Status of Infection Prevention and Control Programmes

European Region

World Health Organization
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Ana Paula Coutinho Rehse
Infection Prevention & Control
Infectious Hazard Management Programme
WHO Health Emergencies Programme
WHO Regional Office for Europe

The man who saved more lives than any other physician in the history of humanity combined

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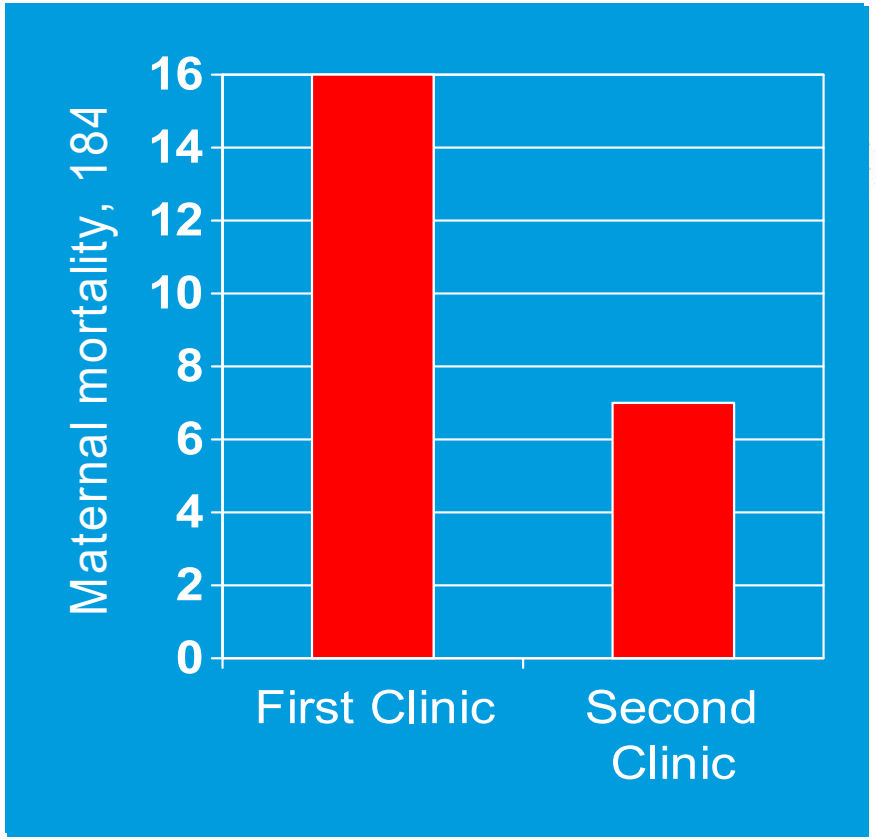
- Dr. Ignac Semmelweis was a Hungarian obstetrician working in the 1800s
- He practiced before Louis Pasteur came up with the germ theory and Joseph Lister popularized hand washing.
- Despite being shunned, ignored and ridiculed, he continued to promote his ideas until his dying day.
- He is an inspiration to all who continue to question the status quo.

1840's: General Hospital of Vienna

Divided by two clinics, alternating admissions every 24 hours:

- First Clinic: Doctors and medical students
- Second Clinic: Midwives



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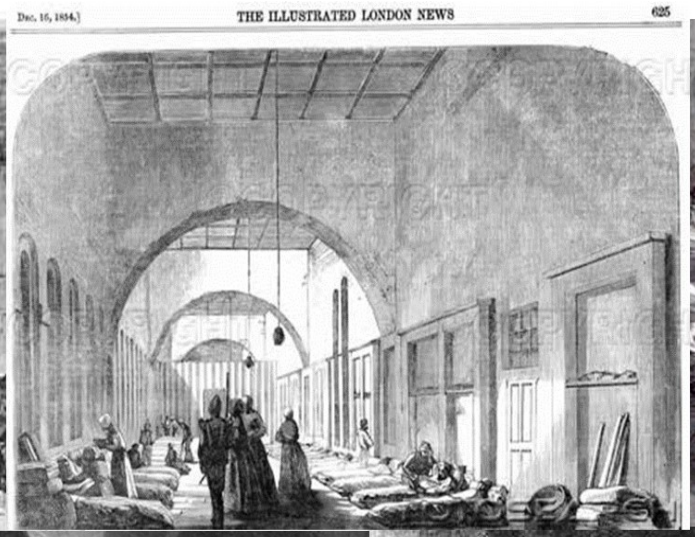

