WHO Global Infection Prevention and Control Network meeting
27-28 February 2017
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<td>antimicrobial resistance</td>
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<td>CDC</td>
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<td>IPC</td>
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<td>SDGs</td>
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<td>TOR</td>
<td>terms of reference</td>
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EXECUTIVE SUMMARY

The World Health Organization (WHO) Global Infection Prevention and Control Network (GIPCN) meeting was held on 27-28 February 2017. The Network had previously been established and formally approved by WHO to coordinate the inputs of infection prevention and control (IPC)-related organizations. However, for several reasons, the Network had been less active over the last few years.

The purposes of the Network are to enhance local, national and international coordination and collaboration in the field of IPC and to support the efforts of WHO and Member States, ranging from preparedness to establishing IPC systems and programme strengthening, as well as outbreak prevention and control and capacity building for surveillance. The Network in its current format comprises a range of organizations working in the field of IPC, from societies to WHO Collaborating Centres. A small selection of relevant new organizations was invited to attend the 2017 meeting.

The overall purpose of the February 2017 meeting was to outline and secure plans for collaboration and collaborative plans between participating organizations and WHO in order to ensure the development, dissemination and implementation of IPC recommendations and products.

This was the first meeting to be held since the coordination of the Network passed to the IPC Global Unit (IPC-GU) within the Service Delivery and Safety Department at WHO. It therefore provided the opportunity to revisit the terms of reference (TOR) and activities of the Network in order to be sure of their relevance to current global IPC needs and in support of progress towards achieving the Sustainable Development Goals (SDGs).

Key outcomes of the meeting:

1. Agreement that the GIPCN should progress and be active in supporting development, dissemination and implementation of IPC recommendations and products.
2. Discussion of the revised draft TOR and agreement that once finalized these will be accepted by all participating organizations.
3. Update and sharing by all GIPCN members of the main current goals and activities of their organizations.
4. Discussion on IPC priorities and challenges for the global agenda and for countries in the next five years with recommendations by participants to be included in a formal “position” paper.
BACKGROUND

Despite many achievements worldwide, the need for robust, fit-for-purpose infection prevention and control (IPC) programmes nationally and at the facility level is clearly reinforced within the WHO guidelines on core components of IPC programmes at the national and facility level launched in November 2016. The IPC Global Unit (IPC-GU), responsible for issuing these guidelines, was established at the end of 2015 within the World Health Organization (WHO) Service Delivery and Safety (SDS) Department to support the strengthening of national and international IPC capacity and implementation of IPC best practices at the health service delivery level. This Unit was a natural extension of the work of the Clean Care is Safer Care (CCiSC) programme, which was established in 2005 as the First WHO Global Patient Safety Challenge. CCiSC was a successful programme that provided the foundations, as well as substantial evidence, to enhance the profile of IPC and place it at the core of the global health agenda.

Defective IPC impacts on a country’s ability to meet the International Health Regulations (IHR) on combating antimicrobial resistance (AMR) and, ultimately, adversely impacts on the quality of health care delivery required to meet the health-related Sustainable Development Goals (SDGs), namely 3.1-3, 3.8, 3.d and 6. The establishment of the IPC-GU and the development of its vision and work plans in the context of global health requires the need for a renewed focus on engagement with experts worldwide. The IPC-GU has the mandate to lead and coordinate WHO’s work on IPC and is committed to collaborating with related units in SDS and other departments in WHO, including regional offices, as well as key international organizations, stakeholders and donors. More details about the IPC-GU including its vision, mission and functions, can be found at http://www.who.int/infection-prevention/en/ and in the booklet Health care without avoidable infections.

The critical role of infection prevention and control.

