World Health Organization

**SEVENTY-FIFTH WORLD HEALTH ASSEMBLY** **A75/A/CONF./5**
**Agenda item 14.6** **25 May 2022**

# Global Strategy on Infection Prevention and Control

## Draft resolution proposed by Bosnia and Herzegovina, Botswana, Colombia, Jordan, Kenya, Kingdom of Saudi Arabia, Lebanon, Norway, Oman, Philippines, Qatar, United Arab Emirates, United States of America and Vanuatu

The Seventy-fifth World Health Assembly,

PP1 Having considered the report by the Director-General on infection prevention and control as part of the universal health coverage and communicable disease agendas towards 2030[1];

PP2 Recalling the resolutions WHA48.7 (1995)[2] on the International Health Regulations, WHA58.27 (2015)[3] on infection prevention and control as objective 3 of the Global Action Plan on Antimicrobial Resistance (AMR), WHA69.1 (2016)[4] on quality care for all, WHA70.7 (2017)[5] on infection prevention and control as part of prevention of sepsis, WHA72.6 (2019)[6] on infection prevention and control as strategy 3.3 of the global patient safety action plan 2021–2030, WHA72.7 (2019)[7] on infection prevention and control as part of water, sanitation and hygiene, WHA73.1 (2020),[8] WHA73.8 (2020),[9] and WHA74.7 (2021)[10] on infection prevention and control as

[1] Document A75/10.

[2] World Health Assembly, 48. (1995). Revision and updating of the International Health Regulations. World Health Organization. https://apps.who.int/iris/handle/10665/178403.

[3] World Health Assembly, 48. (1995). Revision and updating of the International Health Regulations. World Health Organization. https://apps.who.int/iris/handle/10665/178403.

[4] World Health Assembly, 69. (2016). Strengthening essential public health functions in support of the achievement of universal health coverage. https://apps.who.int/iris/handle/10665/250765.

[5] World Health Assembly, 70. (2017). Improving the prevention, diagnosis and clinical management of sepsis. World Health Organization. https://apps.who.int/iris/handle/10665/275646.

[6] World Health Assembly, 72. (2019). Global action on patient safety. World Health Organization. https://apps.who.int/iris/handle/10665/329284.

[7] World Health Assembly, 72. (2019). Water, sanitation and hygiene in health care facilities. World Health Organization. https://apps.who.int/iris/handle/10665/329290.

[8] World Health Assembly, 73. (2020). COVID-19 response. World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf.

[9] World Health Assembly, 73. (2020). COVID-19 response. World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf.

[10] World Health Assembly, 74. (2021). Strengthening WHO preparedness for and response to health emergencies https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R7-en.pdf.

part of the COVID-19 response, strengthening international health regulations, prevention preparedness and response, respectively, within which IPC is a critical component;

PP3 Reaffirming the 2030 Agenda for Sustainable development and its targets which are universal, indivisible, and interlinked and referring in particular to Sustainable Development Goal 3.1 on reducing global maternal mortality, 3.2 on ending preventable deaths of newborns and children under 5 years of age, 3.3 on ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combating hepatitis, water-borne diseases and other communicable diseases, and 3.8 on access to quality essential health care services and equitable access to safe, effective, quality and affordable essential medicines and vaccines for all, and recognizing the important intersections between infection prevention and control and other Sustainable Development Goals, including Goal 6 (clean water and sanitation);

PP4 Noting the declaration of Alma Ata[1] on primary healthcare and the Declaration of Astana[2] on high quality and safe primary health care and health services and recognizing that to achieve it, preventing harm from infection transmission at the entry point to and at all points in the health system is paramount;

PP5 Recognizing the critical importance of infection prevention and control in the human and animal health sectors and that it is a clinical and public health discipline based on a scientific approach, providing proactive, responsive, and practical preventive and control measures grounded in infectious diseases, epidemiology, social, engineering, and implementation science, and health systems strengthening that requires a dedicated specialist health work force;

PP6 Noting that comprehensive infection prevention and control programmes, that take the one health approach into account, at national, subnational and facility levels are essential to produce science-based evidence, support, facilitate, and/or oversee the correct, evidence-based, and risk-informed implementation of infection prevention and control, as well as the resources and material support (such as, personal protective equipment) required;

PP7 Concerned that the COVID-19 pandemic and the recent large outbreaks of Ebola virus disease in West Africa and the Democratic Republic of the Congo have shown the devastating consequences of the lack of preparedness and substandard, insufficient and/or inadequate implementation of infection prevention and control programmes, even in high-income countries, and have brought infection prevention and control to the forefront;

PP8 Recognizing that in addition to outbreaks, at any point in time[3] out of every 100 patients, seven in high-income countries and 15 in low- and middle-income countries acquire at least one health care-associated infection during their stay in acute care hospitals, and a quarter of health care facilities lacked basic water services in 2019, exposing 1.8 billion people, including health care workers and

[1] International Conference on Primary Health Care (1978: Alma-Ata, USSR), World Health Organization & United Nations Children's Fund (UNICEF) (1978). Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 / jointly sponsored by the World Health Organization and the United Nations Children's Fund. World Health Organization. https://apps.who.int/iris/handle/10665/39228.

