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International meeting on the global action plan and monitoring framework for infection prevention and control
16-18 May 2023
Movenpick Hotel, Geneva, Switzerland, and online

Meeting Report

Executive Summary

The meeting was convened as part of the follow-up to the resolution on infection prevention and control (IPC) agreed by the World Health Assembly in 2022. The resolution called for a global strategy on IPC (GSIPC) in healthcare settings accompanied by a global action plan, including a framework for tracking progress, with clear measurable targets to be achieved by 2030. The draft GSIPC, developed after widespread consultation, was approved by the World Health Assembly in 2023.

The principal objective of the meeting was to gather inputs from participants for the development of key elements of the global action plan (GAP) and its monitoring framework (MF). Participants included members of the Global IPC Network (GIPCN), representatives from all three levels of WHO, and country representatives. The meeting sought to gather strategic directions for the effective implementation of the GSIPC, the GAP and the MF, including key indicators.

In addition, the meeting discussed how to strengthen and plan WHO work on IPC in public health emergencies and training and education. This session was convened by the IPC in Public Health Emergencies Working Group to define priorities for activities up to December 2024 in relation to:

- Timely advice for emerging threats
- Development and dissemination of rapid advice and guidance
- Communication and collaboration across networks
- Research priorities for emerging threats.

The agenda of the meeting was built around the eight strategic directions outlined in the GSIPC:

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<tr>
<th>1. Political commitments and policies</th>
<th>5. Data for action</th>
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<td>2. Active IPC programmes</td>
<td>6. Advocacy and communications</td>
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Participants split into working groups for each strategic direction to identify possible elements of the GAP including clear actions to be planned, the roles and responsibilities of different actors and resource requirements. Each working group reported back their findings to the plenary meeting for wider discussion. The process was then repeated for the development of the MF, where the working groups were asked to suggest key monitoring indicators, targets and timelines for their achievement.
The discussions on the GAP for each strategic direction were necessarily wide-ranging and difficult to summarize. **Figure 1** in the report provides an initial summary of the proposed global and national actions for each strategic direction.

As regards the MF, and the choice of key targets and indicators, the working groups made suggestions but there was also much discussion in plenary sessions of the extent to which use could be made of existing indicators relevant to IPC to avoid unnecessary duplication. **Box 1** contains a list of some possible candidates. Of these it was felt that those for TrACCS and the indicators tracked through the self-reporting and joint external evaluations under the auspices of the International Health Regulations, as well as data collected biennially on WASH standards in healthcare facilities under the WHO/UNICEF Joint Monitoring Programme, were likely most relevant.

Discussion also focussed on whether the targets to be set for 2030 should be related to what would be considered realistic judged by rates of progress so far achieved, or whether they should be aspirational. For example, the 2022 WHO Global Report on IPC estimated that only 3.8% of countries met all the minimum IPC requirements established by WHO. Realism would suggest that a target of 75%, or even 100%, of countries reaching minimum standards by 2030 was unattainable. The counterargument was that a global plan, endorsed by Member States, should not set targets that countenanced most countries failing to meet what were regarded by WHO as **minimum standards**. This would also be consistent with the vision of GSIPC that “By 2030, everyone accessing or providing health care is safe from associated infections”.

In the concluding part of the meeting, Benedetta Allegranzi (WHO Technical Lead, IPC Hub) outlined the next steps in the development of the GAP and MF involving several consultations such as those used to develop the GSIPC as well as a Delphi survey. The aim was to complete a draft by October 2023.

The meeting was closed by Bruce Aylward (WHO Assistant Director-General, UHC/Life Course Division) and Mike Ryan (Executive Director, WHO Health Emergencies Programme). They noted that the COVID pandemic had made this an opportune moment to raise the profile of IPC and the importance of strengthening routine IPC as a matter of pandemic preparedness and response but also to promote universal health coverage and primary health care. They also expressed their support for ambitious targets to meet minimum IPC standards.

**Background**

The gaps in infection prevention and control (IPC) programmes and practices highlighted by the catastrophic impact of the COVID-19 pandemic resulted in Member States agreeing a resolution on infection prevention and control at the Seventy-Fifth World Health Assembly.\(^1\)

The resolution called on Member States to focus on thirteen key points to improve IPC in line with WHO’s recommendations for core components of IPC programmes.\(^2\) It also requested the Director-General to develop, in consultation with Member States and regional economic integration organizations, a **draft global strategy** on IPC (GSIPC) in both health and long-term care settings, for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152\(^{nd}\) session.

Further, it asked the Director-General to translate the global strategy into an action plan for IPC, including a framework for tracking progress, with clear measurable targets to be achieved by 2030 for consideration by the Seventy-Seventh World Health Assembly in 2024, through the Executive Board at its 154th session. Thereafter the Director-General should report on progress and results to the World Health Assembly every two years until 2031.

In response to the resolution, building on the content of the WHO report on minimum requirements for IPC programmes, the recent WHO global report on IPC, the Secretariat developed a draft GSIPC. The draft GSIPC was developed in close consultation with Member States’ national focal points and/or delegates responsible for IPC across all three levels of WHO (headquarters, country and regional offices) and with those responsible for antimicrobial resistance (AMR), health emergencies, the health work force, patient safety, primary health care, quality of care, water, sanitation and hygiene (WASH), and occupational health and safety. Members of the Global IPC Network (GIPCN) and civil society, together with other international experts, were also consulted. Two global meetings with these stakeholders and three global consultations with Member States were held between June and October 2022. All regional offices gathered specific input from Member States through either bilateral meetings or four regional consultations. After this meeting, the strategy was approved by the Seventy-sixth World Health Assembly.