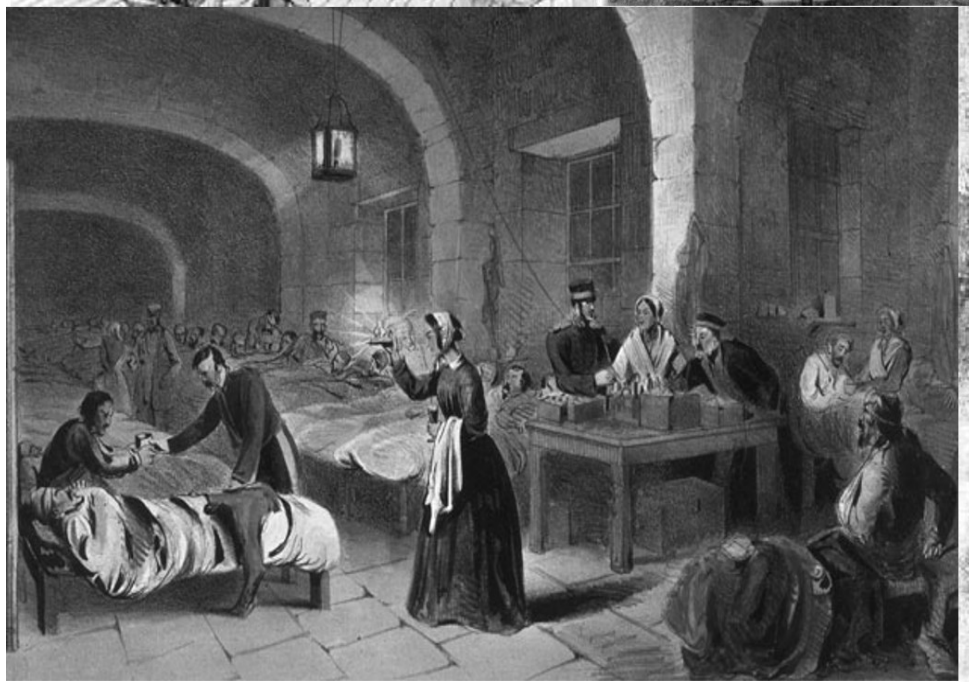

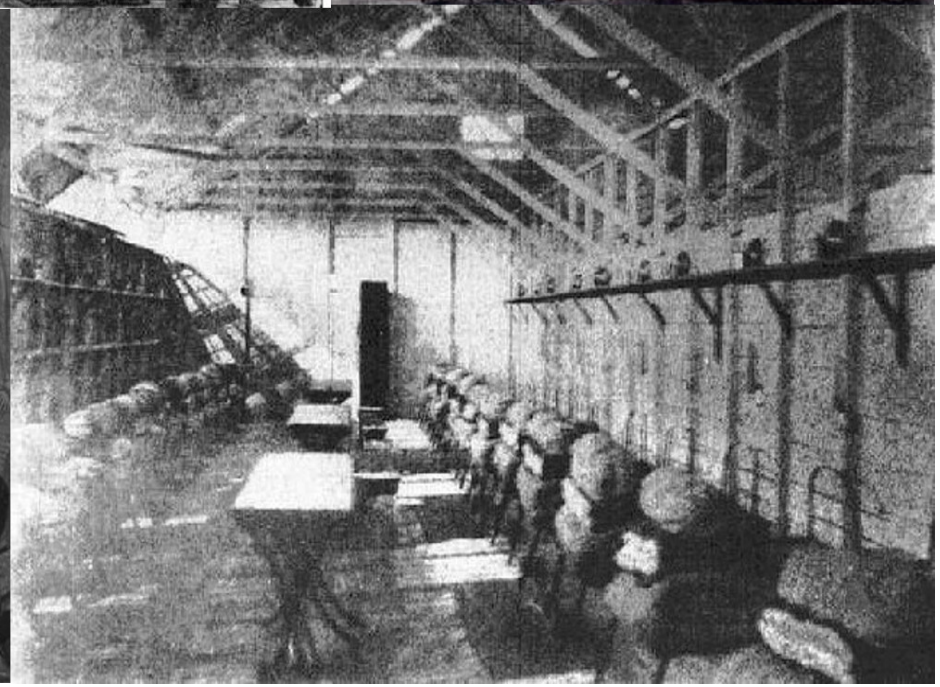

Some interesting facts about Infection Prevention and Control

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- Other names: hospital epidemiology, hospital hygiene, patient safety, quality of care
- Health care-associated infections (HAIs)
  - **8.9 million HAIs** occur every year in acute and long-term care facilities
  - **6** most common **HAI** = **2 X** the total burden of disability-adjusted life years of **all other 32 communicable** diseases combined
- Health care-associated infections and antimicrobial resistance
  - 75% of HAI
- Infection Prevention and Control
  - IPC interventions: prevent 35–70% of HAI
  - IPC programme: **reduce 30% HAI**

Sepsis is the most preventable cause of death and disability in Europe.

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Infections which may lead to sepsis can often be prevented through appropriate **hand hygiene**, access to vaccination programmes, improved **sanitation and water quality** and availability, and other **infection prevention and control** (IPC) best practices.

WHA Resolution A70/13 - Improving the prevention, diagnosis and clinical management of sepsis.

Sepsis mortality is often related to suboptimal quality of care in health care settings, inadequate WASH and health infrastructure, poor IPC, late diagnosis and inappropriate clinical management.

More than half of all cases of health care-associated **sepsis** are thought to be **preventable** through **basic WASH services** and **appropriate IPC measures**

Global Report on the Epidemiology and Burden of Sepsis. Geneva: World Health Organization, 2020 .