The IPC-GU has the responsibility for the coordination of the Global Infection Prevention and Control Network (GIPCN), which draws together all major IPC international organizations and the most relevant WHO Collaborating Centres for IPC. The Network was previously coordinated by the staff in the WHO Pandemic and Epidemic Diseases Department and has held meetings and worked collaboratively on a web-based platform. It is intended that while coordinated by the IPC-GU, work will still be undertaken through close liaison with the WHO AMR secretariat and the WHO Infectious Hazard Management Unit, specifically the clinical management unit. Additionally, connections with the Global Outbreak and Response Network (GOARN) will be facilitated as necessary. This all aims to ensure the successful impact of the Network.

In consideration of the new IPC-GU coordination and its vision and mission, the purpose and TOR of the GIPCN were modified slightly and circulated by the IPC-GU prior to the meeting to ensure fruitful discussion.
MEETING OBJECTIVES

- To outline and discuss recent and current work of the IPC-GU and relevant WHO units.
- To review the work of participating organizations.
- To discuss and agree revised TOR for GIPCN.
- To outline and discuss the purpose of GIPCN in 2017.
- To identify and consider key activities of the GIPCN, as well as priorities for global IPC going forward.
- To agree next steps for GIPCN coordination and collaborations.

MEETING SUMMARY

INTRODUCTION TO THE MEETING

Sir Liam Donaldson (SLD), WHO Patient Safety Envoy, opened the meeting. The following points are highlights of his remarks to participants:

- SLD reminded participants of the reason we are working towards health care without avoidable infections and how this current IPC-GU grew from the First Global Patient Safety Challenge (CCiSC) launched in 2005; in particular, he highlighted the work led by Dr Benedetta Allegranzi (BA);
- he summarized the background to the Network and the importance of the collaboration;
- he emphasized that now is the time to ignite new passion into global IPC and make a stronger move towards implementation;
- he noted that it is important for the GIPCN to focus on outcomes and goals when setting priorities, as well as the strengthening of processes of care and infrastructures;
- he noted that years of learning have taught us that strong implementation is critical and this takes strong leadership and engagement;
- he also promoted the facilitation and support required from others to ensure change at the local level.

BA also welcomed all participants and thanked them for their enthusiastic response to advance the journey of the GIPC Network.

Claire Kilpatrick (CK) then outlined the agenda for the meeting and the objectives as noted in the meeting papers, which were circulated.
OVERVIEW OF WHO IPC GLOBAL UNIT

BA shared a PowerPoint presentation on the vision, functions and work of the IPC-GU and highlighted the following points:

- vision of the IPC-GU and the importance to make health care safer in all Member States;
- many WHO resources emphasizing the importance of IPC are available, including an advocacy booklet;
- importance of positioning IPC in the context of the global health agenda;
- need to consider how we can further leverage our messages to embed IPC in this agenda, noting that it is still not seen as a key priority for addressing, for example, AMR;
- IPC-GU is progressing work by building a strong and consistent voice across all three levels of WHO, collaborating with regional focal points in particular;
- key role of GIPCN to support sharing of tools and other resources; ensuring standardization of these while considering their relevance to all settings, low or high income, and the WHO IPC global agenda;
- support for monitoring and collection of data, particularly in low- and middle-income countries (LMICs), was highlighted as critical to move forward as this is currently lacking and needed to gather more information on the global burden;
- IPC core components and surgical site infection prevention guidelines were outlined and the forthcoming WHO implementation strategies and tools described;
- WHO multimodal improvement strategy and the evidence proving its importance in safety and culture change were highlighted as key factors to support implementation progress, including a call to the Network to focus on how we can explain and emphasize the benefit of this strategy to enhance its uptake;
- new advanced training modules for IPC focal points will be delivered in 2017, which could partially address career path issues in some countries, as well as the supportive work the IPC-GU is doing to progress a resolution on sepsis;
- forthcoming work of the IPC-GU, including an outline of the new communication/advocacy tools and web pages where all information will be accessible.

IPG-GU vision

“Our vision is to protect the lives of patients and health workers across the world through excellence in IPC.”