About the Meeting
The objectives of the meeting were:

- To gather inputs from GIPCN members, country ministry representatives and WHO professionals for the development of the key elements of the WHO global action plan (GAP) and monitoring framework (MF) for IPC;
- To strengthen and plan WHO work on IPC in public health emergencies and IPC training and education, in collaboration with the GIPCN;
- To gather strategic directions for effective implementation of the IPC global strategy, global action plan, and monitoring framework, including key indicators, from all participants and WHO leaders.

Participants at the meeting included a wide range of stakeholders from all three levels of WHO, ministries of health, members of the GIPCN and civil society. The meeting was hybrid with 56 attending in person and 28 online. A list of participants is in Annex A. The agenda of the meeting is in Annex B.

Session 1. Update on the global strategy and introduction to the development of the global action plan and monitoring framework for IPC

After introductory remarks by Hanan Balkhy (Assistant Director-General (ADG) for Antimicrobial Resistance) and Rudi Eggers (Director, Integrated Health Services (IHS)), Benedetta Allegranzi (Technical Lead, IPC Hub and Taskforce, IHS) introduced the chairs

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and participants. Nita Bellare (Project Manager, IPC Hub) then outlined the meeting objectives and the logistics and processes to be used in the meeting to achieve the objectives.

**Development of the GSIPC**

The meeting was updated on the progress to date on the development of the global strategy on IPC by Paul Rogers (Programme Manager, IPC Hub). He noted the comments made by the Executive Board in adopting the WHO GSIPC\(^7\) and then outlined the **guiding principles** underpinning the development of the strategy:

| 1. IPC across the continuum of the health system | 6. Equity-driven |
| 2. People-centered approach | 7. Evidence-informed |
| 5. Clean and safe care as a human right | 10. Accountable |
| | 11. Sustainable. |

Paul Rogers also reviewed the **vision** for the strategy which should apply irrespective of the reason for care, the epidemiological context, or the nature of the healthcare setting:

**By 2030, everyone accessing or providing health care is safe from associated infections.**

The GSIPC **target audience** was stated to be:

1. **Leaders – political and government and health care leaders**
   Government officials, political and health care leaders and policy makers at ministries of health finance, labour, environment, and education; accreditation and health regulatory bodies; and senior managers responsible for planning and budgets.

2. **IPC and other focal points/leaders**
   IPC focal points (ministry of health, public health and other national institutes). Focal points responsible for patient safety and quality of care, AMR, occupational health, WASH, International Health Regulations, and One Health.

3. **All health and care workers**

4. **Educational institutions and professional and scientific organizations, societies, unions**

5. **General Population/Community**
   Including civil society, patient and family networks, labour unions and advocacy groups.

6. **Key stakeholders and donors**
   United Nations agencies, GIPCN members, partners, nongovernmental organizations, faith-based organizations, and others.

7. **Media and communication professionals and bodies**

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\(^7\) EB 152(7). Draft global strategy on infection prevention and control. 2 February 2023. [https://apps.who.int/gb/ebwha/pdf_files/EB152/B152(7)v2-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB152/B152(7)v2-en.pdf)
The overall objectives of the GSIPC (Prevent, Act, Coordinate) are summarised in the diagram below:

**GSIPC Objectives**

1. Prevent infection in health care
2. Act to ensure IPC programmes are in place and implemented
3. Coordinate IPC activities with other areas & vice-versa

**Prevent, Act, Coordinate**

The eight strategic directions provide the guiding framework for global and country actions to implement the strategy:

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<th>Eight Strategic Directions</th>
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<td>1. Political commitments and policies</td>
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**Discussion**

It was noted that there was an absence of career pathways in IPC, particularly for doctors. To achieve change, a formal recognition and accreditation process for an IPC professional was needed. In terms of indicators and targets, there were a number of those related to IPC in various current strategies. Their coherence needed to be addressed. Developing a convincing business case for IPC which could be summarised in a short document accessible to policymakers was very important in gaining political backing for IPC. While improving IPC in healthcare facilities was very important, it was important not to neglect IPC in communities. COVID-19 had demonstrated the close interconnection between what happened in healthcare facilities and communities.

Benedetta Allegranzi then outlined ideas on how to translate the global strategy into a plan of action and monitoring framework. She described a methodology based on the theory of change requiring the **identification of interventions** that could bring about a desired change while making explicit the **key assumptions and risks** that might affect the outcome. She also explained that the eight strategic directions of the GSIPC will be the foundations for discussing the content of and developing the IPC global action plan (GAP) and monitoring...
framework (MF). In particular, these will be based upon the following five aspects to be identified for each strategic direction:

1. Clear actions to be planned
2. Roles and responsibilities
3. Resources needed
4. Monitoring indicators
5. Targets and related timelines.

To close the session, April Baller (IPC team lead, WHO Health Emergencies Programme) set out the framework for IPC in outbreak preparedness and response. She focussed on the lessons learnt from COVID-19 and the work being done to provide a framework and a toolkit to strengthen national readiness and response capabilities. In discussion, the desirability of working closely with the WASH\(^8\) agenda was emphasized, because of its strong enabling role in promoting IPC in health care directly, and through reducing infections in the community. It was also noted that the distinction between emergency and non-emergency was becoming blurred with the more frequent occurrence of the former and this needed to be factored in to plans.