Infection Prevention and Control training strategy

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Foundation

Core components of IPC programmes at national and acute health care facility level

https://www.who.int/infection-prevention/publications/ipc-components-guidelines/en/

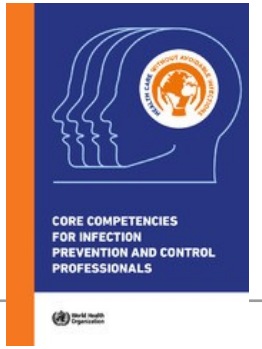
At minimum

Minimum Requirements for infection prevention and control (IPC) programmes

https://www.who.int/infection-prevention/publications/min-req-IPC-manual/en/

In practice

Core competencies for infection prevention and control professionals

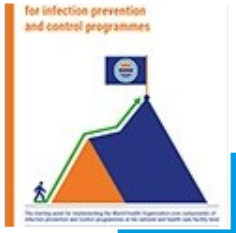


https://apps.who.int/iris/handle/10665/335821

Connecting the dots

Core Components

- CC1 IPC programme
  - foundation for all other components
- CC2 Evidence-based guidelines
- CC3 Education and training
- CC4 HAI surveillance
- CC5 Multimodal strategies
- CC6 Monitoring, audit and feedback



Minimum requirements

- IPC trained health care officer/focal point
- IPC training for all front-line clinical staff and cleaners

Core competencies

- IPC capacity and expertise at the country level depends on the level of implementation of CC 2 and 3
- It is essential that all persons responsible for and working in the IPC programme at the national, sub-national and facility level be competent. (knowledge, skills and attitudes)

Self-assessment exercises

Tripartite AMR Country Self-assessment Survey – TrACSS (4.0) 2019-2020

Food and Agriculture Organization of the United Nations · WORLD ORGANISATION FOR ANIMAL HEALTH · World Health Organization

01 November, 2020

Dear Colleagues,

On behalf of the Tripartite organizations, the Food and Agricultural Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE), and the World Health Organization (WHO), we are pleased to share with you the fourth round of the Tripartite AMR Country Self-assessment Survey (TrACSS).

To ensure effective tracking of country progress in addressing antimicrobial resistance (AMR), we would urge the national AMR focal points in all countries to fully engage all the relevant sectors to help complete the questionnaire. It would also be an opportunity for the national Multisectoral Coordination Group on AMR to come together to assess national progress and provide a consolidated response approved by all the relevant sectors.

We would like to thank you for your contributions to this survey as information from TrACSS has been invaluable to monitor country progress in the implementation of the national action plan on AMR, and help refine global strategies. Information from the third round of the TrACSS, including the list of countries that responded, was also published in the UN Secretary-General's report on AMR to the UN General Assembly in June 2019 (https://undocs.org/en/A/73/869). Additionally, data from TrACSS will contribute to the monitoring of various multisectoral indicators of the Tripartite monitoring and evaluation framework[1] of the Global Action Plan on AMR.

We request you to submit one consolidated country response coordinated by the national AMR focal point by the deadline of 29 February, 2020. For any additional questions or clarifications, or for support regarding the questionnaire, please write to: tracss@who.int. We will provide the results of the survey, including country reports, at https://amrcountryprogress.org/ in June 2020.

We thank you for your continued strong efforts to implement and monitor multisectoral national action plans on AMR in your country. Various tools and guidance documents developed by the Tripartite relevant to each question have been included in the ANNEX to the accompanying guidance note. Through our joint efforts we can help address one of the greatest challenges to human and animal health, food security, livelihoods, and economic growth, and that impacts a number of Sustainable Development Goals.

Sincerely,

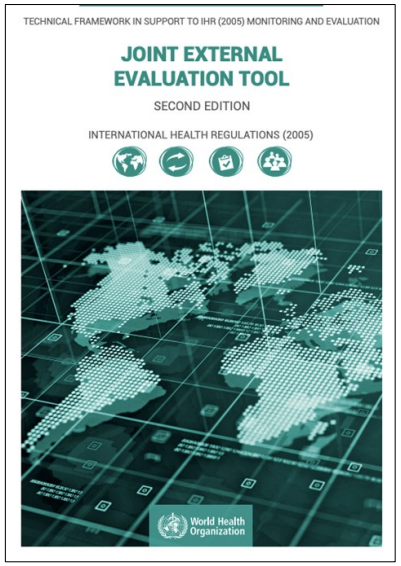
Ms Maria Helena M.Q. Semedo Deputy Director-General Climate and Natural Resources **FAO – Headquarters**	Dr Matthew Stone, Deputy Director General International Standards and Science **World Organisation for Animal Health (OIE) - Headquarters**	Dr Hannan Balkhy Assistant Director-General AMR Division **WHO – Headquarters**

INTERNATIONAL HEALTH REGULATIONS (2005)

STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

Second Edition

World Health Organization



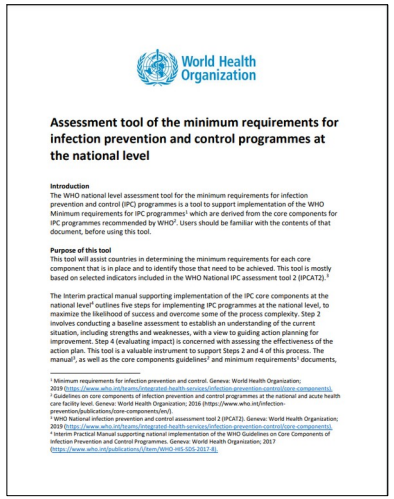
TECHNICAL FRAMEWORK IN SUPPORT TO IHR (2005) MONITORING AND EVALUATION

JOINT EXTERNAL EVALUATION TOOL

SECOND EDITION

INTERNATIONAL HEALTH REGULATIONS (2005)

World Health Organization



World Health Organization

Assessment tool of the minimum requirements for infection prevention and control programmes at the national level