Participants provided insightful and supportive comment on the IPC global activities and concepts presented including:

- importance of IPC in slowing the progress of AMR;
- IPC is more than health care-associated infections (HAI) – new guidelines help outline the overall burden, but messages need to be stronger than just HAI;
• importance of positioning IPC in areas such as integrated people-centred care and the ageing population with complex needs, which is a perfect opportunity to transform messages to meet broader public health challenges;

• universal health coverage is not yet universal and creating safe health systems in all countries requires strong IPC. Talking about IPC in the context of quality safe health care must be a priority and it will ensure our “seat at the table”. SLD asked that all GIPCN participants work towards ensuring that IPC is included in all key global health discussions;

• importance of not duplicating efforts, especially regarding production of guidelines – while one size may not fit all, work already undertaken and published can be adapted, including from WHO;

• when resources are scarce, support from colleagues in other regions will be critical – especially as national IPC programmes continue to be lacking in some Member States;

• the IPC community overall has a responsibility to work together to address community and health care avoidable infections;

• role of the health workforce and how training can standardize and strengthen action, particularly as self-protection is often a motivator - this area was noted as an ongoing challenge given that some countries had progressed since the Ebola virus disease outbreak, but not all;

• importance of integrating IPC competence in the wider community of all health workers;

• importance of national IPC programmes; however, state and local ownership is more important for progress in many countries;

• when in crisis mode, a “command and control” approach is effective, but does this work in peace time? It would be important to address this issue to enhance accountability at all times;

• people still believe that HAI are unavoidable and this must be addressed through better messaging;

• we have to break the cycle of a key “workaround” being people’s attitude of “we have no money”.

BA again noted the opportunity that the new IPC core components provide and how they should link to AMR national action plans. She asked the Network to consider what all organizations could do together to build on the opportunity provided by the core components recommendations.

Julie Storr (JS) outlined a global learning laboratory that has recently been launched by WHO using an online platform for the sharing of quality health care strategies. There will be opportunities for IPC to have a voice on this platform with a new “pod” focused on this topic to be released in 2017.

CK took the opportunity to outline the role of the annual 5 May WHO SAVE LIVES: Clean Your Hands campaign and how it can continue to raise the profile of IPC and behaviour change. GIPCN will be vital to cascade messaging for 5 May 2017 and CK mentioned that more information would be shared during the meeting. CK thanked everyone for their ongoing support for the campaign as people’s actions are what make it successful.
SLD summarized his thoughts following the discussion and noted that we need to drive people to a model that works in practice for the safety of all – there are still too many errors occurring, although the patient safety movement has seen some success that IPC could further learn from. Measuring is critical, as well as ongoing progress towards a culture of openness and honesty to drive change.

In summary, this round of discussion highlighted the ongoing need for IPC reach in the global agenda, the need for more local data/information (especially in LMICs), the need to enhance competence and official IPC programmes in all Member States and, finally, the opportunity to build on the recently launched core components for IPC.

WHO AMR SURVEILLANCE

Dr Sergey Eremin (SE) provided an overview of WHO AMR surveillance activities, now known as the Global AMR Surveillance System (GLASS). The presentation featured the following key points:

- there is still a lack of AMR surveillance and most countries are still without systems for data collection – the key challenge is to obtain local data. Many published studies are unfortunately data-poor and GIPCN could play a role in enhancing studies by an active promotion of surveillance;
- the impact of AMR on human health has driven GLASS work and the importance of the right epidemiology;
- GLASS is not primarily focused on collecting data, but rather on helping countries to standardize their systems – common human bacteria are the first focus for GLASS, based on samples available from laboratories (it is not focused on syndromic surveillance at this stage);
- the approach is to work closely with WHO Collaborating Centres to help drive national work and coordinating bodies;
- the GLASS list of pathogens for research and development is different from the first focus for surveillance data;
- these are just the first steps in collecting and analysing country information in order to present the challenges with both sensitive and resistant organisms;
- enrolment to GLASS is a sign of commitment that we can all build upon given that there is willingness and awareness, but not necessarily the right resources in countries at present;
- GIPCN can continue to support work done in countries to contribute to the WHO surveillance system.