[2] World Health Organization. (2019). Declaration of Astana: Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018. World Health Organization. https://apps.who.int/iris/handle/10665/328123.

[3] Allegranzi B, Bagheri Nejad S, Combescure C, et al. Burden of endemic health-care-associated infection in developing countries: systematic review and meta-analysis. Lancet 2011; 377(9761): 228-41.

patients, to greater risk of infections,[1] highlighting the major gaps in WASH services in healthcare facilities, which play a critical role in infection prevention and control and noting the modest costs for achieving minimal WASH safety, which range from US$ 6.5 to 9.6 billion in the 46 least developed countries; which represent 4-6% of these countries' recurrent health spending;

PP9 Although no precise analysis is possible due to lack of comprehensive data, noting that WHO has estimated that hundreds of millions of patients are affected by health care-associated infections leading to deaths in one in 10 infected patients every year, and noting further that in acute-care hospitals, out of every 100 patients, seven patients in high-income countries (HICs) and 15 patients in low- and middle-income countries (LMICs) will acquire at least one Healthcare-Associated Infections (HAI) during their hospital stay, and that up to 30% of patients in intensive care are affected by HAIs, with an incidence that is two to 20 times higher in LMICs than in HICs;[2]

PP10 Noting the added costs of HAI, which may vary from US$ 1000 to 12 000 on average[3] per episode depending on the country, result in a significant economic burden on health systems and out of pocket expenses for patients and families; and that the mortality among patients affected by health care-associated sepsis was 24.4% and increasing up to 52.3% among patients treated in an intensive care unit and at least two to three times higher among those infected with antimicrobial resistant organism, neonates, and in LMIC;[4]

PP11 Noting that most of antibiotic resistant infections are acquired in health care facilities, 75% of disability-adjusted life years attributable to AMR are due to HAIs.[5] Each year, AMR costs health care systems around US$ 1.2 billion. For example, up to 75% of antimicrobial prescriptions in long term care facilities are inappropriate, yet policies to tackle inappropriate antimicrobial use and AMR, such as antimicrobial stewardship and infection prevention and control, remain underused or suboptimal;[6]

PP12 Noting that a recent systemic analysis and predictive statistical models by AMR collaborators for the year 2019 showed that the estimated deaths associated with bacterial AMR were 4.95 million (3.62–6.57), including 1.27 million (95% UI 0.911–1.71) deaths attributable to bacterial

[1] World Health Organization & United Nations Children's Fund (UNICEF). (2020). Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. World Health Organization. https://apps.who.int/iris/handle/10665/337604.

[2] World Health Organization. (2020). Global report on the epidemiology and burden of sepsis: current evidence, identifying gaps and future directions. World Health Organization. https://apps.who.int/iris/handle/10665/334216

[3] Forrester JD, Maggio PM, Tennakoon L. Cost of Health Care-Associated Infections in the United States. J Patient Saf. 2022 Mar 1;18(2):e477-e479. doi: 10.1097/PTS.0000000000000845. PMID: 33881808.

[4] Markwart R, Saito H, Harder T, Tomczyk S, Cassini A, Fleischmann-Struzek C, et al. Epidemiology and burden of sepsis acquired in hospitals and intensive care units: a systematic review and meta-analysis. Intensive Care Medicine. 2020;46(8):1536-51.

[5] Cassini A, Högberg LD, Plachouras D, Quattrocchi A, Hoxha A, Simonsen GS, Colomb-Cotinat M, Kretzschmar ME, Devleesschauwer B, Cecchini M, Ouakrim DA, Oliveira TC, Struelens MJ, Suetens C, Monnet DL; Burden of AMR Collaborative Group. Attributable deaths and disability-adjusted life-years caused by infections with antibiotic-resistant bacteria in the EU and the European Economic Area in 2015: a population-level modelling analysis. Lancet Infect Dis. 2019 Jan;19(1):56-66. doi: 10.1016/S1473-3099(18)30605-4. Epub 2018 Nov 5. PMID: 30409683; PMCID: PMC6300481.

[6] Eze, N., M. Cecchini and T. Oliveira Hashiguchi (2022), Antimicrobial resistance in long-term care facilities, OECD Health Working Papers, No. 136, OECD Publishing, Paris, https://doi.org/10.1787/e450a835-en.