Introduction

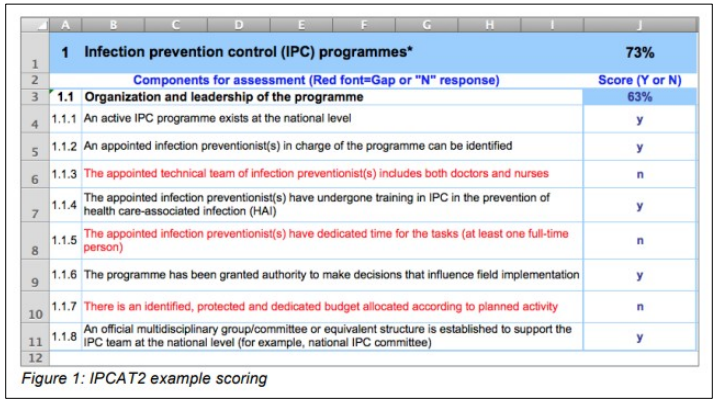
The WHO national level assessment tool for the minimum requirements for infection prevention and control (IPC) programmes is a tool to support implementation of the WHO Minimum requirements for IPC programmes[1] which are derived from the core components for IPC programmes recommended by WHO[2]. Users should be familiar with the contents of that document, before using this tool.

Purpose of this tool

This tool will assist countries in determining the minimum requirements for each core component that is in place and to identify those that need to be achieved. This tool is mostly based on selected indicators included in the WHO National IPC assessment tool 2 (IPCAT2).[3]

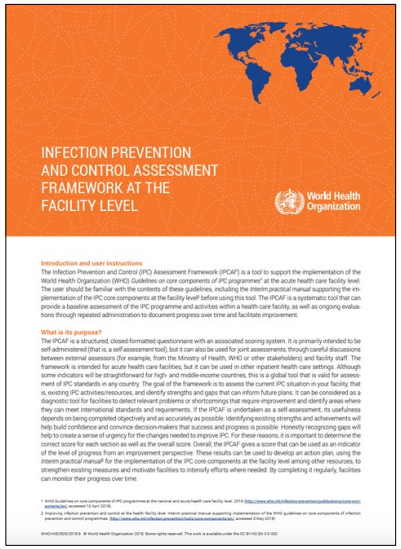
The Interim practical manual supporting implementation of the IPC core components at the national level[4] outlines five steps for implementing IPC programmes at the national level, to maximize the likelihood of success and overcome some of the process complexity. Step 2 involves conducting a baseline assessment to establish an understanding of the current situation, including strengths and weaknesses, with a view to guiding action planning for improvement. Step 4 (evaluating impact) is concerned with assessing the effectiveness of the action plan. This tool is a valuable instrument to support Steps 2 and 4 of this process. The manual[4], as well as the core components guidelines[2] and minimum requirements[1] documents,

[1] Minimum requirements for infection prevention and control. Geneva: World Health Organization; 2019 (https://www.who.int/teams/integrated-health-services/infection-prevention-control/core-components).
[2] Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (https://www.who.int/infection-prevention/publications/core-components/en/).
[3] WHO National infection prevention and control assessment tool 2 (IPCAT2). Geneva: World Health Organization; 2019 (https://www.who.int/teams/integrated-health-services/infection-prevention-control/core-components).
[4] Interim Practical Manual supporting national implementation of the WHO Guidelines on Core Components of Infection Prevention and Control Programmes. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/WHO-HIS-SDS-2017.8).



	A	B	C	D	E	F	G	H	I	J
1		**1**	**Infection prevention control (IPC) programmes***							**73%**
2			**Components for assessment (Red font=Gap or "N" response)**							**Score (Y or N)**
3		**1.1**	**Organization and leadership of the programme**							**63%**
4		1.1.1	An active IPC programme exists at the national level							y
5		1.1.2	An appointed infection preventionist(s) in charge of the programme can be identified							y
6		1.1.3	The appointed technical team of infection preventionist(s) includes both doctors and nurses							n
7		1.1.4	The appointed infection preventionist(s) have undergone training in IPC in the prevention of health care-associated infection (HAI)							y
8		1.1.5	The appointed infection preventionist(s) have dedicated time for the tasks (at least one full-time person)							n
9		1.1.6	The programme has been granted authority to make decisions that influence field implementation							y
10		1.1.7	There is an identified, protected and dedicated budget allocated according to planned activity							n
11		1.1.8	An official multidisciplinary group/committee or equivalent structure is established to support the IPC team at the national level (for example, national IPC committee)							y
12										

Figure 1: IPCAT2 example scoring



INFECTION PREVENTION AND CONTROL ASSESSMENT FRAMEWORK AT THE FACILITY LEVEL

World Health Organization

Introduction and user instructions

The Infection Prevention and Control (IPC) Assessment Framework (IPCAF) is a tool to support the implementation of the World Health Organization (WHO) *Guidelines on core components of IPC programmes*[1] at the acute health care facility level. The user should be familiar with the contents of these guidelines, including the *Interim practical manual* supporting the implementation of the IPC core components at the facility level[2] before using this tool. The IPCAF is a systematic tool that can provide a baseline assessment of the IPC programme and activities within a health care facility, as well as ongoing evaluations through repeated administration to document progress over time and facilitate improvement.

What is its purpose?

