Global action plan and monitoring framework on infection prevention and control (IPC), 2024–2030

World Health Organization

The definitive version of the global action plan and monitoring framework on infection prevention and control will be published in the official records of the Seventy-seventh World Health Assembly in due course.

Contents

Acronyms

AMR	Antimicrobial Resistance
CC	Core Components
GAP	Global Action Plan
HAI	Health care-associated infections
IPC	Infection Prevention and Control
MF	Monitoring Framework
MR	Minimum Requirements
SOP	Standard Operating Procedures;
SPAR	State Party self-assessment Annual Reporting tool
TrACSS	Global Database for Tracking Antimicrobial Resistance (AMR) Country Self- Assessment Survey
WASH	Water, Sanitation and Hygiene
WHHD	World Hand Hygiene Day

Global action plan and monitoring framework on IPC, 2024-2030

World Health Organization

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Global action plan and monitoring framework on IPC, 2024-2030

Report by the Director-General

1. In decision WHA76(11) in May 2023 the Seventy-sixth World Health Assembly adopted the WHO global strategy on infection prevention and control (IPC), whose development for both health and long-term care settings had been requested in resolution WHA75.13 (2022). In that resolution, the Health Assembly had also requested that the global strategy be translated into an action plan, including a framework for tracking progress, with clear measurable targets to be achieved by 2030, for consideration by the Seventy-seventh World Health Assembly, through the Executive Board at the current session.
2. The global action plan and monitoring framework on IPC are designed to support and enable the implementation of the WHO global strategy and were developed through an extensive consultative process including global and regional consultations with Member States, international experts and across the three levels of the WHO secretariat.[1] Actions, indicators and targets have been identified, for each of the eight strategic directions in the global strategy.
3. Both the global action plan and monitoring framework directly refer to: WHO's recommendations and standards included in the guidelines on core components of[2] and the minimum requirements for[3] IPC programmes; the essential water, sanitation and hygiene (WASH) standards in health care;[4,5] and the IPC

[1] Global strategy on infection prevention and control. World Health Organization; 2023 (https://www.who.int/publications/m/item/global-strategy-on-infection-prevention-and-control, accessed 24 November 2023).
[2] Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/251730, accessed 20 November 2023).
[3] Minimum requirements for infection prevention and control programmes. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/330080, accessed 20 November 2023); see also EB154/8 Add.1.
[4] Adams J, Bartram J, Chartier Y, editors. Essential environmental health standards in health care. Geneva: World Health Organization; 2008 (https://iris.who.int/bitstream/handle/10665/43767/9789241547239_eng.pdf?sequence=1, accessed 20 November 2023).
[5] Water and Sanitation for Health Facility Improvement Tool (WASH FIT): A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. Second edition. Geneva: World Health Organization; 2022 (https://www.who.int/publications-detail-redirect/9789240043237, accessed 25 October 2023).

sections of the global patient safety action plan[1] and the global action plan on antimicrobial resistance (AMR).[2,3] Therefore, this present document must be read in conjunction with those documents (particularly the annex reproduced in the accompanying document EB154/8 Add.1), which provide more details on what is proposed to be achieved.

4. The global action plan on IPC proposes key and additional actions at the global and regional, national and subnational, and facility levels. For every action, indicators are proposed for Member States' consideration. In addition, a set of core and additional targets have been identified at each of those levels.
5. The Secretariat recommends that countries include all key actions and core targets at national and facility levels into their own IPC action plans. Additional actions and targets are also suggested as relevant, depending on the local situation and needs.
6. At the national/subnational and facility levels, countries are strongly encouraged both to monitor and evaluate progress in implementing their action plans and provide information for global reporting through WHO. Similarly, as requested in the resolution WHA75.13, the Director-General will report back to the Health Assembly biennially from 2025 until 2031. The intent is to report aggregated data on progress and results at global/regional and national levels.
7. More details about the background, foundations and development process of this action plan and monitoring framework, including instructions for reading the following sections, are provided in Supplementary Annex 1,[4] as well as an outline of the drivers of progress.
8. The appended Table presents proposed actions, targets and indicators for the national/subnational and facility levels.
9. Supplementary Annex 2 lists the actions and related indicators at the global/regional level. Here, the Secretariat, coordinating the work of headquarters, regional offices and country offices and in collaboration with international and national stakeholders and partners, is the key player in providing support to Member States.
10. Supplementary Annex 3 lists the key players for each proposed action at the national and facility level and indicates when the monitoring framework indicators are already existing, including existing systems for data collection.
11. Supplementary Annex 4 shows the results chain according to the theory of change used to develop this global action plan and monitoring framework.

[1] Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/343477, accessed 24 November 2023).
[2] Global action plan on antimicrobial resistance: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2015 (https://iris.who.int/handle/10665/193736, accessed 24 November 2023).
[3] WHO, FAO, OIE. Monitoring and evaluation of the global action plan on antimicrobial resistance: framework and recommended indicators. Geneva, Rome and Paris: World Health Organization, Food and Agriculture Organization, and World Organisation for Animal Health; 2019 (https://iris.who.int/handle/10665/325006, accessed 24 November 2023).
[4] The contents of the supplementary annexes 1–4 are available at https://www.who.int/teams/integrated-health-services/infection-prevention-control/-global-action-plan-and-monitoring-framework-on-ipc (accessed 20 December 2023).

Action by the Executive Board

12. The Board is invited to note the report and consider the proposed actions, targets and indicators for the national/subnational and facility levels. It is also invited to consider the following decision:

> The Executive Board, having considered the report of the Director-General on the global action plan for infection prevention and control, 2024–2030: global action plan and monitoring framework,[1]
>
> Decided to recommend that the Seventy-seventh World Health Assembly adopt the following decision:
>
> > The Seventy-seventh World Health Assembly, having considered the report of the Director-General, decided to adopt the global action plan and monitoring framework on infection prevention and control as contained in the Table in document EB154/8.

[1] Document EB154/8.

Table. Global action plan and monitoring framework on IPC, 2024–2030: actions, indicators and targets for national/subnational and facility levels[2,3]

Strategic direction #1. Political commitment and policies

Action	Indicator(s)
National level	
Key action #1 Develop a national action plan and monitoring framework for IPC integrate it into national health plans, outlining costs and sources of financing	1. IPC national action plan and monitoring framework[4] developed, costed, validated and approved by health ministry or other relevant national authorities within the context of national health plans
Key action #2 Establish the legal framework for IPC to mandate the implementation of IPC programmes at all levels	1. Legislation/regulations in place to address IPC (including IPC professionals) in public health regulatory framework
Key action #3 Develop a national financial investment case aligned with the global business case for IPC	1. National financial investment case developed based on global models (by 2026)
Key action #4 Establish a dedicated IPC budget to fund the national IPC programme and action plan	1. Dedicated budget (in line with the IPC national action plan) allocated to fund the IPC national programme and action plan identified and available 2. Proportion of health care facilities with adequately funded and dedicated budget for IPC
Key action #5 Demonstrate evidence of investment by national authorities in WASH and infrastructure services for health care waste and cleaning and staffing to ensure that all health care facilities have safely managed WASH services to enable IPC practices	1. Dedicated and sufficient funding allocated at the national level for WASH services and activities
Action #6 Establish a national IPC committee[5] actively functioning with dedicated role (regulatory authority) to support implementation of the IPC action plan at the national and facility levels	1. National IPC committee established and functioning (by 2026) 2. Proportion of countries with a national IPC committee established and functioning
Action #7 Introduce IPC indicators in line with WHO's core components and minimum requirements for IPC in the national quality-assurance systems for health care facilities (such as licensing and accreditation systems or similar) where they exist	1. IPC requirements included as indicators in national licensing and accreditation (or similar) systems for health care facilities, where they exist (by 2028)

[2] For the global/regional level, see Supplementary Annex 1 (https://www.who.int/teams/integrated-health-services/infection-prevention-control/-global-action-plan-and-monitoring-framework-on-ipc, accessed 20 December 2023).
[3] Details about the key participants for each action at national and facility levels can be found in Supplementary Annex 4 (https://www.who.int/teams/integrated-health-services/infection-prevention-control/-global-action-plan-and-monitoring-framework-on-ipc, accessed 20 December 2023).
[4] If the IPC national action plan and monitoring framework are part of the antimicrobial resistance or patient safety national action plan and monitoring framework but they are clearly distinguishable, detailed and fulfilling all the attributes of the indicator, this can be considered equivalent to a specific IPC national action plan and monitoring framework.
[5] The national IPC committee (or an equivalent structure) should be established as an official multidisciplinary group to interact with the technical team responsible for the IPC programme. The mandate of this entity would be to integrate IPC in the national health system and enhance cooperation, coordination and information-sharing, particularly with complementary programmes. Other tasks of the group could be to perform a review of the IPC programme content, promote improved practices, ensure appropriate training, review risks associated with new technologies and periodically evaluate the programme.

