and primary care

https://www.who.int/teams/integrated-health-services/quality-health-services
https://www.who.int/teams/integrated-health-services/patient-safety
https://www.who.int/teams/integrated-health-services/infection-prevention-control
IPC & maternal, newborn, child adolescent health and ageing care

- IPC training package for maternal & neonatal care
- Interprofessional Midwifery Education Toolkit
- WHO IPC recommendations for small and sick newborns
- IPC guidance for long term care facilities in the context of COVID-19

[Links]
- https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/covid-19
- https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/overview
IPC and antimicrobial resistance (AMR)

- Implementation of Objective 3 of the Global Action Plan on AMR
- Indicator 3.d.2 for AMR: reducing the percentage of bloodstream infections due to selected antimicrobial-resistant organisms
- Tripartite AMR Country Self-Assessment Survey (TrACSS)
- Global Antimicrobial Resistance and Use Surveillance System
- IPC competencies and curriculum
- IPC integration with antimicrobial stewardship
- Training package: leadership skills to implement multisectoral AMR NAPs
- OpenWHO course: Reducing antimicrobial resistance of treatable sexually transmitted infections in antenatal care

https://www.who.int/teams/integrated-health-services/infection-prevention-control/ipc-and-antimicrobial-resistance
https://www.who.int/teams/surveillance-prevention-control-AMR
Global AMR research agenda
Priority questions (including IPC) to curb AMR

➢ 4 cross-cutting domains
  o Descriptive of AMR burden and drivers
  o Delivery of existing interventions with better quality
  o Development of improved interventions (reduce costs, optimize impact and feasibility)
  o Discovery and demonstration of new tools and interventions

➢ A ranking methodology developed by WHO (CHNRI)

➢ In collaboration with WHO technical teams

➢ Based on scoring from large global panel of experts

➢ Ensuring research triggers effective and actionable interventions
IPC during COVID-19 pandemic: Thematic areas of work

- 15 guidance & policies developed and/or updated
- Country Implementation evaluation
- Dissemination strategies and Regional support
- Global learning platform

- New courses OpenWHO
- Training evaluations
- Global IPC webinar series
- Risk communication

45 research projects
- Health worker infections
- PPE innovations
- AMR & COVID-19
- Modes of transmission

WHO IPC Basic, Advanced and COVID-19 Training

5 COVID-19 courses
- 1,317,000 enrollments
- 74% completion rate

11 basic IPC courses
- 629,000 enrollments
- 64% completion rate

https://openwho.org/
COVID-19 Operational readiness and Country support in Fragile, Conflict, Vulnerable (FCV) States

Checklist for health facility level IPC in the event of a surge of COVID-19

Scaling Up IPC Capacity In Cox’s Bazar In Response To Covid-19 Pandemic Furthers Streamlining Of Best Practices In General Health Facilities

Northern Ethiopia(Tigray): PPE supplies WASH and IPC specialists
Other outbreak responses: Ebola and Marburg Virus Disease and IPC Technical Guidance development

- Technical support to the field teams in Guinea, DRC, Ivory Coast
- IPC EVD training package updates and adaptation of packages for Marburg Virus Disease
- IPC/WASH preparedness and readiness webinars in French and English for surrounding countries:
  - Côte d’Ivoire, Guinée Bissau, Liberia, Mali, Sierra Leone and Senegal >200 participants over 2 days
Framework and Toolkit for IPC Outbreak Preparedness, Readiness and Response

To provide national and subnational authorities with:

1. A practical framework of actions for strengthening IPC outbreak preparation, readiness and response.
2. A toolkit that provides resources to assist in the development of local contingency or action plans to strengthen IPC outbreak preparedness, readiness and response.
THANK YOU and to WHO IPC colleagues!

Alessandro Cassini        April Baller
Nita Bellare              Mandy Deeves
Claire Kilpatrick         Hannah Hamilton
Aimee Ramos               Lauretha Madumere
Paul Rogers               Patrick Mirindi
Julie Storr               Madison Moon
Ermira Tartari            Pierre Yves Oger
Joao Toledo               Maria Clara Padoveze
Anthony Twyman            Leandro Pecchia
Sara Tomczyk              Paul Schumacher
Vicky Willet


https://www.who.int/teams/integrated-health-services/infection-prevention-control
Member States Information Session on Infection Prevention and Control

COUNTRY CAPACITY BUILDING SUPPORTED BY REGIONAL OFFICES

Dr Maha Talaat, IPC focal point, Eastern Mediterranean Regional Office

World Health Organization

7 March 2022
A stepwise approach for implementation

https://www.who.int/publications/i/item/9789241516945
Supporting countries with a tailored, stepwise implementation approach

Implementation cycle

Step 1: Preparing for action
Step 2: Baseline assessment
Step 3: Developing and executing the plan
Step 4: Evaluating impact
Step 5: Sustaining the programme over the long-term

Multidisciplinary team

Multimodal improvement strategy embedded within each step in the cycle of continuous improvement

https://www.who.int/teams/integrated-health-services/infection-prevention-control/core-components
Assessments in a spirit of improvement

- Regular assessments of IPC programmes are essential for continuous quality improvement.

- Assessment helps to identify existing strengths and take stock of achievements made so far to convince decision-makers that success and progress is possible.

- Assessment also helps to identify gaps and create a sense of urgency for the changes needed to improve IPC.