The IPCAF is a structured, closed-formatted questionnaire with an associated scoring system. It is primarily intended to be self-administered (that is, a self-assessment tool), but it can also be used for joint assessments, through careful discussions between external assessors (for example, from the Ministry of Health, WHO or other stakeholders) and facility staff. The framework is intended for acute health care facilities, but it can be used in other inpatient health care settings. Although some indicators will be straightforward for high- and middle-income countries, this is a global tool that is valid for assessment of IPC standards in any country. The goal of the framework is to assess the current IPC situation in your facility that is, existing IPC activities/resources, and identify strengths and gaps that can inform future plans. It can be considered as a diagnostic tool for facilities to detect relevant problems or shortcomings that require improvement and identify areas where they can meet international standards and requirements. If the IPCAF is undertaken as a self-assessment, its usefulness depends on being completed objectively and as accurately as possible. Identifying existing strengths and achievements will help build confidence and convince decision-makers that success and progress is possible. Honestly recognizing gaps will help to create a sense of urgency for the changes needed to improve IPC. For these reasons, it is important to determine the correct score for each section as well as the overall score. Overall, the IPCAF gives a score that can be used as an indicator of the level of progress from an improvement perspective. These results can be used to develop an action plan, using the *Interim practical manual*[2] for the implementation of the IPC core components at the facility level among other resources, to strengthen existing measures and motivate facilities to intensify efforts where needed. By completing it regularly, facilities can monitor their progress over time.

[1] WHO Guidelines on core components of IPC programmes at the national and acute health care facility level. 2016 (http://www.who.int/infection-prevention/publications/core-components/en/, accessed 13 April 2018).
[2] Improving infection prevention and control at the health facility level. Interim practical manual supporting implementation of the WHO guidelines on core components of infection prevention and control programmes. (http://www.who.int/infection-prevention/tools/core-components/en/, accessed 3 May 2018).

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Hand Hygiene Self-Assessment Framework 2010

Introduction and user instructions

The Hand Hygiene Self-Assessment Framework is a systematic tool with which to obtain a situation analysis of hand hygiene promotion and practices within an individual health-care facility.

What is its purpose?

While providing an opportunity to reflect on existing resources and achievements, the Hand Hygiene Self-Assessment Framework also helps to focus on future plans and challenges. In particular, it aids

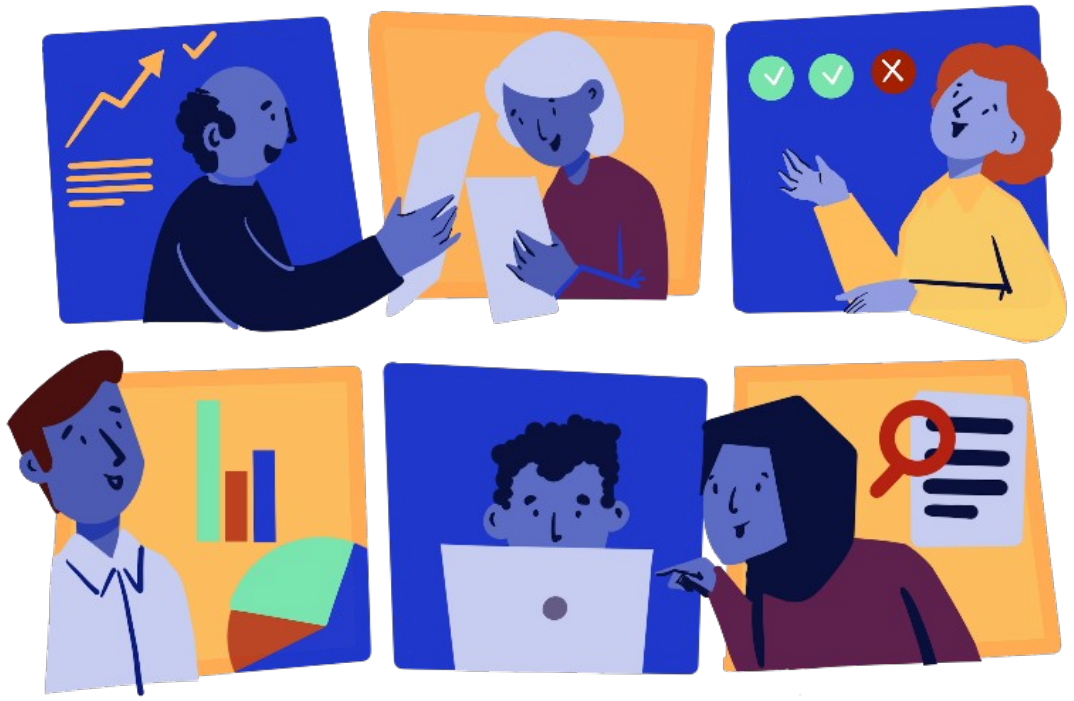
Intermediate: an appropriate hand hygiene promotion strategy is in place and hand hygiene practices have improved. It is now crucial to develop long-term plans to ensure that improvement is sustained and progresses.

Advanced: hand hygiene promotion and optimal hand hygiene practices have been sustained and/or improved, helping to embed a culture of safety in the health-care setting.