Action #8 Establish adequate staffing levels, including IPC professionals, according to the local needs and use of standardized tools	1. Adequate staffing levels met in line with the requirements for IPC core components (core component 1 for IPC professionals and core component 7 for health and care workers) (by 2030) 2. Proportion of facilities that meet predefined national standards for staffing levels
Facility level	
Key action #1 Demonstrate commitment and support of facility senior managers to IPC through adequate dedicated budget allocation to the IPC programme and team, including funding to implement the annual action plan	1. Adequate dedicated budget available for IPC (that is, to fund the IPC programme and team and the annual action plan, including equipment for IPC practices)

Strategic direction #1 – Global targets and related indicators	
Core target 1/top eight global targets	*Proportion of countries with a costed and approved national action plan and monitoring framework on IPC* Increase of the proportion of countries with a costed and approved national action plan and monitoring framework for IPC to: 30% by 2026 50% by 2028 >80% by 2030
Core target 2/top eight global targets	*Proportion of countries with legislation/regulations in place for IPC (including IPC professionals) as part of the public health regulatory framework* Increase of the proportion of countries with legislation/regulations for IPC to: 30% by 2026 50% by 2028 >80% by 2030
Core target 3/top eight global targets	*Proportion of countries having an identified dedicated (in line with the IPC national action plan) budget allocated to fund the IPC national programme and action plan* Increase of the proportion of countries having an identified dedicated budget allocated to the national IPC programme and action plan to: 50% by 2026 75% by 2028 >90% by 2030 Baseline (2021–2022): 41%
Additional target	*Proportion of countries with dedicated and sufficient funding for WASH services and activities* Increase of the proportion of countries with dedicated and sufficient funding for WASH services and activities to: 40% of countries by 2026 80% of countries by 2028 100% of countries by 2030 Baseline (2022): 3%
Strategic direction #1 – National targets and related indicators	
Additional target	*Proportion of health care facilities with adequate dedicated budget for IPC (to fund the IPC programme and team and the annual action plan, including equipment for IPC practices)* Increase of the proportion of health care facilities with adequate dedicated budget for IPC to: 30% by 2026 50% by 2028 >80% by 2030

Strategic direction #2. Active IPC Programmes

Action	Indicator(s)
National level	
Key action #1 Establish a national IPC programme and/or demonstrate evidence of improvement of IPC programmes, including WASH (namely, meet WHO's minimum requirements at national and facility levels)	1. All WHO's minimum requirements for IPC at national level (see document EB154/8 Add.1) met (to be assessed through WHO's Global IPC portal)[6] 2. Proportion of health facilities meeting all WHO's minimum requirements for IPC at facility level (to be assessed through WHO's IPC portal) 3. Proportion of health care facilities with basic water, sanitation, hygiene, and waste services (per each indicator, to be assessed through the definitions of the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene)
Key action #2 Support the establishment of active IPC programmes (that is, with objectives and action plan, supported by dedicated human resources and financing) at least in tertiary and secondary care facilities, and identification of an IPC link person in each primary care facility, within broader health services development	1. Proportion of tertiary/secondary care health facilities with an active IPC programme 2. Proportion of primary care facilities with an IPC link person
Key action #3 Establish national targets on reducing health care-associated infections (HAIs) and support the implementation of multimodal improvement strategies7 to reduce HAIs in health care facilities at all levels, according to local priorities	1. Proportion of facilities with implemented interventions based on multimodal strategies to reduce specific HAIs according to local priorities
Key action #4 Develop national IPC guidelines, including policies for enabling environments for IPC, infrastructure, supplies and infection prevention among health and care workers at facility level, and link these guidelines with strategic principles for the control of AMR	1. Evidence-based IPC guidelines and policies available at the national level
Facility level	
Key action #1 Establish an active IPC programme for tertiary and secondary care facilities (that is, with objectives and an annual action plan, supported by dedicated human resources and budget) and ensure there is an IPC link person in each primary care facility, within broader health services development	1. Active IPC programme established (that is, with objectives and annual action plan, supported by dedicated human resources and adequate funding) (by 2026)

[6] WHO Global IPC Portal. For more information, see website (https://ipcportal.who.int, accessed 24 November 2023).

[7] A multimodal strategy comprises several components or elements (three or more, usually five) implemented in an integrated way with the aim of improving an outcome (prevention of HAIs and antimicrobial resistance) and changing behaviour. It includes tools, such as bundles and checklists, developed by multidisciplinary teams that take into account local conditions. The five most common elements are: (i) system change (availability of the appropriate infrastructure and supplies to enable good practices in IPC); (ii) education and training of health and care workers and key players (for example, managers); (iii) monitoring infrastructures, practices, processes and outcomes and providing data feedback; (iv) reminders in the workplace/communications; and (v) cultural change within the establishment or the strengthening of a safety climate.

Key action #2 Make, fund and implement IPC improvement plans in order to achieve WHO's minimum requirements for IPC according to the facility level, including availability of adequate facility infrastructure and IPC supplies	1. WHO's minimum requirements for IPC in the health care facility met according to the facility level 2. Percentage of WHO's minimum requirements for IPC met in the health care facility, according to the facility level

Strategic direction #2 – Global targets and related indicators	
Core target 4/top 8 global targets	*Proportion of countries meeting all WHO's minimum requirements for IPC programmes at national level (through WHO's IPC portal)* Increase of the proportion of countries meeting all WHO's minimum requirements for IPC programmes at national level to: 30% by 2026 60% by 2028 >90% by 2030 Baseline (2021–2022): 4%
Core target 5/top 8 global targets	*Proportion of countries with national IPC programmes at Level 4 or 5 in section C9.1 of SPAR*[8] *and Level D or E in section 3.5 of TrACSS*[9] *(highest levels)* Increase of the proportion of countries with national IPC programmes at Level 4 or 5 in section C9.1 of SPAR 9.1 and Level D or E in section 3.5 of TrACSS to: 50% by 2026 75% by 2028 >90% by 2030 Baseline (2022): 39% in SPAR section C9.1; 38% in TrACSS section 3.5
Additional target	*Country scoring improved within section C9.1 of SPAR and/or within section 3.5 of TrACSS* Step improvement in the country level within section C9.1 of SPAR and/or within section 3.5 of TrACSS to: 50% of countries moved to the next level by 2026 75% of countries moved to the next level by 2028 100% of countries moved to the next level by 2030
Core target 6/top 8 global targets	*Proportion of countries with basic water, sanitation, hygiene and waste services in all health care facilities (per each indicator as monitored in the definitions of the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene)*[10] Increase of the proportion of countries with basic water, sanitation, hygiene and waste services in all health care facilities to: 60 % by 2026 80% by 2028 100% by 2030 Baseline (2022) – water: 78%; sanitation: not determined; hand hygiene: 51%; waste services: not determined

[8] SPAR: IHR State Party Self-Assessment Annual Reporting tool; section C9.1 covers IPC programmes. For more information see the SPAR website (https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/states-parties-self-assessment-annual-reporting, accessed 21 November 2023).

[9] TrACSS: Tripartite AMR Country Self-Assessment Survey; for more information see the TrACSS website (https://amrcountryprogress.org/#/map-view, accessed 21 November 2023); section 3.5 covers Infection Prevention and Control (IPC) in human health care. The same website also contains the full Global Database for Tracking Antimicrobial Resistance (AMR) Country Self- Assessment Survey.