**Session 2. Development of the global action plan and monitoring framework for IPC**

Lindsay Grayson (senior advisor, IPC hub) presented the details related to the first four strategic directions which were indicated as the focus of the following working groups to develop key actions for the GAP and indicators and targets for the monitoring framework (MF). He reminded participants the five key aspects necessary for each strategic direction (clear actions to be planned; roles and responsibilities; resources needed; monitoring indicators; targets and timelines).

**Discussion**

Participants noted that strong regulatory authority was needed to embed IPC in working practice – for instance in imposing penalties on facilities for not complying with hand hygiene rules. But often regulation was weak in sanctioning non-compliance, partly because the sanction might mean, for example, closing beds in already overstretched facilities. The other challenge was, partly because of the lack of IPC content in medical training, many healthcare workers neglected IPC. Younger staff might be more aware but might lapse in the face of a culture amongst their seniors inimical to good IPC. To change the culture, patient safety needed to be accorded a much higher priority by senior doctors and managers as a metric in quality care, and IPC in undergraduate and postgraduate curricula needed strengthening.

**Methodology for the working groups**

Each of the four working groups was assigned a chair and a facilitator from outside WHO; in-person participants chose which group to join whereas online participants were assigned to a working group by the organizers. In two sessions of 1.25 hours, one covering the GAP components and one the MF targets and indicators, the groups worked to populate templates with their proposals on each of the five key components for strategic directions 1-4. This exercise was then repeated on Day 2 for strategic directions 5-8. After every working group session, they each reported back their findings to the plenary for a general discussion over another 1.25 hours.

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\(^8\) Water, Sanitation and Hygiene.
**Actions for Strategic Directions 1-4: Feedback**

**Strategic Direction 1: Political Commitments and Policies**

The group emphasised the need to demonstrate the economic case for IPC, globally and nationally, to mobilize political commitment. At the global level high-level commitment could be demonstrated through, for example, a UN General Assembly agenda item. IPC should be appropriately included in amendments to the International Health regulations (IHR) and in a new pandemic instrument. At national level, there should be a national IPC strategy with a dedicated budget and a review of existing legal and regulatory provisions to identify gaps.

In discussion, the difficulty of defining the cost of IPC in relation to building the economic case, was raised. It was proposed that the number of countries meeting minimum requirements as proposed by WHO should be utilized as indicators – for instance, in this context, the proportion of countries with a dedicated IPC budget. It was noted that a dedicated budget did not necessarily mean a sufficient budget – there needed to be a way to assess this qualitatively.

**Strategic Direction 2: Active IPC Programmes**

The group proposed the following actions at national level including dedicated and funded IPC programmes at healthcare facilities at all levels; development of national IPC action plans; a research framework to clarify core IPC questions; a supportive legal and regulatory framework; inclusion of IPC in preparedness and response for emergencies; developing norms and standards for the enabling environment for IPC such as infrastructure and supplies and a monitoring framework to track progress.

The point was again made that progress could be measured by the number of countries meeting minimum requirements, which had not been discussed by the group.

**Strategic Direction 3: IPC Integration and Coordination**

The group considered that IPC needed to be integrated and coordinated across diverse fields and policies including AMR, patient safety, One Health and emergencies. How that could be done related to appropriate governance structures and the avoidance of silos. IPC needed to be integrated in all policies. It recommended a national coordinating and oversight committee, with “teeth”.

The issue of supply chain management was discussed. A problem was to generate a common understanding of what IPC entailed.

**Strategic Direction 4: IPC Knowledge of health and care workers and career pathways for IPC professionals**

The group proposed the development of core IPC knowledge for all healthcare workers which should be integrated in pre-graduate educational programmes. There should be allocated slots for IPC education in academic courses. Attention should also be paid to educating the general population through schools and by other means. For postgraduate training, there should be a programme and curriculum for IPC professionals. IPC professionals should be recruited from more diverse backgrounds. There should be provision for refresher training to maintain expertise.

In discussion, there was a question as to whether the emphasis for healthcare workers should be embedding competences - it was not just about IPC in curricula. In assessing quality there was a debate about accreditation and the problems experienced by many countries in
maintaining accreditation standards. Was there a role for WHO in setting standards? The need for recertification was mentioned because the field was advancing rapidly.

Indicators

Benedetta Allegranzi surveyed the use of indicators. We need them to measure progress, inform decision making, improve performance and support resource allocation. She defined various kinds of indicator – for example to define inputs, processes, outputs or ultimate impact – and various kinds of targets that could be set. She suggested that good indicators should have relevance, validity, sensitivity, feasibility, availability and actionability.

To facilitate the groups’ work on indicators in the MF, Anthony Twyman (Consultant, IPC Hub) mapped existing indicators on IPC from other relevant initiatives in the interests of avoiding unnecessary duplication. (See Box 1).

Box 1

Some Existing IPC Indicators

Target 3 of the Sustainable Development Goals (SDGs) - Ensure healthy lives and promote well-being for all at all ages – contains an indicator (3.d.2):

Percentage of bloodstream infections due to selected antimicrobial-resistant organisms.

Participants noted that IPC required coverage of all infectious organisms, whether resistant or not.