Discussion ensued with participants providing their comment on AMR surveillance activities including:
• AMR work needs to be linked more closely to HAI surveillance and IPC – those who have already started their progress with HAI and IPC do not always map across the GLASS request for surveillance;
• in LMICs, samples are often based on the cheapest option, that is, urine, while high-income countries tend to be more focused on blood samples; thus, it was perceived that a disparity will exist in results obtained from any global reporting;
• need for key human resources, including clinical microbiologists for meaningful results, epidemiological expertise to analyse and present trends in surveillance data, as well as physicians/clinicians who are trained to take reliable samples and act on laboratory results;
• what is the plan in countries where there are no (or no well-functioning) national reference laboratories? Can other laboratories be identified to support?;
• will the approach to prioritizing surveillance of key organisms drive empirical antibiotic treatment? Diagnostic stewardship was noted as important;
• the need to exploit the opportunity of AMR being given a global profile and high political commitment to get more collective responsibility for both surveillance and action;
• WHO regional focal points voiced their support for GLASS as a starting point and noted that the G20 discuss only three health topics: AMR is one of them, so again it is now an opportunity to heighten awareness on surveillance;
• Divisions exist between country-level knowledge, decision making and clinicians, as well as sometimes confusion over which guidelines to follow when aiming for IPC improvement.

WHO CLINICAL MANAGEMENT

When a communicable disease outbreak occurs in a community, health care settings are called upon to identify and care for infected individuals. In routine or outbreak situations, if IPC practices are inadequate or not in place, the health care setting may become a source of infectious disease amplification and spread. Member States have requested that WHO (all three levels) plays a strong coordinating role in global IPC including response efforts. Hence, once again, the importance of GIPCN in supporting such efforts is highlighted.

Dr Nikki Shindo (NS) outlined the work of the WHO clinical management unit, part of WHO Infectious Hazard Management Department. The PowerPoint slide set presented featured the following key points:
• coordination and a clear role within WHO is important to IPC work – the clinical management unit’s position was explained;
• IPC-GU is at the heart of supporting coordination and management of HAI outbreaks;
• a greater understanding of standard precautions is critical and GIPCN should provide support on this aspect in all countries, which in turn will support action during emergencies or outbreaks;
• experiences from Ebola virus disease clinical units are still informing how safer care can be delivered.

Discussion ensued with participants providing their comment on the presentation including:
• triage needs to be safe in all facilities in order to manage infectious disease spread/outbreaks;
• an evidence base is still needed for protocols as practices are poor (for example, donning of personal protective equipment). Additionally, the patient’s view is often missing and values and preferences replace decision making when there is a lack of evidence available. More research is crucial to close the gaps in guidelines and protocols;
• fear still drives health worker actions, even if guidance is available, and better communications to address this issue was again highlighted;
• realistic needs and goals in IPC standards needs to be supported;
• GIPCN should allow for a better engagement in support of standards, including now the core components for IPC and technical advice;
• participants were asked how many have a function in their organization to provide on the ground support and expertise in emergency situations;
• participants from Europe noted that they could support those who need direction in the Eastern Mediterranean region when French materials were required;
• information about the work of other non-governmental organizations was also shared;
• It was ultimately agreed that the Network needs to help progress in all countries so that standards will finally be the same.

UPDATES FROM GIPCN MEMBER ORGANIZATIONS

All GIPCN members presented their organizations’ current work and priorities in five slides each. This was upon a request from WHO prior to the meeting and provided an excellent opportunity to hear concise summaries of work in progress, as well as any synergies and novel approaches. These presentations formed the main part of the first day of the meeting.