[10] Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children's Fund; 2018 (https://www.who.int/publications/i/item/9789241514545, accessed 30 October 2023)

Strategic direction #2 – Global targets and related outcome indicators	
Denominator for Core target 7	*Proportion of countries that have a national target on reducing HAIs (monitored by WHO's Patient Safety Flagship secretariat)* Increase of the proportion of countries that have a national target on reducing HAIs to: 50% by 2026 75% by 2028 100% by 2030 Baseline (2023): 31%
Core target 7/top 8 global targets	*Proportion of countries that have achieved their national targets on reducing HAIs*[11] *(existing indicator in the Global Patient Safety Action Plan 2021–2030)* Increase of the proportion of countries that have achieved their national targets on reducing HAIs (among those having such target) to: 30% by 2026 50% by 2028 >80% by 2030
Strategic direction #2 – National targets and related indicators	
Core target 2/top 4 national targets	*Percentage of WHO's minimum requirements for IPC met at the national level* Increase in the percentage of WHO's minimum requirements for IPC met at the national level to: 50% by 2026 75% by 2028 >90% by 2030
Core target 1/top 4 national targets	*Proportion of facilities meeting all WHO's minimum requirements for IPC programmes* Increase of the proportion of facilities meeting all WHO's minimum requirements for IPC programmes to: 30% by 2026 60% by 2028 >90% by 2030 Baseline (2019): 16%
Strategic direction #2 – Facility level target and related indicator	
Additional target	*Percentage of WHO's minimum requirements for IPC met in the health care facility, according to the facility level* Increase of the percentage of WHO's minimum requirements for IPC met by the facility to: 30% by 2026 60% by 2028 >90% by 2030

[11] HAIs caused by priority pathogens recommended to be addressed are: surgical site infections related to selected surgical procedures (existing indicator in the global action plan on antimicrobial resistance); bloodstream infections among inpatients; and central line-associated bloodstream infections.

Strategic direction #3. IPC integration and coordination

Action	Indicator(s)
National level	
Key action #1 Ensure inclusion of IPC principles, standards and indicators within strategies and documents of other complementary national programmes[12]	1. Desk review and situational analysis of integration of IPC within other programmes completed (by 2028) 2. Key existing IPC principles, standards and indicators identified, appropriately included and cross-referenced within other national complementary programmes, as appropriate (by 2030)
Key action #2 Ensure the IPC programme is aligned with and contributes to other complementary national programmes' strategies and documents	1. Desk review and situational analysis of integration of other complementary programmes within the IPC programme completed (by 2028) 2. Key existing policies, principles, standards and indicators from other complementary programmes identified, appropriately included and cross-referenced within IPC documents and programmes, as appropriate (by 2030)
Key action #3 Ensure IPC clinical practices and appropriate prescribing of antimicrobial agents (that is, antimicrobial stewardship) are embedded in policies related to patient care pathways/programmes at the national, subnational and facility levels for tertiary, secondary and primary health care	1. Clinical packages (for example, policies and standard operating procedures) available for integrating IPC and appropriate antimicrobial prescribing within clinical care (such as surgery, maternal and neonatal care) (by 2028)
Action #4 Ensure inclusion of IPC principles, strategies and standards in policies, national action plans and implementation projects on AMR	1. AMR policies, national action plans and implementation projects including IPC available (by 2026) 2. Modified Sustainable Development Goal indicator 3.d.2 in inpatients: proportion of bloodstream infections due to methicillin-resistant Staphylococcus aureus, Acinetobacter spp., Klebsiella spp. and Pseudomonas spp. resistant to carbapenems
Action #5 Ensure IPC is included as a component of the national preparedness, readiness and response plan within the context of public health emergencies	1. IPC section including budget, personnel, and supplies included in the national preparedness, readiness and response plan
Action #6 Develop and cost national plans for WASH in health care facilities	1. Costed road maps (that is, national plans) for WASH in health care facilities which include IPC elements available 2. Standards for water, sanitation, hygiene, cleaning and health care waste in health care facilities available
Action #7 Ensure IPC is included as a component of national occupational health and safety programmes for health and care workers, including plans for prevention, reporting and follow-up of occupational infections	1. National plans for prevention, reporting and follow-up of occupational infections, including a policy for vaccination of health and care workers available 2. Proportion of countries having a national policy for occupational health and safety for health and care workers (an indicator for global reporting)

[12] Examples of programmes/areas of work complementary to IPC programmes include those on antimicrobial resistance; occupational health; patient safety; public health emergencies; quality of care; water, sanitation and hygiene and health care waste; and specific infectious diseases (such as HIV infection and tuberculosis).

	3. Proportion of countries with a vaccination programme for health and care workers (indicator for global reporting)
Action #8 Integrate IPC supplies/equipment in the national lists of essential medicines and priority medical devices and identify those essential for emergencies	1. Agreed list of essential IPC supplies (for instance, alcohol-based hand rub products, personal protective equipment and disinfectants) available (by 2026) 2. Assessment of which IPC supplies are included in the national lists of essential medicines and priority medical devices completed (by 2028) 3. Agreed list of essential IPC supplies included in lists of essential medicines and priority medical devices, including specifications for emergencies (by 2030)
Facility level	
Key action #1 Establish an IPC committee[13] ensuring representation of and collaborative activities with other complementary programmes (for tertiary/secondary care facilities)	1. IPC committee established with representation of and collaborative activities with other complementary programmes (by 2026)
Key action #2 Ensure both IPC clinical practices and appropriate antimicrobial prescribing are embedded in all patient care pathways/wards	1. Standard operating procedures available integrating IPC and appropriate antimicrobial prescribing within clinical care (for example, surgery, maternal and neonatal care) (by 2028) 2. Increased compliance with IPC practices in specific wards and among specialized professionals (for example, injection safety, hand hygiene and waste management in surgical wards, operating theatres and critical care units) demonstrated (by 2030) 3. Increased compliance with appropriate antimicrobial prescribing (for example, at least one annual audit) demonstrated

Strategic direction #3 – Global targets and related indicators	
Core target 6/top 8 global targets	*Proportion of countries with costed road maps (namely, national plans) for WASH in health care facilities* Increase of the proportion of countries with costed road maps (namely, national plans) for WASH in health care facilities to: 80% countries by 2026 90% countries by 2028 100% countries by 2030 Baseline (2022): 63% of countries
Additional target	*Proportion of countries with updated standards for water, sanitation, hygiene, cleaning and health care waste in health care facilities available* Increase of the proportion of countries with updated standards for water, sanitation, hygiene, cleaning and health care waste in health care facilities available to: 75% countries have updated standards by 2026 90% countries have updated standards by 2028 100% of countries have updated standards by 2030 Baseline (2022): 53% of countries have standards

[13] An IPC committee is a multidisciplinary group with interested stakeholders from other complementary programmes (for example, patient safety, quality of care, occupational health, antimicrobial resistance/antimicrobial stewardship and WASH) across the facility, which interacts with and advises the IPC team.

Additional target	*Proportion of countries reporting data regarding the modified Sustainable Development Goal indicator 3.d.2 (proportion of patient bloodstream infections due to methicillin-resistant* Staphylococcus aureus*,* Acinetobacter *spp.,* Klebsiella *spp., and* Pseudomonas *spp. resistant to carbapenems in inpatients)* Increase of the proportion of countries reporting the modified indicator 3.d.2 to: 30% by 2026 50% by 2028 >80% by 2030
Strategic direction #3 – National targets and related indicators	
Additional target	*Proportion of facilities with a dedicated and sufficient funding for WASH services and activities* Increase of the proportion of facilities with a dedicated and sufficient funding for WASH services and activities to: 40% of facilities by 2026 80% of facilities by 2028 100% of facilities by 2030
Additional target	*Proportion of health care facilities with an IPC committee established with representation of and collaborative activities with other complementary programmes* Increase of the proportion of health care facilities with such an IPC committee established to: 30% by 2026 50% by 2028 >80% by 2030

Strategic direction #4. Knowledge about IPC among health and care workers and career pathways for IPC professionals