SDG Target 6 on water and sanitation contains an indicator on the proportion of population using safe sanitation and a hand-washing facility with soap and water. But there is no specific reference to health facilities.

The WHO/UNICEF Joint Monitoring Programme has defined global indicators for water, sanitation, hand hygiene, cleaning and health care waste in healthcare facilities for which global reports and databases are updated every 2 years. More details are available at https://washdata.org/monitoring/health-care-facilities.

Objective 3 in the Global action plan on AMR has a specific IPC indicator ranking countries on five levels (A-E) ranging from having no IPC programme to one conforming with WHO core components guidelines. The FAO, OIE, WHO Tripartite Antimicrobial Resistance Survey (TrACSS) includes a section dedicated to IPC in its self-assessment survey. Details at:


Similar indicators (ranked 1-5) are used in the States Party self-assessment annual reporting tool (SPAR) and Joint External Evaluations (JEE) under the International Health Regulations. These also include five level indicators relating to the quality of surveillance of health care-associated infections and the safety of the health facility environment. Details are at:

https://cdn.who.int/media/docs/default-source/health-security-preparedness/cap/spar/9789240040120-eng-new.pdf?sfvrsn=5dc09bd9_3

The Global Patient Safety Action Plan has a Strategic Objective 3 where the indicator is the percentage of countries that have achieved their national targets on reducing the health

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Indicators and Targets for Strategic Directions 1-4: Feedback

**Strategic Direction 1: Political Commitments and Policies**

The group focused on the need to achieve high level political commitment to IPC, by building the economic case for IPC. A global indicator could be a special UN General Assembly meeting on IPC. Discussion focused on the need for national IPC plans, and whether it was possible to have a defined national IPC budget, given the variety of funding sources for IPC. In addition, there was a need to define what was a sufficient budget for IPC to fund the national plan, not just that a budget existed. The need for appropriate legislative and regulatory measures nationally was also highlighted. There was discussion about finding the appropriate balance between the “carrot and the stick” to incentivise good IPC behaviours.

**Strategic Direction 2: Active IPC Programmes**

Feedback focused on whether the targets proposed for IPC programmes (75% of countries at Level 4 by 2030) was realistic or whether it should be differentiated by country income levels. The issue was to strike the right balance between setting aspirational or more realistic targets. Another approach could be to set targets for a reduction in the number of countries that are at levels 1 and 2. It was also argued by Benedetta Allegranzi that a better approach might be to focus on the proportion of countries meeting the minimum requirements.

**Strategic Direction 3: IPC Integration and Coordination**

The group proposed indicators for the national mapping of IPC, and the establishment of a national IPC coordination committee and to include IPC in all policies. In discussion, it was mentioned that IPC should be represented in disease programmes such as for malaria, tuberculosis and HIV. It was proposed that a national glossary should be created so that there was a common understanding within and across sectors of what IPC entailed. It was important to involve and educate politicians in this area.

**Strategic Direction 4: IPC Knowledge of health and care workers and career pathways for IPC professionals**

The group proposed at national level the development of core IPC knowledge for all healthcare workers to be integrated in pre-graduate educational programmes. Indicators would include the presence of IPC competences in existing programmes plus a possible new indicator on compliance with core competences. There should also be an indicator responding to the call for a WHO policy document on core competences. And another indicator for evaluating the quality of IPC education and training. A question was whether the IPCAT indicators were fit for this purpose or whether new ones needed to be identified.

In discussion, the decline in the number of accrediting institutions for national IPC training was noted. These were a necessity in maintaining quality. An indicator might be the number of countries having such institutions. In this field there needed to be collaboration between ministries of Education and Health. Should one indicator be an accredited curriculum for each of pre-graduate, in service and postgraduate training? It was noted that a curriculum as such might not be appropriate for in-service training – it was more about ensuring core knowledge and competences. Consideration should also be given to regular certification of IPC trainers because the field was dynamic.

**Actions for Strategic Directions 5-8**
Lindsay Grayson described the issues in developing actions and indicators and targets for strategic directions 5-8. In discussion, the point was raised, regarding advocacy and communications, that while differences in the professional community were understandable, COVID-19 had demonstrated the importance of providing the public with a consistent message and combatting the large quantity of misinformation that had emerged in social media and elsewhere. The importance of involving patients alongside professionals in developing consistent messaging was also emphasized. Another comment was the lack of research during the pandemic on transmission dynamics – this was important alongside operational research.

**Actions for Strategic Directions 5-8: Feedback**

*Strategic Direction 5: Data for action*

The group concentrated on data relating to core components 4 and 6 on healthcare-associated infections (HAI) surveillance and monitoring, audit and feedback. There was a discussion about the desirability of sharing data globally, but there were several reservations concerning the variability in data quality and concerns about sharing potentially sensitive data. There were currently two systems collecting relevant data for global comparisons, but many believed that the main purpose of data collection should be to improve performance at national and local level facilities. In Australia, the sharing of data on hand hygiene was approached sequentially and voluntarily – mandatory sharing of sensitive data would have been strongly resisted initially – but was later enforced in a collaborative manner. It might be necessary to consider how governance might be improved to encourage more data sharing. One comment was that the actions proposed by the group were a bit vague and there needed to be a bit more emphasis on how things could be achieved at a practical level.