Key topics raised during presentations included dedicated work on:
• catheter-associated urinary tract infection;
• gap analysis on IPC implementation measures against multidrug-resistant gram-negative bacteria;
• behaviour change, including courses;
• IPC text books/manuals;
• surveillance;
• IPC competences/training/curricula (including videos and e-learning tools);
• surgical site infection prevention;
• an action compendium for implementation;
• antibiotic stewardship;
• multidrug-resistant laboratory and technology aspects;
• a roadmap for AMR and local indicators;
• new technologies;
• outbreak, laboratory and tracing systems/support;
• research working groups.

Some organizations described the different countries/regions their work is supporting or, for example, how many international members they reach in their societies. This demonstrates the leadership and strength of GIPCN and what the organizations bring to global IPC improvement.

Remarkable opportunities for synergies were evident in the context of some of the topics presented. Everyone concurred that such updates are extremely helpful and it was agreed that the PowerPoint slide sets from the presentations would be shared.

Points discussed during this agenda item also included:
• a proposal to map training resources and projects to inform discussions on promotion by the Network and possible collaborations in order to prevent duplication of effort;
• the concept of IPC certification and the usefulness of establishing a mechanism for international certification to support countries, which still do not have a national one;
• “link nurses” or other IPC link professionals is a model that could still support different health care settings – we need to all consider how to continue to motivate people to take on IPC;
• it would useful to share translated materials as this is a huge (and costly) task and some organizations have materials in other languages given that they support different countries;
• it was highlighted that the “right people around the table” to achieve culture change in all countries is critical;
• it was noted that GIPCN participants are mainly IPC technical experts and input from other disciplines may at times be necessary;
• demonstrable leadership by all can create the right culture going forward; we all should be role models. We should all learn how to better sell the message of IPC to make it more attractive. It was acknowledged that hand hygiene campaigning is a good example, although challenges remain;
• IPC messages must be more engaging, their tone can be patronizing and “turn off” clinicians; IPC leads need to appreciate more the pressure other health professionals are under to embed IPC in practice – diplomacy was highlighted, as was breaking down silos;
• JS specifically noted the role of policy briefs and how they can influence and ensure IPC exists in the minds of decision makers – we should all be working together to achieve IPC integration in country priorities around safe, quality health systems;
• finally, a discussion on punitive versus incentive approaches ensued and it was noted that different countries and cultures will respond to
different approaches, so one recommendation may not be suitable unless more research is available.

The WHO regional focal points contributed to the discussion by providing additional important comments on regional activities including the need for sharing solutions to convince many different stakeholders and audiences, including doctors, of the need for IPC actions, for example, more surveillance, and inter-sector communications.

BA concluded that our ongoing challenge remains that people still believe that HAI are unavoidable – an issue that must be addressed.

**DISCUSSION ON THE REVISED TERMS OF REFERENCE FOR GIPCN**

CK led the discussion on the TOR that had been shared prior to the meeting, noting the changes made to the original GIPCN TOR. It was clearly noted that the existing TOR have already been approved by WHO Legal Counsel in order for the GIPCN entity to exist and, therefore, it would be important to maintain the overall structure and content. Key comments from participants were recorded during the discussion. Individuals can agree to participation in GIPCN on behalf of an organization, but it should be clear that the organization knows about the role of GIPCN and participation can be sustained. It was noted that the TOR should reflect a more active than passive approach to collaborative working. It was highlighted that if a GIPCN work plan could be developed, it could include a detailed description of work, rather than making major changes to the existing TOR. Among the objectives, it was noted that there were too many focused on support to outbreaks and merging these into one or maximum two was recommended. A discussion ensued regarding recruitment and approval of any new participating organizations, with WHO confirming that clarification on this point will be included in the revised TOR. The proposed approach is that GIPCN participants should be informed and involved in such decision making. It was noted that keeping the group small would keep it manageable and more productive. Any risks related to participation and outputs should be able to be explained. As noted in the TOR, BA reiterated that WHO does not conduct quality control or take responsibility for any statements made by participating organizations as they do not speak on behalf of WHO. SE contributed information on how decisions were made previously regarding GIPCN participation.