Action	Indicator(s)
National level	
Key action #1 Develop a national curriculum for IPC professionals aligned with WHO's core competencies for infection prevention and control professionals or endorse an international curriculum	1. Curriculum for IPC professionals developed or international curriculum endorsed and in use (by 2028) 2. Proportion of countries with a curriculum for IPC professionals developed and in use (indicator for global target)
Key action #2 Establish a national postgraduate[14] IPC certificate[15] programme (including training courses on emergency preparedness on specific situations) for IPC professionals that is aligned with existing international standards or require existing certificates	1. Postgraduate IPC certificate programme established or requirement for an existing certificate (by 2030) 2. Proportion of colleges and universities offering postgraduate IPC training 3. Proportion of countries with an IPC certificate programme or equivalent or requiring existing certificates (indicator for global target)
Key action #3 Develop and establish a national curriculum on IPC (or adopt an international one) for pregraduate[16] training and education for all relevant health care disciplines (in, for example, medical, nursing and midwifery schools), endorsed by the appropriate national or international body, and integrate it within health educational curricula, with embedded evaluation mechanisms	1. IPC pregraduate curriculum for all relevant health care disciplines developed and endorsed by the appropriate national or international body ensuring that quality and standards (national/international) are met (by 2028) 2. IPC pregraduate curriculum integrated within health educational curricula, with embedded evaluation mechanisms (by 2030)
Key action #4 Develop a national in-service[17] curriculum on IPC (or adopt an international one) for all health and care workers, in particular frontline clinical, cleaning and management staff and create a national (or subnational) training programme to support in-service IPC training	1. National in-service IPC curriculum developed (by 2026) 2. National (or subnational) IPC training programme to support in-service training created (by 2028), introduced and regularly updated (by 2030) 3. Proportion of countries with a national in-service curriculum on IPC (indicator for global target)
Key action #5 Mandate that all health and care workers, in particular frontline clinical, cleaning and management staff, receive education and training in standard operating procedures for IPC upon employment and regularly (for instance, annually) thereafter	1. Legal mechanism or well-defined strategies established to mandate IPC in-service training (by 2028) 2. Proportion of facilities providing and/or requiring mandatory training for all health and care workers, in particular frontline clinical and cleaning staff upon employment and annually thereafter and for managers upon employment 3. Proportion of facilities achieving all WHO's minimum requirements for IPC training and education according to facility level 4. Proportion of countries with a national (or subnational) IPC training programme (indicator for global target)

[14] Postgraduate qualification: a type of qualification that is completed after a relevant undergraduate degree or diploma. Postgraduate degrees encompass a range of qualifications, including master's degrees, postgraduate diplomas and certificate and doctorates.
[15] A certificate is awarded following the completion of a course or series of courses that provides education and training around an intended learning outcome.
16 Pregraduate: a person is taking an academic course (such as a diploma or degree programme) but has not yet graduated.
17 In-service: training that is given to employees during the course of employment, carried out by an institution or agency. It includes orientation programmes.

Key action #6 Create a career pathway for IPC professionals	1. Framework/policy document developed that outlines the steps to create a career pathway for IPC professionals (by 2028) 2. Specific positions for IPC professionals/focal points created/available in the national health care system 3. Proportion of hospitals with at least one full-time IPC professional per 250 beds
Facility level	
Key action #1 Make implementation plans and provide resources (human and financial) to achieve all WHO's minimum requirements for IPC training and education and to progressively achieve all requirements of core component 3 on IPC education and training	1. All WHO's minimum requirements for IPC training and education met, according to facility level (by 2030)

Strategic direction #4 – Global targets and related indicators	
Additional target	*Proportion of countries with a curriculum for IPC professionals developed or endorsed and in use* Increase of the proportion of countries with a curriculum for IPC professionals developed or endorsed and in use to*:* 30% by 2026 50% by 2028 >80% by 2030
Additional target	*Proportion of countries with an IPC certificate programme or equivalent or requiring existing certificates* Increase of the proportion of countries with an IPC certificate programme or equivalent to: 30% by 2026 50% by 2028 >80% by 2030
Additional target	*Proportion of countries having IPC training programme for health and care workers* Increase of the proportion of countries having an IPC training programme for health and care workers to: 30% by 2026 50% by 2028 >80% by 2030
Strategic direction #4 – National target and related indicator	
Core target 3/top 4 national targets	*Proportion of facilities providing and/or requiring training of all frontline clinical and cleaning staff upon employment and annually and to managers upon employment* Increase of the proportion of facilities providing and/or requiring training to all frontline clinical and cleaning staff upon employment and annually and to managers upon employment to: 30% by 2026 60% by 2028 >90% by 2030

Strategic direction #5. Data for action

Action	Indicator(s)
National level	
Key action #1 Establish and/or strengthen national IPC monitoring system and ensure health care facilities participate in the national IPC monitoring networks	1. National strategic plan for IPC monitoring in place, including an integrated IPC monitoring system for collection, analysis and feedback of data 2. Proportion of tertiary/secondary-level health care facilities having an IPC monitoring system for collection, analysis and feedback of data 3. Proportion of countries with a national IPC monitoring system (indicator for global reporting)
Key action #2 Establish and/or strengthen a national surveillance system for HAIs and related AMR including for early warning the ability to detect epidemic- and pandemic-prone pathogens and for monitoring antimicrobial consumption, and ensure that tertiary/secondary health care centres (at least referral centres) participate in national or international HAI and AMR surveillance networks	1. National strategic plan for surveillance of HAIs and related AMR (with a focus on priority infections based on the local context) developed by a multidisciplinary technical group (by 2026) within the context of a broader surveillance system 2. National/subnational surveillance system for HAIs and related AMR (including for early warning the ability to detect epidemic- and pandemic-prone pathogens causing HAIs) established and supported (including financially) by governmental and national/subnational authorities (by 2028) 3. Proportion of tertiary/secondary health care facilities participating in the national/subnational or international network for surveillance of HAIs and related AMR, if existing 4. Proportion of tertiary/secondary health care facilities having a surveillance system for HAIs and related AMR including for early warning the ability to detect epidemic- and pandemic-prone pathogens
Key action #3 Establish and/or strengthen a system for monitoring hand hygiene in health care facilities as a key national indicator	1. Hand hygiene compliance monitoring and feedback established as a key national indicator, at the very least for reference hospitals (by 2026) 2. National programme for improving hand hygiene compliance in place (by 2026) 3. National hand hygiene monitoring system (compliance or product consumption) established and implemented (by 2028) 4. Proportion of health care facilities at all levels monitoring hand hygiene and providing data through the national system
Action #4 Integrate IPC and HAI indicators and data into national health information and accreditation systems and/or other relevant quality-improvement activity	1. IPC and HAI data included as key criteria in national health care accreditation systems and/or other relevant quality improvement activity (by 2028) 2. IPC and HAI data included in health management information system (by 2028)
Action #5 Ensure training and expertise in data collection, analysis, interpretation and reporting in order to maximize data accuracy and quality	1. Training programme for data collection, analysis, interpretation and reporting on IPC, HAIs and antimicrobial consumption established (by 2026)

	2. National training courses regularly organized (by 2028)
Action #6 Support health care facility activities concerning IPC, HAIs and antimicrobial consumption in the areas of data analysis, reporting/feedback and interpretation to facilitate development and update of local improvement plans	1. Regular reports of data on IPC, HAIs and antimicrobial consumption produced and shared with health and care workers and administrators (by 2026) 2. Local action plans regularly developed/updated in light of reported data (by 2028)
Facility level	
Action #1 Make implementation plans and provide resources (human and financial) to achieve all WHO's minimum requirements for HAI surveillance according to facility level and to progressively achieve all requirements of core component 4 on HAI surveillance	1. Percentage of WHO's minimum requirements for HAI surveillance met (only for tertiary and secondary care facilities)
Action #2 Make implementation plans and provide resources (human and financial) to achieve all WHO's minimum requirements for IPC monitoring and feedback according to facility level, and to progressively achieve all requirements of core component 6 on Multimodal strategies for implementing IPC activities	1. Percentage of WHO's minimum requirements for IPC monitoring and feedback met

Strategic direction #5 – Global targets and related indicators	
Additional target	*Proportion of countries reporting annually through WHO's IPC portal* Increase of the proportion of countries reporting annually through WHO's IPC portal to: 30% by 2026 50% by 2028 >80% by 2030
Additional target	*Proportion of countries with a national IPC monitoring system* Increase of the proportion of countries with a national IPC monitoring system to: 30% by 2026 50% by 2028 >80% by 2030
Core target 8/top 8 global targets	*Proportion of countries with a national surveillance system for HAIs and related AMR, including for early warning to detect epidemic- and pandemic-prone pathogens causing HAIs* Increase of the proportion of countries with a national surveillance system for HAIs and related AMR to: 30% by 2026 50% by 2028 >80% by 2030
Strategic direction #5 – National targets and related indicators	
Additional target	*Proportion of tertiary/secondary health care facilities having an IPC monitoring system for collection, analysis and feedback of data* Increase of the proportion of tertiary/secondary health care facilities having an IPC monitoring system to: 30% by 2026 50% by 2028 >80% by 2030