AMR and reflect the burden of AMR as a leading cause of deaths globally, with a high impact in low-resource settings;[1]

PP13 Observing that most cost-effective interventions to limit the spread of antimicrobial resistance in health care are those aiming at improving all hospital associated drivers, including hygiene and antimicrobial stewardship, with the potential to prevent three out of four attributable deaths;[2]

PP14 Noting that public health emergencies have demonstrated that infection prevention and control, together with core capacities required by the International Health Regulations (2005), play a critical role in preventing and timely and effectively responding to public health risks and emergencies of national and international concern;

PP15 Recognizing that the COVID-19 pandemic has also demonstrated the critical role of health system resiliency in providing essential health services and maintaining functional health systems and that the cornerstone of health system resiliency is keeping health care workers, patients and visitors safe through a series of measures, including infection prevention and control, best practices and essential infrastructure, including transmission-based precautions, water, sanitation, and waste management wherever healthcare is provided;

PP16 Recognizing the unique opportunity to harness the experience of the heightened global awareness and investments made during the COVID-19 pandemic for sustained improvements in infection prevention and control;

1. CALLS ON Member States:[3]

OP1: to take steps to support and/or to ensure that infection prevention and control is one of the key components of global health preparedness, prevention and response;

OP2: to acknowledge that clean, high-quality, safe, affordable care should be universally available and that no one should be unnecessarily exposed to infection due to suboptimal infection prevention and control practices;

OP3: to take steps to support and/or to ensure that science-based functional infection prevention and control, both for community acquired and healthcare associated infections, taking into account the One Health approach, programmes exist, are implemented, monitored, and updated at national, sub-national, and/or facility levels , as appropriate to national contexts and in line with the WHO core components of such programmes;[4]

[1] Antimicrobial Resistance Collaborators. Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. Lancet. 2022 Feb 12;399(10325):629-655. doi: 10.1016/S0140-6736(21)02724-0. Epub 2022 Jan 19. PMID: 35065702; PMCID: PMC8841637.

[2] European Centre for Disease Control and Prevention and OECD. Antimicrobial resistance. Tackling the burden in the European Union. Briefing note for EU/EAA countries. 2019. https://www.oecd.org/health/health-systems/AMR-Tackling-the-Burden-in-the-EU-OECD-ECDCBriefing-Note-2019.pdf.

[3] And, where applicable, regional economic integration organizations.

[4] World Health Organization. (2016). Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. World Health Organization. https://apps.who.int/iris/handle/10665/251730.

OP4: to take steps to support relevant authorities and/or ensure that at least the minimum requirements for infection prevention and control programmes at the national, sub-national and health care facility level are implemented, and monitored inclusive of environmentally conscious and appropriate waste management to reduce further impact on human, animal, and environmental health;

OP5: to support and ensure that the transmission-based precautions for infection prevention and control are implemented with fidelity and quality at national and facility levels, and functional administrative, environmental and personal protection measures are in place to prevent and/or halt further transmission;

OP6: to take steps to support and /or to ensure that sustainable infection prevention and control, water, sanitation and hygiene infrastructures and resources are in place and utilized across all health care facilities, including in primary health care, home and community-based settings, and long-term care settings as appropriate to national context;

OP7: to take steps to recognize the value of having infection prevention and control professionals across a variety of settings with appropriate competencies, skills, career pathways, and empowerment with a clear mandate and authority, while being held accountable, and work within the clinical governance framework of their organizations for implementation and reporting the impact of infection prevention and control programmes as appropriate to the national context;

OP8: to take steps toward creating and implementing accredited infection prevention and control curricula within pre-graduate, post-graduate and in-service continuous education, where and as appropriate in national contexts, for all health care workers and all relevant disciplines;

OP9: to take steps to ensure that infection prevention and control programmes, are integrated and aligned with antimicrobial resistance, quality of care, patient safety, water, sanitation and hygiene, construction and remodelling of the infrastructure of the health care facilities, and health emergencies programmes, as well as blood borne infectious diseases, tuberculosis, acute respiratory infections, vaccine preventable diseases, neglected tropical diseases occupational health, sexual and reproductive health and maternal, neonatal and child health, and other relevant programmes where and as appropriate for national contexts;

OP10: to provide decisive and visible political commitment and leadership engagement at the highest levels to sustain and improve implementation of functional infection prevention and control programmes at the regional, national, local, and facility levels, including encouraging allocation of national and local dedicated budgets where and as appropriate and guided by domestic context;

OP11: to introduce guidance, regulations and /or legal frameworks to enforce infection prevention and control requirements, polices, and implementation of best practices through systems for accrediting health facilities and other mechanisms, as appropriate and guided by domestic context;

OP12: to undertake as appropriate to national contexts, regular, detailed and multilevel assessments of infection prevention and control programmes, practices, and surveillance of health care-associated infections and antimicrobial resistance in order to generate and share data to be used for action and improving outcomes;

OP13: to continue to encourage investments in research on infection prevention and control.

2. REQUESTS the Director-General:

(1) to develop, in consultation with Member States and regional economic integration organizations, a draft global strategy, in alignment with other strategies with infection prevention and control efforts, like the Global Action Plan on Antimicrobial Resistance, on infection prevention and control in both health and long term care settings, for consideration by WHA76 via EB152;

(2) to translate this global strategy, by WHA77 via EB154, into an action plan for infection prevention and control, including a framework for tracking progress with clear measurable targets to be achieved by 2030;

(3) to continue to update and develop as required technical guidance on infection prevention and control programmes and practices for health and long term care settings;

(4) to report back on progress and results to the Seventy-eighth World Health Assembly in 2025, and thereafter every two years until 2031.

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