Based on these comments, a plan was outlined to undertake some revision, finalize the TOR and share once again with the GIPCN participants for final agreement.

CK then provided a brief summary of day 1 and the meeting was closed for the day.
Day 2 was opened again by SLD who made key statements on the following:

- universal health coverage is a priority;
- IPC must be seen as a part of quality and safety going forward – shift our language to show that IPC is a true dimension of this and use the experiences of quality leads who have championed IPC as a leading example;
- closer alliances could be beneficial;
- the value of bi-directional approach should be made clear to all;
- IPC has a “visible face” and this is a positive factor.

Participants were then asked to undertake an exercise to consider priorities and principles for IPC improvement going forward, both in LMIC and high-income countries.

**OUTLINE OF IPC GLOBAL PRIORITIES AND RECOMMENDATIONS AS NOTED BY GIPCN**

Participants split into small groups and undertook a short exercise using prompt questions circulated by WHO staff with a focus on the identification of IPC priorities for the global agenda and for countries in the next five years. The outcome of this important discussion was reported to the plenary.

In addition to group feedback, WHO regional focal points were given the opportunity to provide their views on the global IPC agenda priorities. Comments ranged from aiming to support IPC at its infancy stage in some countries to advanced innovations to ensure accountability, technology and culture change.

A summary of the key points highlighted by the groups follows:

- availability of resources where they are lacking;
- establishment and execution of IPC programmes where they are lacking;
- demonstrable commitment to IPC, particularly at political and senior executive levels;
- consideration to advanced and connected informatics tools;
- IPC as a quality indicator with clear accountability;
- improved education and training;
- stronger networks and communications;
- enhanced data collection and presentation in support of implementation;
- a clear IPC research and development agenda, fit for purpose and in support of the SDGs to be delivered by 2020.

The participants agreed that the publication of a statement from GIPCN could support the points collated to some extent and would serve as a call to action, particularly in support of the implementation of IPC core components. SLD
noted other situations where this had happened, including “declarations”. The target audience for the publication should be considered in order to achieve the greatest impact.

**IPC CHALLENGES AND SOLUTIONS**

BA then stimulated the participants to finally consider any outstanding points on IPC challenges and solutions in order to further outline what might shape WHO work and the collaborative working of GIPCN. While more challenges than solutions were shared, the following list provides points presented and questions worthy of consideration:

- different audiences need to be targeted – have champions in different disciplines;
- ongoing financial challenges – convince politicians and senior management that IPC is cost-effective – we have to make them listen – speak “safety and quality” language;
- lack of data on the cost of HAI, including in LMIC, leading to financial challenges (it was noted that the Pan American Health Organization is about to publish a short report on the cost of HAI in that region, as well as a recent report from the United States of America describing a US$ 100,000 input to improvement with achieved savings of US$ 300,000);
- key groups with whom IPC can partner should be a priority, for example, quality and safety – it is the patient that matters;
- could collaborative working achieve an IPC recognized certification following training?;
- ongoing challenge of health worker attitudes and lack of awareness of infectious harms – starting in medical schools was noted as a potential solution;
- multidisciplinary team work is still a challenge;
- lack of harmonization and standardization of IPC principles and approaches in training around the world as IPC training is provided by different organizations, including non-governmental organizations and private providers. One solution to consistent standards might be for GIPCN members to work more closely or even partner in the development of training resources;
- educating the public would be beneficial for the understanding of IPC concepts in general and also specifically applied to health care;
- more learning from a wider range of country examples would be beneficial, for example, their use of tools from sociology, social science, etc.