Core target 4/top 4 national targets	*Proportion of tertiary/secondary health care facilities having a surveillance system for HAIs and related AMR, including early warning to detect epidemic- and pandemic-prone pathogens* Increase of proportion of tertiary/secondary health care facilities having a surveillance system for HAIs and related AMR to: 30% by 2026 50% by 2028 >80% by 2030
Additional target	*Proportion of health care facilities at all levels monitoring hand hygiene and providing data through the national system* Increase of the proportion of health care facilities monitoring hand hygiene and providing data through the national system to: 30% by 2026 60% by 2028 >90% by 2030

Strategic direction #6. Advocacy and communications

Action	Indicator(s)
National level	
Key action #1 Develop and implement a national IPC advocacy and communications strategy and implementation plan (as stand-alone or a part of wider strategies, for example, on AMR, patient safety or WASH), aligned for consistency with the WHO global strategy on infection prevention and control and including engaging local champions and the community	1. National advocacy and communications strategy and implementation plan, including the identification of local experts/champions, developed and implemented (by 2026)
Action #2 Establish a training programme on advocacy and risk communication and community engagement for IPC professionals and champions	1. National training programme on advocacy and communications for IPC established (by 2028)
Action #3 Organize national communication campaigns on IPC priority topics and participate in WHO's World Hand Hygiene Day as a country with national initiatives	1. National campaigns on IPC priority topics organized annually 2. National initiative to participate in the annually-organized World Hand Hygiene Day 3. Proportion of facilities participating in World Hand Hygiene Day with local activities and/or participating in national event
Facility level	
Key action #1 Organize events and/or communications and campaigns on IPC priority topics (for example, hand hygiene, AMR and WASH), including patient and community participation	1. At least one event/communications per year organized
Key action #2 Participate in WHO's World Hand Hygiene Day	1. Activities for WHO World Hand Hygiene Day organized every year

Strategic direction #6 – Global target and related indicator	
Additional target	*Proportion of countries having a national advocacy and communications strategy and implementation plan* Increase of the proportion of countries having a national advocacy and communications strategy and implementation plan to: 30% by 2026 50% by 2028 >80% by 2030

Strategic direction #7. Research and development

Action	Indicator(s)
National level	
Key action #1 Develop country-specific national research agenda and priorities for IPC (as stand-alone or a part of wider strategies, for example, on AMR, patient safety and WASH), adapted from the global research agenda and including a multisectoral and multidisciplinary approach	1. National research agenda and priorities for IPC developed
Key action #2 Prioritize, fund and implement research projects on IPC in selected facilities, according to local priorities	1. Biennial number of scientific publications/publicly-available reports of research results on priority IPC topics
Facility level	
Key action #1 Seek research funds for projects on IPC, according to the facility's priorities	1. Grant proposals for IPC research projects submitted
Key action #2 Implement research projects on IPC and report on the results	

Strategic direction #7 – Global target and related indicator	
Additional target	*Proportion of countries having a national IPC research agenda* Increase of the proportion of countries having a national IPC research agenda to: 30% by 2026 50% by 2028 >80% by 2030

Strategic direction #8. Collaboration and stakeholders' support

Action	Indicator(s)
National level	
Key action #1 Map national partners, professional societies, civil society organizations, patient advocacy and community groups, and international organizations relevant for IPC, taking a multisectoral and multidisciplinary approach	1. National mapping exercise performed and available (by 2026) and mechanisms in place for regular updates 2. National agenda for collaboration to improve collaborating agenda on IPC developed (by 2028) 3. Profiles of IPC national stakeholders (such as organizations, societies, partners and donor supporting and/or working on IPCs) regularly updated (by 2030)
Key action #2 Encourage and implement multistakeholder activities and/or initiatives, according to country needs and including sharing of data on IPC, HAIs, AMR and WASH	1. Proportion of countries with multisectoral taskforce that includes a strong focus on IPC and WASH in health care facilities 2. Number of joint IPC activities with national IPC stakeholders in line with national plan and local needs and context (by 2030)
Facility level	
Key action #1 Seek collaborations, networking and partnerships with other health care facilities and national IPC societies (if present) to support IPC implementation	1. Proportion of collaborative or multidisciplinary projects, networking events or partnerships established

Strategic direction #8 – Global target and related indicator	
Additional target	*Proportion of countries having a national multisectoral/multipartner taskforce that includes a strong focus on IPC and WASH in health care* Increase of the proportion of countries having a national multisectoral/multipartner taskforce that includes a strong focus on IPC and WASH in health care facilities to: 30% by 2026 50% by 2028 >80% by 2030

Supplementary annex 1. Global action plan and monitoring framework on infection prevention and control (IPC): background, structure, development process, actions and responsibilities of key players, and drivers of progress

Background

Over the past decade, major outbreaks such as H1N1, Ebola virus disease, Middle East respiratory syndrome and, more recently, the COVID-19 pandemic, have demonstrated how epidemic-prone pathogens can spread rapidly through health care settings with transmission to the community and vice versa.

Furthermore, other less visible health emergencies, such as the burden of endemic health care-associated infections (HAIs) and antimicrobial resistance (AMR), harm millions of patients every year across all health care systems and can also affect health and care workers and other individuals accessing health facilities[1].

IPC consists of evidence-based practices and interventions with a demonstrated impact and cost-effectiveness to decrease the transmission of infectious agents across all levels of the health care system. It is fundamental to patients and health and care workers' safety and for the provision of high-quality care delivery. IPC is also critical to maintain the population's trust in the health system.

The COVID-19 pandemic, as well as recent reports[1,2,3], revealed that many countries do not have a sufficiently strong IPC programme and that global action plans and inefficiencies in the implementation of IPC exist, especially in low- and middle-income countries. Major global action plans worldwide in water, sanitation, hygiene (WASH) and waste management services in health care facilities also hinder the implementation of good IPC practices[4]. Nevertheless, the momentum created by the COVID-19 pandemic has shown clear country investments and some progress in scaling-up improvements in IPC, which is being strongly supported by WHO and other key players[1].

Sustaining and further expanding this progress in the longer term is critical and requires urgent investments to ensure adequate financial and human resources, particularly in resource-limited settings.

The Seventy-fifth World Health Assembly in May 2022 adopted a resolution on IPC (WHA75.13)[5], which included 13 calls to Member States aimed at improving IPC at the national, subnational and/or facility levels. In consultation with Member States and regional economic integration organizations, a **global strategy[6] on IPC** was developed by the WHO Secretariat and adopted at the Seventy-sixth World Health Assembly in May 2023. This strategy addresses IPC in all health care settings, both in the public and private health sectors, including acute, primary and long-term care facilities. The resolution WHA75.13 also requested the Director-General to develop an action plan for IPC to be achieved by 2030, including a framework for tracking progress with clear measurable targets[7], for consideration by the Seventy-seventh World Health Assembly in 2024 through the Executive Board at its 154th session in January 2024. Member States also highlighted the importance of strengthening and implementing infection prevention practices in the community settings, starting from schools and other educational facilities;

[1] Global report on infection prevention and control. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/354489, accessed 26 July 2023).
[2] Addressing the burden of infections and antimicrobial resistance associated with health care. Focus on G7 countries. 18 October 2022. WHO, Organisation for Economic Co-operation and Development. 2022 (https://www.oecd.org/health/Addressing-burden-of-infections-and-AMR-associated-with-health-care.pdf, accessed 25 October 2023).
[3] Embracing a One Health framework to fight antimicrobial resistance. Paris: Organisation for Economic Cooperation and Development Publishing, 2023 (https://www.oecd.org/health/embracing-a-one-health-framework-to-fight-antimicrobial-resistance-ce44c755-en.htm, accessed 25 October 2023).
[4] Progress on WASH in health care facilities 2000-2021: special focus on WASH and infection prevention and control. Geneva: World Health Organization, United Children's Fund; 2023 (https://iris.who.int/handle/10665/366657, accessed 30 October 2023).
[5] Resolution WHA75.13. In: Seventy-fifth World Health Assembly, Geneva, 22-28 May 2022. Resolutions, decisions, annexes. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/365610, accessed 30 October 2023).
[6] Global strategy on infection prevention and control. World Health Organization. Regional Office for the Eastern Mediterranean; 2023 (https://iris.who.int/handle/10665/366599, accessed 30 October 2023).
[7] Target: a specific numerical target citing a baseline value (absolute target), or a relative change that is independent of the initial value of the starting point (relative target).

however, these settings were not the focus of the resolution and the documents requested from the Director-General.