- Data are of value, ONLY if they are used for action, i.e. to elaborate and implement targeted and feasible improvement plans and to track progress.
Member States Information Session on
Infection Prevention and Control

PRIORITIES AND STRATEGIC DIRECTIONS FOR IPC

Dr Zsuzsanna Jakab, Deputy Director-General and ExD a.i., UHC/LC division

7 March 2022
IPC is a tried-and-true approach that is effective and cost-saving

5 reasons to invest in IPC

1. Ensures quality of care and patient and health workers' safety
2. Directly improves key health outcomes and saves lives
3. Reduces health care costs and out-of-pocket expenses
4. Consists of proven strategies supported by implementation aids
5. Is scalable and adaptable to the local context
### Critical priorities for IPC in national and international health agendas (1)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Details</th>
</tr>
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</table>
| **1. Functional IPC programmes** | - Dedicated budget  
- Trained IPC professionals |
| **2. IPC minimum requirements** | - At national and facility levels in all countries  
- Demonstrated by M&E of key IPC and WASH indicators |
| **3. Decisive and visible political commitment and leadership engagement** | - At the highest levels  
- Allocation of national and local health budgets  
- Establishing targets for IPC investment |
| **4. Regulations and legal framework** | - To enforce IPC requirements and policies through accreditation and accountability systems  
- Reporting of key IPC performance indicators and targets |

*Source: EB150 Report*
### Critical priorities for IPC in national and international health agendas (2)

<table>
<thead>
<tr>
<th>5. Integration and alignment with other programmes</th>
<th>• Specific IPC programme that horizontally integrates/aligns with existing ones</th>
</tr>
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</table>
| 6. Embedding IPC within the patient pathway and clinical care | • Tools and SOPs to support IPC understood and practiced at the point of care in all clinical areas  
• Workflow, human factors, ergonomics to be considered |
| 7. IPC training and education at all levels | • Implementation of accredited IPC curricula (pre- & postgraduate, in-service)  
• Based on the WHO IPC core competencies |
| 8. Human resources and career pathway for IPC | IPC professionals:  
• with a recognized career pathway  
• empowered with a clear mandate and authority  
• accountable for implementation and reporting impact |

Source: EB150 Report
## Critical priorities for IPC in national and international health agendas (3)

### 9. Surveillance of HAIs and AMR in health care
- Connected with existing platforms (e.g. GLASS)
- Existing standardized surveillance protocols (e.g. ECDC PPS)
- Data must be used locally for action

### 10. Monitoring IPC programmes
- Using standard M&E approaches
- Regular assessments and feedback to health workers
- Data must be used locally for action
- WHO Global IPC Portal is a protected and confidential solution

### 11. IPC and communications
- Tailored & consistent communications
- Authoritative source, based on science
- Multiple target audiences

*Source: EB150 Report*
IPC part of other health priorities & resolutions

1995: WHA resolution 48.7 on IPC as part of IHR

2015: WHA resolution 58.27 on IPC as 3rd objective of GAP AMR

2015: WHA resolution 72.6 on IPC as crucial part of quality of care

2017: WHA resolution 70.7 on IPC as part of prevention of sepsis

2019: WHA resolution 72.6 on IPC as part of patient safety

2019: WHA resolution 72.7 on IPC as part of WASH

2020: WHA resolution 73.8 on IPC as part of strengthening IHR

2020: WHA resolution 73.1 on IPC as part of the COVID-19 response

2020: WHA resolution 73.8 on IPC as part of strengthening IHR

2021: WHA resolution 74.7 on IPC as part of preparedness and response
Elevating the importance of IPC

WHO advocacy & MS highlights of IPC at WHA/EB 2021

IPC on EB150 agenda

EB report

MS information session 1

EB150 discussions
Thanking all Member States (MS) intervening at EB150

- Interventions were made by the following MS; France for the EU, Colombia, Malaysia, Singapore, Tajikistan, Denmark, UK, Republic of Korea, Japan, Kenya, USA, Canada, Thailand, Spain, China and Brazil, Guinea Bissau on behalf of the African region, Oman, Philippines, Singapore, Syria on behalf of the Easter Mediterranean region and Timor Leste

- MS consistently highlighted the importance of IPC in addressing:
  - the widespread concern about the silent burden of AMR and health care-associated infections (HAI) but also its
  - infectious hazard health emergency preparedness and response
  - health worker and patient safety
  - provision of high-quality and safe health care through
  - health systems strengthening with a primary health care approach.

- MS fully recognized the gaps in IPC programmes highlighted by the pandemic

- MS highlighted that the COVID-19 pandemic response also presents a unique opportunity to
  - strengthen IPC programmes at all levels
  - save lives and money
  - help restore communities’ trust in health care

- Guinea Bissau on behalf of the African region, Oman, Philippines, Singapore, Syria on behalf of the Easter Mediterranean region and Timor Leste called for WHO to develop a global IPC strategy
Ideal next steps for IPC

- EB discussions
- MS information session 2
- WHA resolution requesting IPC global strategy
- IPC global strategy decision by WHA
- IPC global strategy development
- IPC global strategy adoption by EB and WHA 2023
Conclusions: Preventing HAI and AMR is Now!

• **Harm** acquired where healthcare is provided should no longer be accepted.

• Several countries have been able to introduce IPC standards despite limited resources and constrained situations.

• A **global strategy** would support a wider implementation of the WHO core components for IPC and WASH.

• This will **save patient and health worker lives** and health care costs.
Thank you for your attention

https://www.who.int/teams/integrated-health-services/infection-prevention-control