Assessments in a spirit of improvement

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

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

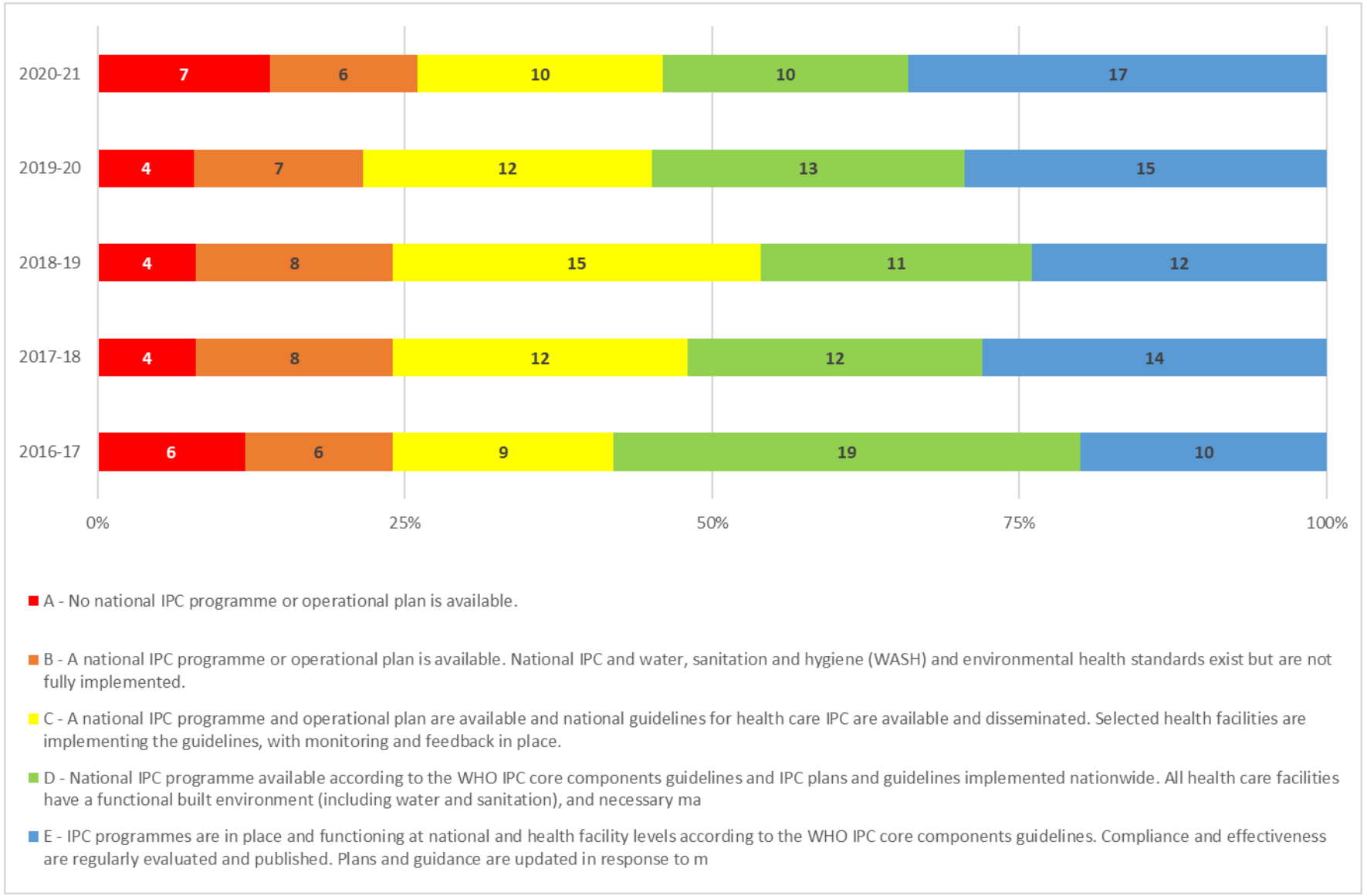


- Assessment helps to identify **existing strengths** and take stock of achievements made so far to convince decision-makers that success and **progress is possible.**

- 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**

Global Database for the Tripartite Antimicrobial Resistance (AMR) Country Self-assessment Survey (TrACSS)

https://amrcountryprogress.org/#/map-view



Tripartite Antimicrobial Resistance Country Self-assessment Survey (TrACSS)
WHO European Region data

World Health Organization
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	2016-17	2017-18	2018-19	2019-20	2020-21
No national IPC programme or operational plan is available.	Bulgaria Finland Kazakhstan Montenegro Poland Romania	Hungary Ireland	Ireland Luxembourg Poland Ukraine	Luxembourg Montenegro Poland	Azerbaijan Bulgaria Luxembourg Montenegro North Macedonia Poland Ukraine
IPC programmes are in place and functioning at national and health facility levels according to the WHO IPC core components guidelines. Compliance and effectiveness are regularly evaluated and published. Plans and guidance are updated in response to monitoring.	Austria Denmark Germany Israel Latvia Malta Monaco Netherlands Russian Federation United Kingdom of Great Britain and Northern Ireland (the)	Austria Belarus Belgium Denmark France Germany Israel Malta Monaco Netherlands Norway Russian Federation Spain United Kingdom of Great Britain and Northern Ireland (the)	Austria Belarus Belgium Denmark France Germany Israel Malta Netherlands Norway Portugal Sweden	Austria Belgium Croatia Denmark France Germany Greece Israel Malta Monaco Netherlands Norway Portugal Spain Sweden	**Austria** **Belgium** **Croatia** **Finland** **France** **Germany** **Greece** **Ireland** **Israel** **Kyrgyzstan** **Malta** **Netherlands** **Norway** **Portugal** **Spain** **Sweden** **United Kingdom of Great Britain and Northern Ireland (the)**