Structure and development process

Based on the consultations conducted to date, the global action plan and monitoring framework on IPC have been structured around the following eight strategic directions indicated in the global strategy:

1. political commitment and policies;
2. active IPC programmes;
3. IPC integration and coordination;
4. knowledge of IPC by health and care workers and career pathways for IPC professionals;
5. data for action;
6. advocacy and communications;
7. research and development;
8. collaboration and stakeholder support.

The global action plan and monitoring framework IPC are designed to support and enable the implementation of the WHO global strategy on IPC, which has the following vision and three strategic objectives:

> **Vision:** "By 2030, everyone accessing or providing health care is safe from associated infections."
>
> **Strategic objectives**
>
> 1. Prevent infections in health care settings for staff, patients and visitors.
> 2. Act to ensure IPC programmes are in place and implemented.
> 3. Coordinate IPC activities with other areas and sectors and vice-versa.

Furthermore, the global action plan and monitoring framework directly refer to WHO recommendations and standards established through the **guidelines on core components**[8] **and minimum requirements**[9] **for IPC programmes** since several years (Addendum 1 to the global action plan and monitoring framework on IPC, 2024-2030), and other key documents (for example, AMR, epidemics and pandemics, WASH and occupational health). They are also aligned and refer to the IPC sections of the *Global patient safety action plan*[10] and the *Global action plan on AMR*[11,12]. Therefore, the global action plan and monitoring framework on IPC, 2024-2030, must be read in conjunction with these documents (in particular Addendum 1), which provide more details on what is proposed to be achieved.

The global action plan on IPC consists of **actions** at the **global/regional, national/subnational and facility** levels that are necessary to follow each strategic direction of the global strategy and to finally achieve its objectives. It is important consider that in some countries, the subnational level (for example, State, region or province/district) has

[8] Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/251730, accessed 25 October 2023).
[9] Minimum requirements for infection prevention and control programmes. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/330080, accessed 25 October 2023).
[10] Global patient safety action plan. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/343477, accessed 25 October 2023).
[11] Global action plan on antimicrobial resistance. Geneva: World Health Organization; 2016 (https://iris.who.int/bitstream/handle/10665/193736/9789241509763, accessed 25 October 2023).
[12] Monitoring and evaluation of the global action plan on antimicrobial resistance: framework and recommended indicators. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/325006, accessed 25 October 2023).

a prominent role in decision-making and implementation and thus actions indicated for the national level may be more pertinent for the subnational level.

The implementation of the global action plan will require strong action by the WHO Secretariat, international and national stakeholders and other key players in support to Member States. Supplementary annex 2 lists the **actions and related indicators at the global/regional level** for which the WHO Secretariat, led by the IPC unit and also involving other areas of work across the three levels of the Organization, is the key player in collaboration with external stakeholders. It also includes some indicators to monitor actions expected by the WHO Secretariat and international partners. The WHO Secretariat commits to provide strong technical support to Member States to develop and implement their national plans and monitor their progress and impact, including support for gathering data to feed into the global monitoring framework.

Key players for achieving each action at the different levels have been identified among the target audience of the global strategy on IPC (see Supplementary annexes 2 and 3).

Actions identified as ***"key"*** should be high priority for the key players at the global/regional, national/subnational and facility levels; additional actions are also critical, but they might be less urgent or relevant depending on the local context.

For each action, indicators are proposed for country consideration, according to the local situation and needs. In addition, a set of ***core*** targets, as well as ***additional*** targets, have been identified both at the global and national levels, to measure progress made towards 2030 (see main global action plan document). Regarding indicators and targets at the facility level, countries are encouraged to include both public and private health care facilities and to develop their sampling method according to the local context.

The **global/regional** level incorporates process and outcome measures for country-level monitoring, as well as indicators of international action by the WHO Secretariat at all three levels and international partners. The global monitoring framework includes monitoring country progress in the implementation of IPC national plans and programmes and the overall impact of national activity.

At the **national/subnational** level, countries will need to both monitor their progress in implementing the actions proposed in the global action plan and evaluate progress being made, including the extent to which this is making an impact at national level. Indicators and targets proposed in this monitoring framework should be adopted and adapted according to the country's own situation and context.

At the **facility** level, actions, indicators and targets are also suggested, in line with the actions, outputs and outcomes expected at the national level.

Core targets and the related indicators are considered as critical and are recommended to be included into national action plans and monitoring frameworks on IPC; additional actions and targets are also suggested as relevant, according to the local situation and needs.

Actions, indicators and targets were identified by working across all three levels of WHO and through an extensive consultative process with Member States, the global IPC network and other partners, including two global and five regional consultations, individual country consultations, written feedback by Member States, and several technical meetings. Members of these groups also participated in a Delphi survey and confirmed agreement with the proposed indicators and targets and provided a prioritization list that allowed to distinguish the targets in "core" and "additional" (see above). Sixty- four percent of the Delphi survey participants were from Member States.

To design an effective monitoring and evaluation framework for the global action plan, principles and methods inspired by the Theory of Change have been adopted in such a way that actions identified are expected to lead to

specific changes by drawing on a causal analysis based on available evidence[13]. Based on this, the causal pathways connecting the global action plan's inputs, activities and outputs with the desired outcomes and impact goals are visualized in the "results chain" (see Supplementary annex 4).

Importantly, while the proposed plan of work and targets are undoubtedly ambitious, most actions and indicators are not new and directly refer to existing WHO recommendations and standards. Furthermore, many of the proposed indicators and targets are/or can be collected through different existing global databases and monitoring systems (see Supplementary annex 3).

WHO also provides clear guidance on implementation strategies by indicating a stepwise approach, which allows countries and health facilities to identify and prioritize actions based on local progress and available resources[14,15]. The same approach is also recommended when considering the actions suggested in this global action plan. Notably, **an implementation manual** to support the uptake of the global action plan and its use for national action plan development will be available in 2024.

Actions and responsibilities of key players

Member States are encouraged to have sustainable national action plans on IPC in place by 2026, integrated with national health plans. These would be tailored to national priorities and local governance arrangements, but they would be aligned with the strategic objectives and actions of the WHO global action plan as far as possible, and in accordance with the WHO IPC core components and the associated WHO IPC minimum requirements.

Member States are also encouraged to develop appropriate monitoring and reporting frameworks associated with their national action plans on IPC, in line as much as possible with the indicators and targets proposed in the WHO monitoring framework of this global action plan, and tailored to IPC actions and improvements needed in their own context.

Member States are invited to report biennially to WHO on the core global and national indicators and targets contained within the WHO monitoring framework and, as relevant to local conditions, report on any additional contextual national indicators contained within the framework.

IPC national monitoring and reporting frameworks should facilitate global monitoring by WHO as far as possible to enable it to fulfil its obligation related to resolution WHA75.13, that is, to biannually report progress on IPC implementation and its impact where possible to the World Health Assembly. Equally important, such reporting by the WHO Secretariat will facilitate WHO's ability to keep IPC high on the global public health agenda, advocate for resources, and provide more targeted support for country IPC capacity building.

The WHO Secretariat will strongly support and facilitate Member States in the aforementioned work by supporting countries to develop IPC national action plans and associated monitoring frameworks, and providing countries with free, on-line access to the full suite of WHO IPC assessment tools through the WHO IPC global portal that allows for secure data upload and storage.
The WHO Secretariat will publish an implementation manual by 31 December 2024 to further support Member States in the development and implementation of national IPC action plans and associated monitoring frameworks.

[13] Companion guidance - United Nations Development Assistance Framework (UNDAF) -Theory-of-Change. United Nations Development Group, 2017 (https://unsdg.un.org/resources/theory-change-undaf-companion-guidance, accessed 25 October 2023).
[14] Interim practical manual: supporting national implementation of the WHO guidelines on core components of infection prevention and control programmes. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/330073, accessed 25 October 2023).
[15] Improving infection prevention and control at the health facility: an interim practical manual. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/279788, accessed 25 October 2023).