*Strategic Direction 6: Advocacy and communications*

The group suggested creation of a global advocacy strategy to build champions among leaders; support for the development of a national strategy; addressing misinformation and building capacity for IPC professionals. The discussion started with a question about WHO’s communications. The importance of crafting the right message for diverse audiences was emphasized and contextualizing the way the information is communicated. The pandemic had heightened the importance of communications in, for instance, messaging about new guidelines or new risks identified as well as the need to counter misinformation.

*Strategic Direction 7: Research and development*

The group suggested a research gap analysis to identify research priorities; methods development; funding mechanisms; pandemic preparedness research and several other actions. In discussion, the importance of doing research on converting single-use to multiple-use devices was mentioned. It was noted that the potential research agenda on IPC was extremely large, and that work needed to be done, perhaps through economic modelling, to identify the highest priorities in terms of potential return. The plea was also made for the inclusion of behavioural science and the use of transdisciplinary research teams to address IPC. Similarly, consideration needed to be given to multi-sectoral research – for example how the built environment can impact IPC.

*Strategic Direction 8: Collaboration and stakeholders’ support*
The group proposed at the global and national levels mapping all potential partners and engaging with them to learn the lessons learned from previous outbreaks and establishing coordinating mechanisms. There was no significant discussion.

**Indicators and Targets for Strategic Directions 5-8: Feedback**

*Strategic Direction 5: Data for Action*

The targets and indicators proposed included:
- Countries implementing national HAI surveillance systems – 100% by 2030
- Hospitals participating in national HAI surveillance – 75% of tertiary hospitals by 2030
- Monitoring hand hygiene compliance – 90% of countries by 2030
- *HAI survey results used to stimulate action* – 75% of countries by 2030.

The last target was added after the feedback session because of the observation that the first three indicators made no link to action. A question was raised about the realism of the targets set for HAI reduction in Strategic Objective 3 of the Global Patient Safety Action Plan and how this should be treated in the IPC action plan.

*Strategic Direction 6: Advocacy and communications*

The group proposed unspecified targets on indicators around the number of countries committed; engagement of global champions; number of countries that have an advocacy programme and the number of IPC professionals trained. A member of the working group noted that it did not contain any professional expertise on communications, and they would need to seek further input from communications professionals to strengthen the action plan and indicators.

*Strategic Direction 7: Research and development*

The group proposed establishment of an IPC global research agenda by 2026 and country-specific national IPC agendas adapted from the global research agenda perhaps two years later. There should also be a demonstration of commitment in the form of IPC representation in national and global calls for research proposals and the creation of an IPC national budget for research. A key priority was to identify the gaps in IPC research knowledge to help outline a future research plan/agenda that addressed these matters, ensured greatest efficiency, and avoided unnecessary duplication of research effort.

*Strategic Direction 8: Collaboration and stakeholders’ support*

The group included a global target for increasing the reach of GIPCN by 2030. The validity of this target was questioned as GIPCN was already open to new members and the coverage of relevant organizations was kept under review. It might make more sense to promote more partnerships both within countries (for example, between NGOs and with governments to improve collaboration and avoid duplication) and between countries (for example the joint work on IPC in West Africa after Ebola or the collaborations supported by ECDC and others in Europe on HAI surveillance). The question was also asked about the engagement of patients as partners.

**Final decision making on core indicators and targets**

Benedetta Allegranzzi introduced a discussion on selecting core/priority indicators. She highlighted the indicator used in the 2022 Global Report tracking the percentage of
countries fulfilling the IPC minimum requirements at national level (currently only 3.8%). WHO was also developing tools for monitoring facility level compliance. She proposed that there should be a global target of 75% of countries meeting minimum requirements and 75% of national health care facilities meeting minimum requirements by 2030. She noted the importance of WASH and proposed using one or more of the indicators for health care facilities used by the WHO/UNICEF Joint Monitoring Programme. She suggested that political commitment could be measured by the percentage of countries having an identified protected and dedicated budget allocated to the IPC programme (2030 target - 75%).

She then reviewed the existing indicators monitoring the implementation of IPC programmes – TrACCS and the three SPAR/JEE indicators on IPC programmes, HAI surveillance and the safe environment in health facilities. She noted that, compared to TrACCS, the latter indicators had more elements addressing preparedness. She thought targets could be set for the proportion of countries moving from lower to higher on both sets of indicators. She then noted the objective in the global action plan on AMR to reduce the incidence of infection through effective sanitation, hygiene, and infection prevention measures but there were questions about its implementability in practice. The effectiveness of the AMR-related SDG target on bloodstream infections also needed to be assessed, particularly in the wider context of IPC. She also reiterated her reservations about the practicability in the Global Patient Safety Action Plan of the IPC indicator in Objective 3.

In discussion, there was a question about the absence of baselines in meeting minimum requirements for IPC programmes. Benedetta Allegranzi explained that they planned another survey to update the current data relating to 2019 and 2021. There followed a discussion about whether the targets should be aspirational or simply pushing the boundaries of what could be considered realistic. Many participants thought was that as these were minimum standards the target should be 100% achievement by 2030 (not, for instance, 75%) in line with the vision for the global strategy that everyone should be safe from infection in health care facilities by 2030. Others thought that a degree of realism needed to be introduced in setting targets. Account should be taken of the baseline in each country – an aspirational target could be framed around percentage improvement over the baseline. Similar points were raised about the budget and WASH indicators – if the overall goal was aspirational then the target should be 100% as these were part of the minimum requirements.