State Parties Self-Assessment Annual Reporting on the implementation of the IHR (data year 2021)
Core Capacity – Infection Prevention and Control

World Health Organization
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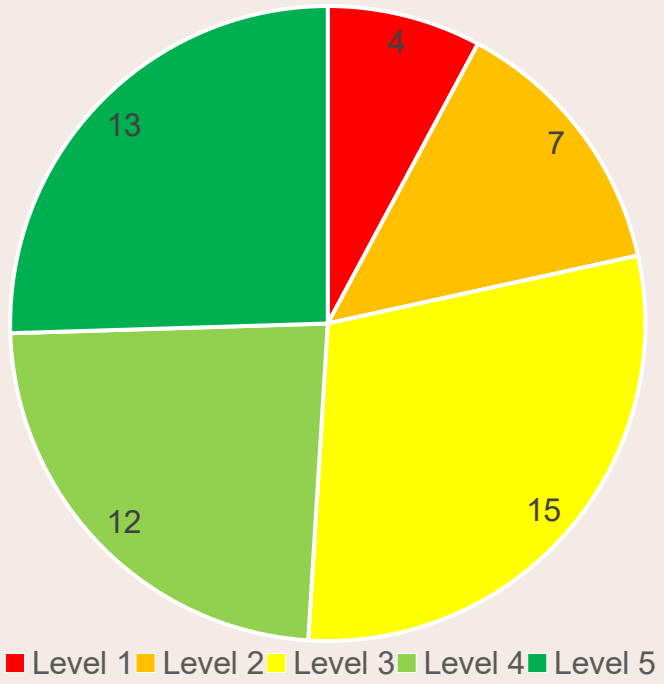
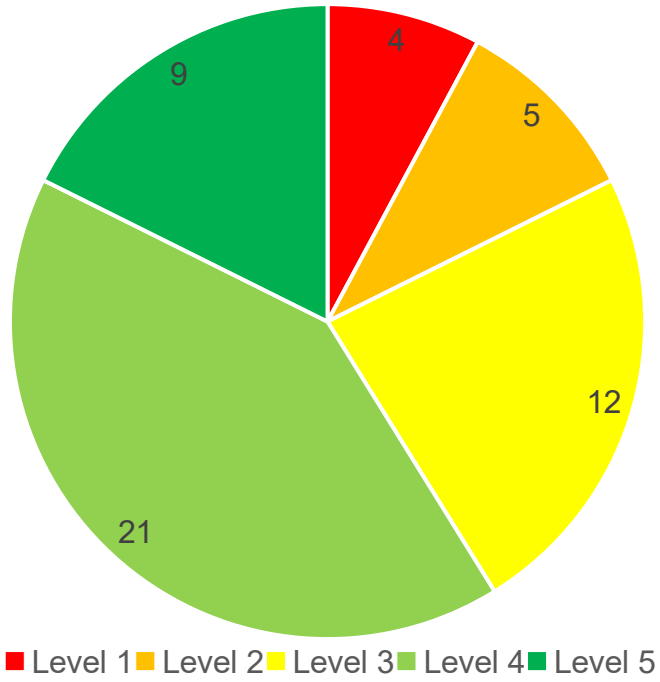
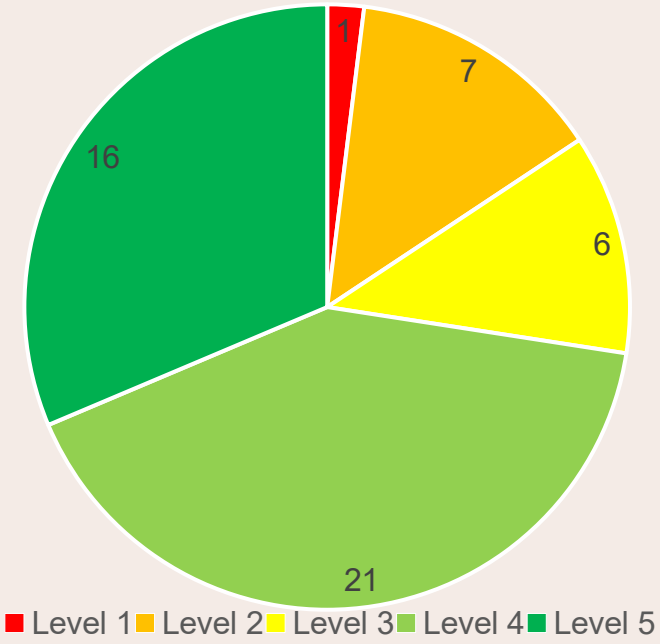
C9.1 IPC programmes
Average Global Capacity: **level 4**
Average European Region**: level 4**



C9.2 HCAI surveillance
Average Global Capacity: **level 3**
Average European Region: **level 4**



C9.3. Safe envir. in health facilities
Average Global Capacity: level 4
Average European Region: level 4