Drivers of progress

Financing

The implementation of this global action plan and monitoring framework, particularly roll-out at country level, requires significant financial investments as part of broader efforts to increase overall investments in other priority areas, such as combating AMR, epidemics and pandemic preparedness and response, and improving WASH in health care facilities. Financial needs to cover the proposed activities proposed should be addressed through national budgets for health, as well as international funding mechanisms (for example, the Pandemic Fund)[16]. Furthermore, partners and donors should prioritize supporting the implementation of national action plans in line with this global action plan, as well as the monitoring activities and system to track their progress and impact.

Political commitment, leadership and collaborations

Effective implementation requires strong political commitment and decision-making on the prioritization of IPC as part of other urgent issues mentioned above. Leadership and expertise is required from IPC national and facility focal points not only to advocate for the prioritization of IPC as a pillar to achieve safe, high-quality, people-centred care delivery, but also to adequately pursue and successfully implement and monitor the actions proposed in this global action plan at national level.

As indicated in strategic direction three of the WHO global strategy on IPC, a close collaboration with other programmes complementary to IPC[17] are of the utmost importance for the implementation of this global action plan and the achievement of its targets. On the one hand, IPC activities must be integrated and aligned with those of other programmes but, on the other hand, activities of other programmes are critical to achieve the core objective of IPC, that is to reduce infection and AMR affecting those accessing or providing health care. This is why this global action plan strongly advocates for actions to enable cross-fertilization and collaborative working towards a common goal, with the purpose to avoid duplications and work in silos.

[16] World Bank Group. The Pandemic Fund. 2023 (https://fiftrustee.worldbank.org/en/about/unit/dfi/fiftrustee/fund-detail/pppr, accessed 30 October 2023).

[17] Programmes/areas of work complementary to IPC programmes: AMR; occupational health; patient safety; public health emergencies and biosafety and biosecurity; quality of care; WASH and health care waste; specific infectious diseases programmes (for example, human immunodeficiency virus, tuberculosis); others.

Supplementary annex 2. Global actions and indicators for the WHO Secretariat and international and national stakeholders and partners in the context of the global action plan on infection prevention and control (IPC) and the related monitoring framework

Strategic direction #1. Political commitment and policies

Action	Key players	Indicator(s)
Global and regional (supranational) level		
Key action #1 Achieve demonstrable high-level commitment to IPC at the global and regional level.	Leaders of the WHO Health Emergencies Programme (WHE), Universal Health and Life Course (UHL), and Antimicrobial Resistance (AMR) Divisions, IPC secretariat at WHO headquarters, Patient Safety Flagship, quality of care, AMR, occupational health, water, sanitation and hygiene (WASH); regional IPC focal points; WHO country offices. Government leaders, officials and United Nations delegations, political and health care leaders and policy-makers at ministries of health (and other relevant ministries such as water or environment and finances), and senior managers and administrators responsible for planning and budgets; global IPC network members and other key stakeholders and partners.	1. Global action plan (GAP) and monitoring framework (MF) adopted at the Seventy-seventh World Health Assembly (May 2024). 2. IPC units created in WHO regional offices and IPC focal points located in each WHO country office. 3. All the following indicators are achieved and IPC is: a. represented in the International Health Regulations (IHR) amendment (May 2024); b. addressed in the pandemic prevention, preparedness, and response accord; c. mentioned in the United Nations General Assembly (UNGA) resolution on WASH; d. included in the AMR agenda item at UNGA (September 2024); e. placed on the agenda for future UNGA meetings (for example, on universal health coverage (UHC), primary health care (PHC), etc.) (2030).
Key action #2 Develop the financial investment case for prioritizing IPC.	WHO IPC secretariat, international partners and relevant academic institutions.	1. Publication of the 2024 updated global report on IPC, including the financial investment for IPC based on new cost-effectiveness data from WHO/Organisation for Economic Co-operation and Development (OECD) modelling (2024). 2. New WHO cost and cost-effectiveness data/calculator tool for IPC for use by countries, developed, tested and published (2025).

Strategic direction #2. Active IPC programmes

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Work across the three levels of WHO to support countries to establish or strengthen active national IPC programmes.	WHO IPC teams at headquarters; IPC focal points in WHO regional offices and country offices. Political, government and health care leaders; IPC focal points, leaders at public health and other national institutes.	1. Proportion of countries with national IPC programmes at level 4 or 5 (highest levels) according to the WHO State Party self-assessment annual reporting tool (SPAR 9.1) and level D or E in the Tripartite AMR country self-assessment survey (TrACSS 3.5). 2. Country scoring improved within section 3.5 of TrACSS and/or within section 9.1 of SPAR.
Key action #2 Demonstrate evidence of a global improvement of national IPC programmes (i.e., meet WHO minimum requirements)	WHO IPC teams at headquarters; IPC focal points in WHO regional offices and country offices. International and national stakeholders and partners. Political, government and health care leaders; IPC focal points, leaders at public health and other national institutes	1. Proportion of countries meeting all WHO IPC minimum requirements for IPC programmes at national level (through the WHO IPC global portal). 2. Proportion of countries that have a national target on reducing health care-associated infections (HAIs) (monitored by the WHO Patient Safety Flagship). 3. Proportion of countries that have achieved their national targets on reducing HAIs (based on self-assessment).
Key action #3 Support and demonstrate improvement globally in WASH and cleaning and waste services in order to enable IPC practices.	Political, government and health care leaders; IPC focal points, leaders at public health and other national institutes. WHO/United Nations Children's Fund (UNICEF), WASH and IPC leaders and teams; WASH and IPC focal points in WHO regional and country offices.	1. Basic WASH and waste services available in all health care facilities (per each indicator as monitored in the WHO/UNICEF Joint Monitoring Programme; see footnote in Strategic direction 2 for definitions).

Strategic direction #3. IPC integration and coordination

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Establish mechanisms for crosscutting work/collaborations across all programmes relevant for/complementary to IPC[1] (as listed in the global strategy on IPC) within WHO headquarters and regional offices.	WHO - focal points/leaders and teams in the IPC programmes and other complementary programmes at WHO headquarters, as well as regional and country offices.	Global and regional taskforces established including all relevant programmes related to IPC with terms of reference and in line with WHO's 14th General Programme of Work (2026).
Key action #2 Ensure that IPC principles, indicators and tools are reflected/cross-referenced in each WHO programme that is complementary to IPC.	WHO - focal points/leaders and teams in the IPC programmes and other complementary programmes at WHO headquarters, as well as regional and country offices.	1. Desk review and situational analysis for IPC integration within other programmes completed (2026). 2. Key existing IPC policies, principles, indicators and tools identified, appropriately included and cross-referenced within each WHO programme complementary to IPC (2028).
Key action #3 Ensure that principles, indicators and tools of other WHO programmes complementary to IPC are reflected/cross-referenced in the IPC programme within WHO headquarters and regional offices.	WHO - focal points/leaders and teams in the IPC programmes and other complementary programmes at WHO headquarters, as well as regional and country offices.	1. Desk review and situational analysis of integration of other programmes within the IPC programme completed. (2026). 2. Key existing policies, principles, indicators and tools from each WHO programme identified, appropriately included and cross-referenced within the IPC programme (2028).

[1] Programmes/areas of work complementary to IPC programmes: AMR; occupational health; patient safety; public health emergencies; quality of care; WASH and health care waste; specific infectious diseases programmes (for example., human immunodeficiency virus, tuberculosis); others.

Strategic direction #4. IPC knowledge among health and care workers and career pathways for IPC professionals

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Develop international IPC standardized curricula	IPC and other focal points/leaders in WHO headquarters and regional offices; WHO Academy; education working group within the global IPC network	1. WHO international IPC curricula for: a. pre-graduate education; b. postgraduate education; c. in-service training published (2026).
Key action #2 Establish an international IPC certification and/or support and promote existing certificates	IPC and other focal points/leaders in WHO headquarters and regional offices; WHO Academy; education working group within the global IPC network	1. International IPC certification established and in use (2030).

Strategic direction #5. Data for action

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Establish/strengthen global data collection and tracking systems for IPC monitoring (with a hand hygiene compliance monitoring system as a subset).	IPC and other leaders at WHO headquarters and regional offices. International and national stakeholders and partners.	1. Global IPC monitoring and reporting system (IPC global portal) strengthened and fully implemented (to track progress of IPC minimum requirement and core components' implementation at national and facility levels) (2026). 2. Standardized global hand hygiene compliance monitoring system established (2026). 3. Proportion of countries regularly reporting via the IPC global portal.
Key action #2 Working across the three levels of WHO, support countries to establish or strengthen national IPC monitoring systems.	WHO – IPC and leaders of other divisions and departments (for example, WASH); WHO regional and country offices. International and national stakeholders and partners. Leaders at public health and other national institutes, and in health information management systems; national IPC focal points and teams.	1. Guidance and data collection tools for IPC monitoring, taking into account country specificities, developed/reviewed in all countries (2028).