Attention then focussed on the SDG and Patient Safety Action Plan targets. It was widely felt that for IPC, there should be monitoring of all bacterial infections, not just resistant ones. At the same time, the huge difficulties, financial and logistic, in collecting the data needed to be recognized. The Patient Safety target was widely thought to be unrealistic because many countries did not have adequate surveillance or had even set targets for reducing infections against which progress could be measured. It was argued that it might be better to have targets related to the establishment of a surveillance infrastructure which would help to build capacity.

To end the session, Benedetta Allegranzi outlined the next steps which would involve consultations with partners and Member States on similar lines to those used in developing the global strategy as well as a Delphi survey. The objective, driven by the tight timeline set by the resolution, was to complete a draft of the plan of action and monitoring framework by mid-October 2023.
Session 3. Activities on IPC in Public Health Emergencies (PHE) and IPC training and education

The IPC in PHE Working Group was created to enable rapid response to public health emergencies, recognizing the importance of advanced planning for preparedness and response. This session of the Working Group was convened to define priorities for 2023-2024, in the context of the development of the global action and monitoring framework for IPC.

Participants were invited to discuss gaps and priorities for activities from June 2023 to December 2024. The discussion was organized around the four objectives of the Working Group and the following points were made:

- **Timely advice for emerging threats**
  - Improve peer-to-peer communication in a safe environment for information sharing, including early sharing of information from frontline health workers with other countries to support readiness and response
  - Develop strategies to communicate when there is a lack of certainty about emerging guidance
  - Develop targeted advice addressed to the needs and perspectives of specific groups, such as politicians, families, and community members.

- **Development and dissemination of rapid advice and guidance**
  - Explore the potential of community engagement in IPC
  - Develop IPC standards for disaster responses
  - Improve approaches to create and validate living guidance documents as outbreaks evolve
  - Develop guidance to optimize the procurement of PPE and other supplies.

- **Communication and collaboration across networks**
  - Empower and institutionalize GIPCN focal persons
  - Build and expand relationship between the Working Group and other key stakeholders and networks, particularly those with specific expertise to offer
  - Expand, pool and build capacity of potential deployment resources.

- **Research priorities for emerging threats**
  - Develop a research prioritization exercise, with a particular focus on low-resource settings
  - Develop and define standing research protocols and platforms before an event happens.

The points raised in the Working Group will inform an action plan for the period, which will be further detailed and validated by the Working Group.

Session 4. Final strategic discussion on the global action plan and monitoring framework for IPC with WHO leaders

To introduce the final session Benedetta Allegranzi welcomed Bruce Aylward (WHO Assistant Director-General, UHC/Life Course Division) and proceeded to present the key elements of the GAP and MF as developed during the meeting (See Figure 1)
| Political commitment and policies | • Develop GS & GAP & MF  
• Provide cost-effectiveness data on IPC | • Develop business case for IPC  
• Include IPC within national budget for health  
• Establish legal Framework for IPC  
• Give the mandate to operate to IPC programme |
|----------------------------------|---------------------------------------------|---------------------------------------------|
| Active IPC programmes | • Develop and implement funded annual action plan  
• Develop norm and standards for enabling environment for IPC, infrastructure, supplies, health and care workers  
• Implement the IPC core components according to local priorities | |
| IPC integration & coordination | • Maintain WHO IPC Taskforces  
• Maintain 3-level working group  
• Strengthen GIPCN | • Create active multidisciplinary national IPC committee  
• Create multisectoral coordination mechanism  
• Map IPC within other areas of work  
• Consistently integrate IPC within other policies & strategies  
• Ensure inclusion of IPC programme in emergency preparedness and response  
• Develop clinical packages integrating IPC  
• Integrate IPC supplies in the national list of EM |
| IPC knowledge among health & care workers & career pathways for IPC professionals | - Develop global IPC curricula  
- Establish international IPC certificate | - Develop IPC curricula  
- Establish IPC certificate  
- Establish career pathway for IPC professionals  
- Make IPC training mandatory according to MR |
|---|---|---|
| Data for action | - Establish/strengthen **global tracking system** for IPC indicators  
- Support **HAI surveillance capacity building** incl early warning systems | - Establish/strengthen IPC monitoring and HAI surveillance systems  
- Establish specific **system for feedback and translation into action plans**  
- Integrate IPC and HAI data in **national health information and accreditation systems**  
- **Organize national training** for data collection, analysis interpretation and reporting |
| Advocacy and communications | - Develop **global advocacy strategy for IPC**  
- **Actively address** misinformation, and accuracy and consistency in communications | - Develop & implement **national advocacy strategy for IPC**  
- **Actively address** misinformation and accuracy and consistency in comms  
- Train IPC professional on **basic skills in communications** |
| Research and development | - Develop a **global research agenda for IPC**, incl pandemic preparedness and response research  
- Include IPC in calls for **research proposals**  
- Develop **standard methods/protocols** for IPC research | - Include key priorities from the GRA in **national research agenda** according to local needs  
- Include **IPC in national budget for health research**  
- Build IPC research capacity, incl transdisciplinary |
Collaboration and stakeholders’ support

- Map all partners, international org, societies incl multi-sectorial approach
- Engage stakeholders in lessons learned from previous outbreaks
- Develop coordinating mechanisms with all stakeholders and donors, incl at regional level

Benedetta Allegranzi then reiterated, for the benefit of Bruce Aylward and Mike Ryan (Executive Director, WHO Health Emergencies Programme) who joined online, the issues around the various existing indicators and next steps as discussed in her previous intervention. Bruce Aylward and Mike Ryan then introduced themselves noting, amongst other things, how the COVID pandemic made this a very opportune time to raise the profile of IPC. The pandemic had shown everybody the importance of IPC and how poor IPC can amplify epidemics, so it was important to strengthen routine IPC practices as a matter of pandemic preparedness and response.