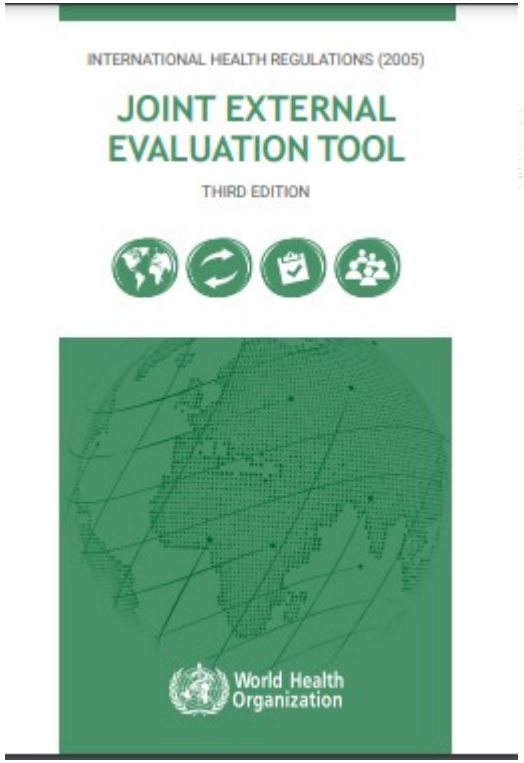


Joint External Evaluation (JEE)

16 countries

Average score 3 (1-5)

Albania, Armenia, Belgium, Finland, Georgia, Kyrgyzstan, Latvia, Lithuania, Moldova, Montenegro, North Macedonia, Serbia, Slovenia, Switzerland and Liechtenstein, Tajikistan and Turkmenistan



Proportion of countries with selected reported IPC minimum requirements in the European Region, 2021-2022

Core Component	Indicator	European Region Number (%)	Total Countries Number (%)
IPC programmes	Active national IPC programme	16 (47.1)	58 (54.7)
	Trained IPC focal point with dedicated time	13 (38.2)	49 (46.2)
	Dedicated budget	15 (44.1)	49 (46.2)
National and facility level IPC guidelines;	Evidence-based national IPC guidelines according to international standards	26 (76.5)	58 (64.2)
	Guidelines adapted and implemented	28 (82.4)	69 (65.1)
IPC education and training	National IPC curriculum for in-service training	25 (73.5)	85 (80.2)
HAI surveillance;	National strategic plan for HAI surveillance	31 (91.2)	88 (83.0)
Multimodal improvement strategies for implementing IPC activities	IPC improvement interventions coordinated and supported by national IPC focal point	29 (85.3)	96 (90.6)
	Multimodal strategies promoted	31 (91.2)	93 (87.7)
IPC monitoring, audit and feedback	National strategic plan for IPC monitoring	27 (79.4)	80 (75.5)
	Hand hygiene compliance as key national indicator	22 (64.7)	67 (63.2)

Elevating the importance of IPC

Many years of advocacy

2021
IPC core capacity IHR

Jan 2022
IPC EB 150

May 2022
Global IPC report (featuring KAZ)

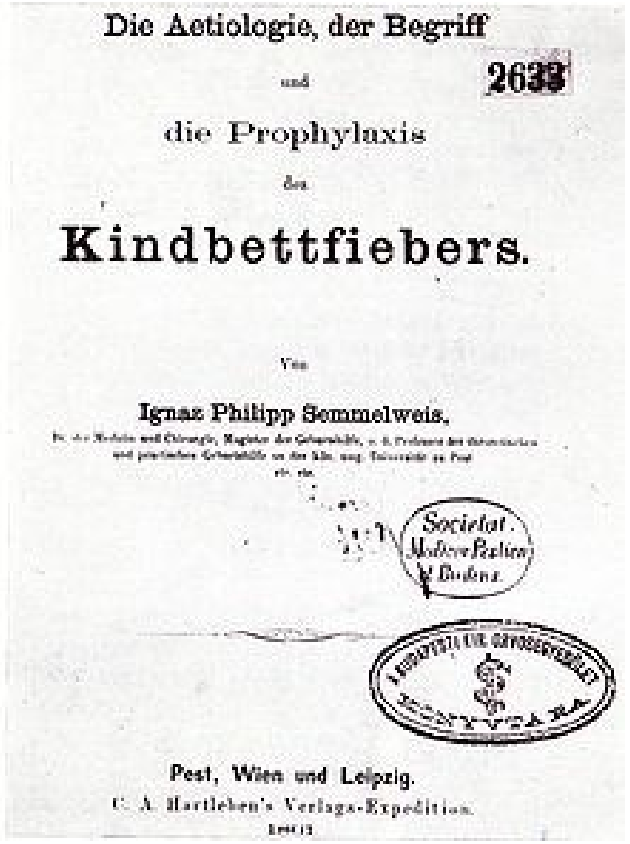
May 2022
WHA IPC resolution

September 2022 MS consultations

Jan 2023 Draft Global IPC strategy

May 2023
Global IPC strategy adoption

Transforming and retaining



Die Aetiologie, der Begriff

und 2633

die Prophylaxis

des

Kindbettfiebers.

Von

Ignaz Philipp Semmelweis,

Societat. Medico-Practica Lipsiens.

Pest, Wien und Leipzig.

C. A. Hartleben's Verlags-Expedition.

HEALTH CARE WITHOUT AVOIDABLE INFECTIONS

World Health Organization

REGIONAL OFFICE FOR Europe

Thank you!

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