**TOP RESEARCH AND EVIDENCE-BUILDING PRIORITIES FOR IPC**

Participants further discussed research priorities. While much research on IPC is available, it’s progress should be better focused, including better quality
outputs, to address ongoing challenges and emerging threats, and not repeat what is already known in this field. The following research and evidence-building priorities were identified:

- **impact of interventions on HAI, AMR and behaviour change and on policy making, including local solutions and cost-effective interventions for low resource settings;**
- **the achievements and challenges in implementing IPC core components and the role of IPC within antibiotic stewardship;**
- **demonstration and impact of integrating IPC with patient safety, quality, water, sanitation and hygiene, the built environment and emergency response programmes;**
- **economic data on IPC effectiveness and understanding the role of big data in future economic analyses/reports;**
- **cost and clinical effectiveness of decision support technology, augmented reality, reminders.**

**OUTLINE OF COLLABORATING WORKING METHODS**

CK presented information on how GIPCN had worked in the past and posed questions on what participating organizations would like to happen now. SE contributed information on the previous online platform.

In summary, the discussion led to the following agreed points for future perspective and way of working together:

- sharing of products and information would be helpful for all organizations to refer to;
- at times, opening up the platform to others might be useful and necessary for progress;
- a calendar function would be useful to understand when participating organizations will be present at the same events/conferences;
- sub-groups for working on key topics might be necessary (“IPC training and education” was identified as the first priority topic);
- a map or visual of roles of different WHO groups involved in IPC or related areas and how they link would be helpful.

There were two contrasting views noted overall; (1) we should start the journey of interaction and sharing again now to see how GIPCN might progress collectively; and (2) only sharing and talking could waste some time, while a focus on producing one product together could be more helpful to global IPC. Finally, it was noted that it could be helpful to map the work of participating organizations in countries in order to understand where collaborations could be potentially established and where progress is being made, including where there might be relevant gaps to address.
CLOSING REMARKS

BA and CK thanked everyone for their attendance and contribution and highlighted key contributions from SE, NS and WHO regional focal points.

BA noted the next steps that had emerged from the meeting. Importantly, she also highlighted that coordination and input takes time and money, which needs to be considered when going forward. Sharing between participants of the Network is already evidenced and valuable and should not be belittled. BA outlined the forthcoming ICPIC meeting in Geneva and CK the call to action for the annual 5 May WHO SAVE LIVES: Clean Your Hands campaign. BA asked all participants to communicate back to their host organizations and other partners and to consider any donor organizations that could support future IPC global work.

SUMMARY OF NEXT STEPS

- Reissue of TOR (with revision of the points discussed at the meeting) for all participating organizations to agree to by return of email to WHO.
- GIPCN to continue to support 5 May WHO SAVE LIVES: Clean Your Hands campaigning,
- A plan for ongoing communications, including the use of an online platform to be presented.
- A plan for meeting again at the ICPIC meeting in June 2017.
- Future mapping of the reach and expertise available within the GIPCN, as well as gaps to be considered.
- A short draft paper on IPC global priorities, challenges and recommendations to be presented to GIPCN based on the meeting discussions, together with a plan for submission to a scientific journal.
## ANNEX 1: MEETING AGENDA