In response to several questions, Bruce Aylward and Mike Ryan made the following points. Regarding realistic versus aspirational targets, they were very clear that if minimum standards meant what they say, then one had to go for 100% achievement. As regards attracting funding for research on IPC Mike Ryan recognized that there was an enormous agenda that could offer large benefits, in operational and other kinds of research, but it was more difficult to attract funding for this as compared to research directed at producing medicines or vaccines. “One Health” was important but was an approach, not a way of attracting funding. It was important to demonstrate that better IPC saved lives. Bruce Aylward emphasised that IPC had to be recognized as fundamental to health emergencies and to promoting universal health coverage and primary health care. He did not support regarding emergency IPC in outbreaks as a different “animal” from routine IPC in health care. However, he agreed that IPC needed to be given a higher profile in the discussions on the IHR and a pandemic instrument -- but that this was a matter for Member States not the WHO secretariat.
Annex A

List of Participants
Global Infection Prevention and Control Network (GIPCN) members

In-person attendance

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Annex B Agenda

International meeting on the global action plan and global monitoring framework for infection prevention and control

16-18 May 2023

Movenpick Hotel, Geneva, Switzerland and online

Agenda

Day 1 – 16 May 2023

<table>
<thead>
<tr>
<th>TIME (CET)</th>
<th>AGENDA ITEM</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-09:00</td>
<td>Arrival of participants and registration</td>
<td>All</td>
</tr>
<tr>
<td>09:00 – 09:15 (15m)</td>
<td>Welcome remarks</td>
<td>Hanan Balkhy, Assistant Director General (ADG), Antimicrobial Resistance (AMR) &amp; Rudi Eggers, director, Integrated Health Services (IHS), Universal Health Coverage/life Course (UHL), WHO HQ</td>
</tr>
<tr>
<td>09:15 – 09:45 (30m)</td>
<td>Introduction of the Chairs and participants</td>
<td>Benedetta Allegranzi, Technical Lead, IPC Hub and Taskforce, IHS, WHO HQ</td>
</tr>
<tr>
<td>09:45 – 09:55 (10m)</td>
<td>Meeting Objectives and housekeeping notes</td>
<td>Nita Bellare, Project Manager, IPC Hub</td>
</tr>
<tr>
<td>09:55 – 10:15 (20m)</td>
<td>Update on the status and outline of the key content WHO global strategy on IPC</td>
<td>Paul Rogers, Programme Manager, IPC Hub</td>
</tr>
<tr>
<td>10:15 – 10:35 (20m)</td>
<td>Examples and methods for the development of the global action plan and monitoring framework</td>
<td>Benedetta Allegranzi</td>
</tr>
<tr>
<td>10:35 – 10:50 (15m)</td>
<td>Coffee/tea break</td>
<td></td>
</tr>
<tr>
<td>10:50 – 11:10 (20m)</td>
<td>Framework for IPC in outbreak preparedness, readiness and response</td>
<td>April Baller, IPC team lead, WHO Health Emergencies (WHE) Programme, WHO HQ</td>
</tr>
</tbody>
</table>

Session 2. Development of the global action plan and monitoring framework for IPC

<table>
<thead>
<tr>
<th>TIME (CET)</th>
<th>AGENDA ITEM</th>
<th>SPEAKER</th>
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</thead>
<tbody>
<tr>
<td>11:10 – 11:45 (35m)</td>
<td>Presentation of the strategic directions 1-4</td>
<td>Lindsay Grayson, senior advisor, IPC Hub</td>
</tr>
<tr>
<td>11:45 – 12:00 (15m)</td>
<td>Working groups instructions</td>
<td>Benedetta Allegranzi</td>
</tr>
<tr>
<td>12:00 – 12:45 (1h)</td>
<td>Lunch</td>
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<tr>
<td>TIME (CET)</td>
<td>AGENDA ITEM</td>
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<tr>
<td>12:45 – 14:00 (1h15m)</td>
<td>Working groups on actions for strategic directions 1-4</td>
<td></td>
</tr>
<tr>
<td>14:00 – 15:15 (1h15m)</td>
<td>Reporting back and discussion on actions for strategic directions 1-4</td>
<td></td>
</tr>
<tr>
<td>15:15 – 15:30 (15m)</td>
<td>Coffee/tea break</td>
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</tr>
<tr>
<td>15:30 – 15:45 (15m)</td>
<td>Evidence on health care-associated infections (HAI) surveillance and IPC monitoring at the national level</td>
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<tr>
<td>15:45 – 16:00 (15m)</td>
<td>Evidence on HAI surveillance and IPC monitoring at the facility level</td>
<td></td>
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<tr>
<td>16:00 – 16:10 (10m)</td>
<td>Indicators and targets</td>
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<tr>
<td>16:10 – 16:30 (20m)</td>
<td>Existing IPC indicators</td>
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<tr>
<td>16:30 – 16:40 (10m)</td>
<td>Examples of accreditation indicators relevant for IPC</td>
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<tr>
<td>16:40 – 16:50 (10m)</td>
<td>Q&amp;A on presentations on evidence and indicators</td>
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<tr>
<td>16:50 – 17:30 (40m)</td>
<td>Working groups on indicators and targets for actions 1-4 (Part 1)</td>
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<tr>
<td>17:30</td>
<td>Day 1 closure</td>
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Day 2 – 17 May 2023