Infection Prevention and Control Global Unit, WHO

WHO Global Infection Prevention and Control Network Meeting

**WHO, Geneva, Switzerland**

**Salle D**

### Day 1, Monday, 27 February 2017

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<td>11.45-12.30</td>
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<td>12.30-13.30</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>13.30-15.15</td>
<td>Presentations from participants focused on institution IPC priorities of work and discussion</td>
<td>All</td>
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<tr>
<td>15.15-15.30</td>
<td><strong>Break</strong></td>
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<tr>
<td>15.30-16.45</td>
<td>Presentations from participants focused on institution IPC priorities of work and discussion</td>
<td>All</td>
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<tr>
<td>16.45-17.15</td>
<td>Overview of the revised Terms of Reference for the Network and discussion</td>
<td>All (facilitated by C. Kilpatrick)</td>
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<tr>
<td>17.15-17.30</td>
<td>Closure of day 1</td>
<td>C. Kilpatrick</td>
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<tr>
<td>19.00</td>
<td>Dinner</td>
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</tbody>
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### Day 2, Tuesday, 28 February 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter(s)</th>
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<tr>
<td>08.30-08.45</td>
<td>Welcome and recap on day 1</td>
<td>Chair</td>
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<tr>
<td>08.45-10.30</td>
<td>Discussion on current priorities for the global IPC agenda</td>
<td>All (facilitated by B. Allegranzi)</td>
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<tr>
<td>10.30-10.45</td>
<td><strong>Break</strong></td>
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<tr>
<td>10.45-11.30</td>
<td>Discussion on challenges and potential solutions within the framework of GIPCN</td>
<td>All (facilitated by B. Allegranzi)</td>
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<tr>
<td>11.30-12.45</td>
<td>Agreement on priorities for work and on plans for future collaborative methods of working</td>
<td>All (facilitated by C. Kilpatrick)</td>
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<tr>
<td>12.45-13.00</td>
<td>Closing remarks</td>
<td>B. Allegranzi, N. Shindo</td>
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</tbody>
</table>
ANNEX 2: LIST OF PARTICIPANTS

American University of Beirut Medical Centre (Southa Kanj)

Association for Professionals in Infection Control and Epidemiology (APIC) (Katrina Crist, Linda Greene)

Baltic Antibiotic Resistance collaborative Network (BARN) (Birgitta Lytsy)

Centers for Disease Control and Prevention (CDC), USA (Neil Gupta, Alex Kallen)

National IPC programme, Ministry of Health, Chile (Mauro Orsini)

European Committee on Infection Control (EUCIC) and European Society of Clinical Microbiology and Infectious Diseases (ESCMID) (Nico Mutters)

European Network to Promote Infection Prevention for Patient Safety (EUNETIPS) (Silvio Brusaferro)

Infection Control Africa Network (ICAN) (Shaheen Mehtar, Folasade Ogunsola, Babacar Ndoye)

Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh (M Mushtuq Husain)

International Federation of Infection Control (IFIC) (Terrie B. Lee)

Jhpiego - an affiliate of Johns Hopkins University, USA (Chandrakant Ruparelia)

Médecins sans Frontières (MSF) (An Caluwerts)

Ministry of Health, Kingdom of Saudi Arabia (Ahmed M. Hakawi)

National Centre for Infectious Diseases, Tan Tock Seng Hospital, Singapore (Marimuthu Kalisvar)

North Western State Medical University, Russian Federation (Batyrbek Aslanov, Anna Lubimova)

OASIS Global, USA (Joe Solomkin)

Public Health Agency of Canada (Katherine Defalco)

Society for Healthcare Epidemiology America (SHEA) (Nalini Singh)

School of Nursing, University of Sao Paulo, Brazil (Maria Clara Padoveze)
Tohoku University, Japan (Mitsuo Kaku)

WHO Collaborating Centre for Infectious Disease Epidemiology and Control, China (Wing Hong Seto)

WHO Collaborating Centre for IPC and AMR, Ministry of National Guard Health Affairs, Kingdom of Saudi Arabia (Hanan H. Balkhy)

WHO Collaborating Centre, Infection Control Unit, US Naval Medical Research Unit, Egypt (Maha Talaat)

WHO Collaborating Centre on Patient Safety, University Hospitals of Geneva, Switzerland (Mohammad Abbas on behalf of Didier Pittet)

WHO Collaborating Centre for Reference and Research in AMR, Public Health England (Nandini Shetty)

**WHO Regional Focal Points**

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Giorgio Cometto
Health Workforce

Jérôme Delauzun
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Service Delivery and Safety

Sir Liam Donaldson
WHO Patient Safety Envoy

Sergey Eremin
Antimicrobial Resistance Surveillance

Lindsay Grayson
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Service Delivery and Safety

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Nikki Shindo
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Anthony Stewart
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Service Delivery and Safety
Sara Tomczyk
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Service Delivery and Safety

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