**Session 2 continuation. Development of the global action plan and monitoring framework for IPC**

<table>
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<tbody>
<tr>
<td>09:00 – 09:45 (45m)</td>
<td>Working groups on indicators and targets for actions 1-4 (cont.)</td>
</tr>
<tr>
<td>09:45 – 11:00 (1h15m)</td>
<td>Reporting back from working groups on indicators and targets for actions 1-4 and discussion</td>
</tr>
<tr>
<td>11:00– 11:15 (15m)</td>
<td>Coffee/tea break &amp; group photo</td>
</tr>
<tr>
<td>11:15 – 11:45 (30m)</td>
<td>Presentation of the strategic directions 5-8</td>
</tr>
<tr>
<td>11:45– 13:00 (1h15m)</td>
<td>Working groups on actions for strategic directions 5-8</td>
</tr>
<tr>
<td>13:00 – 13:45 (45m)</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:45 – 15:00 (1h15m)</td>
<td>Reporting back on actions for strategic directions 5-8 and plenary discussion</td>
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### Day 2 – 17 May 2023

<table>
<thead>
<tr>
<th>TIME (CET)</th>
<th>AGENDA ITEM</th>
<th>SPEAKER</th>
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</thead>
<tbody>
<tr>
<td>15:00 – 16:15 (1h15m)</td>
<td>Working groups on indicators and targets for actions 5-8</td>
<td>All</td>
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<tr>
<td>16:15 – 16:30 (15m)</td>
<td>Coffee/tea break</td>
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<tr>
<td>16:30 – 17:30 (1h)</td>
<td>Reporting back from working groups on indicators and targets for actions 5-8 and plenary discussion</td>
<td>All</td>
</tr>
<tr>
<td>17:30</td>
<td>Day 2 closure</td>
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<tr>
<td>18:00</td>
<td>Departure for dinner at the WHO cafeteria by public transport</td>
<td></td>
</tr>
<tr>
<td>21:00</td>
<td>Return to the hotel</td>
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### Day 3 – 18 May 2023

<table>
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<tr>
<th>TIME (CET)</th>
<th>AGENDA ITEM</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:45 – 09:45 (1h)</td>
<td>Final decision-making discussion on core indicators and targets</td>
<td>All</td>
</tr>
<tr>
<td>09:45 – 10:00 (15m)</td>
<td>Next steps for GAP &amp; MF development</td>
<td>Benedetta Allegranzi</td>
</tr>
</tbody>
</table>

#### Session 3. Activities on IPC in Public Health Emergencies (PHE) and IPC training and education

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 – 10:10 (10 mins)</td>
<td>Opening remarks for session 3</td>
<td>Nedret Emiroglu, director, Country Readiness Strengthening, WHE, WHO HQ</td>
</tr>
<tr>
<td>10:10 – 10:40 (30m)</td>
<td>Global roster of IPC professionals</td>
<td>Joao Toledo, medical officer, IPC Hub</td>
</tr>
<tr>
<td>10:40 – 10:50 (10m)</td>
<td>Coffee/tea break</td>
<td></td>
</tr>
<tr>
<td>10:50 – 12:40 (1h 50m)</td>
<td>IPC in PHE (separate agenda to follow)</td>
<td>April Baller and all</td>
</tr>
<tr>
<td>12:40 – 13:30 (50m)</td>
<td>Lunch</td>
<td></td>
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<tr>
<td>13:30 – 13:50 (20m)</td>
<td>Recap and next steps on IPC in PHE</td>
<td>All</td>
</tr>
<tr>
<td>13:50 – 15:50 (2h)</td>
<td>IPC training and education (separate agenda to follow)</td>
<td>Mandy Deeves and all</td>
</tr>
<tr>
<td>15:50 – 16:00 (20m)</td>
<td>Coffee/tea break</td>
<td></td>
</tr>
<tr>
<td>16:00 – 16:20 (20m)</td>
<td>Recap and next steps on IPC training and education</td>
<td>All</td>
</tr>
</tbody>
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#### Session 4. Final strategic discussion on the global action plan and monitoring framework for IPC with WHO leaders

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>16:30 – 16:50 (20m)</td>
<td>Summary presentation of key elements of GAP and MF to WHO HQ leaders</td>
<td>Benedetta Allegranzi/All</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Presenter(s)</td>
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</tr>
<tr>
<td>16:50 – 17:20 (30m)</td>
<td>Views and from WHO HQ leaders</td>
<td>Bruce Aylward, ADG, UHL Division Mike Ryan, Executive Director, WHE</td>
</tr>
<tr>
<td>17:20 – 17:30 (10m)</td>
<td>Closing remarks</td>
<td>Bruce Aylward and Mike Ryan</td>
</tr>
<tr>
<td>17:30</td>
<td>Meeting closure</td>
<td></td>
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</tbody>
</table>