Key action #3 Support HAI surveillance capacity building in countries through the establishment of a technical working group and the development/review of guidance, standardized protocols and data collection tools (including early warning systems) for HAI surveillance within the existing national disease surveillance systems.	WHO – IPC and leaders of other divisions and departments (for example, AMR, WHE); WHO regional and country offices. International and national stakeholders and partners. Leaders in national surveillance systems and health information management systems, and at public health and other national institutes; national IPC focal points and teams; IPC committees and technical expert working groups.	1. Guidance, standardized protocols and data collection tools for priority HAIs taking into account country specificities, developed/reviewed in all countries (2028).
Key action #4 Working across the three levels of WHO, support countries to establish or strengthen national HAI surveillance systems within/in line with existing national disease surveillance systems, including for pathogens that are antimicrobial-resistant and/or prone to epidemics and pandemics and for monitoring antimicrobial consumption.	WHO – IPC and leaders of other divisions (for example, AMR, WHE), including surveillance of other infectious diseases; WHO regional and country offices. International and national stakeholders and partners. Leaders in national surveillance systems and health information management systems, and at public health and other national institutes; national IPC focal points and teams; IPC committees and technical expert working groups.	1. Proportion of countries reporting to the WHO Global antimicrobial and use surveillance system (GLASS) with discrimination of community versus hospital origin of pathogens.

Strategic direction #6. Advocacy and communications

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Develop global and regional IPC communications and advocacy strategies (as stand-alone or apart of wider strategies, for example, on AMR, patient safety or WASH), including engaging global and regional champions, addressing the importance of integrated and coordinated advocacy and communications across WHO programmes complementary to IPC, and supporting countries to develop their national advocacy and communication strategy and plans for IPC.	WHO – IPC and leaders of other divisions and departments and teams, with the support of WHO communication departments. International and national stakeholders and partners.	1. Global and regional IPC advocacy and communications strategies (according to Key action #1) developed (2026). 2. Proportion of global and regional IPC advocacy champions.
Key action #2 Ensure that IPC and AMR in health care are included in efforts addressing misinformation and infodemics about medical and public health topics.	WHO – IPC and leaders of other divisions and teams, with the support of WHO communication departments. International and national stakeholders and partners.	1. IPC included in a global programme that is designed to manage and actively respond to misinformation and infodemics (2026).
Key action #3 Develop an IPC communications template to be implemented early in and throughout future outbreaks.	WHO – IPC and leaders of other divisions and teams, with the support of WHO communication departments.	1. IPC communications template for outbreaks developed (2026).

Strategic direction #7. Research and development

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Develop a global IPC research agenda, as well as a research gap analysis, based on country needs, including a multisectoral and multidisciplinary approach with a focus on AMR, a public health emergency programme, WASH and low-resource settings.	WHO – IPC and other teams (for example, Research for Health, AMR, public health emergency programme, WASH) in collaboration with the global IPC network, WHO Collaborating Centres, research institutions, other stakeholders and donors.	1. Global IPC research agenda developed, including a summary of the current state of IPC research (best practices and methodology) and gap analysis and research questions (2026).
Key action #2 Develop guidance on methods/protocols and tools for IPC research.	WHO – IPC and other teams (for example, Research for Health, AMR, public health emergency programme, WASH), in collaboration with the global IPC network, WHO Collaborating Centres, research institutions, other stakeholders and donors.	1. Protocols and tools for IPC research are developed and hosted on a readily available central platform (2028).
Key action #3 Engage global and national donors and grant/funding bodies for the inclusion of IPC in research calls and projects.	WHO – IPC and other leaders (for example, Integrated Health Services, UHL, Research for Health, AMR, public health emergency programme, WASH) in collaboration with the global IPC network, research institutions, other stakeholders and donors.	1. Proportion of annual: a. calls for IPC research proposals; b. funded research projects on IPC. 2. Proportion of publications on IPC research per year.
Key action #4 Lead/support research in line with the IPC research priorities included in the WHO global AMR[2], IPC, patient safety research agendas.	WHO – IPC and other focal points/leaders and teams; global IPC network, research institutions, other stakeholders and donors.	1. Proportion of published research results in line with the IPC research priorities included in the AMR research agenda.

[2] Global research agenda for antimicrobial resistance in human health, Geneva: World Health Organization; 2023 (https://www.who.int/publications/m/item/global-research-agenda-for-antimicrobial-resistance-in-human-health, accessed 7 Dec 2023).

Strategic direction #8. Collaboration and stakeholder support

Action	Key players	Indicator(s)
Global and regional level		
Key action #1 Map partners, international organizations and societies relevant for IPC at the global and regional levels, taking a multisectoral and multidisciplinary approach.	WHO – IPC and other leaders and teams in WHO headquarters, as well as regional and country offices, in collaboration with the global IPC network and other stakeholders.	1. Global and regional mapping exercises performed and available (2026) and mechanisms in place for regular updates. 2. Global collaboration agenda to support IPC developed (2028). 3. Profile of IPC global and regional stakeholders regularly updated (for example, annually) (organizations/societies/partners/donors/etc.) (2030).
Key action #2 Maintain and strengthen the global IPC network, including organizing international IPC meetings/conferences to share country experiences.	WHO – IPC leaders and teams in WHO headquarters and in collaboration with regional offices.	1. Proportion of consultative processes of the global IPC network per year (minimum 1 per year). 2. Proportion of WHO products developed in collaboration with the global IPC network per year. 3. Proportion of international IPC meetings/conferences organized by WHO and/or global IPC network members per year.
Key action #3 Establish regional multi-stakeholder partnerships and networks on IPC including terms of reference and a memorandum of understanding aligned with the objectives of the global strategy and action plan on IPC and country needs.	WHO – IPC and other leaders and teams in WHO headquarters, region and country offices; the global IPC network and other stakeholders.	1. Proportion of regional IPC stakeholder partnerships and networks (baseline and 2030). 2. Proportion of active members in the WHO IPC Community of Practice.

Supplementary annex 3. Key players, pre-existing indicators and monitoring systems in support of the implementation of the global action plan and monitoring framework on infection prevention and control (IPC)

Strategic direction #1. Political commitment and policies

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Develop a national action plan and monitoring framework for IPC, outlining costs and sources of financing.	Government and health care leaders; IPC national focal point and team; national IPC committee; leaders at public health and other national institutes.	1. IPC national action plan and monitoring framework developed, costed, validated, and approved by the ministry of health or other relevant national authorities within the context of national health plans.	WHO IPC global portal[1].	IPCAT2[2] – 1.1.7: there is an identified, protected and dedicated budget allocated according to planned activity.
				IPCAT2[2] – 1.2.2: development of a national plan for preventing health care-associated infections (HAIs) relating to endemic pathogens and those with epidemic potential, for example, including national goals, objectives and strategies.
				IPCAT2[2] – 1.2.3: development of national monitoring frameworks to measure implementation with policies, guidelines and standards.
			eSPAR[3].	SPAR[4] 9.1: IPC programmes.
Key action #2 Establish the legal framework for IPC to mandate the implementation of IPC programmes nationally and at facility level.	Government and health care leaders; IPC and other focal points/leaders; accreditation and health regulatory bodies and leaders.	1. Legislation/ regulations in place to address IPC (including IPC professionals) as part of the public health regulatory framework.	*No current existing indicators or systems.*	
Key action #3	IPC and other focal points/leaders; finance leaders; national public	1. National financial investment case developed based on global models (2026).	*No current existing indicators or systems.*	

[1] Global IPC portal. Geneva: World Health Organization; 2023 (https://ipcportal.who.int, accessed 24 October 2023).
[2] Core components for infection prevention and control programmes national assessment tool (IPCAT2). Geneva: World Health Organization; 2017 (https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/core-components/ipcat2.xls?sfvrsn=d087b1de_4, accessed 24 October 2023).
[3] Electronic International Health Regulations (IHR) State Party self-assessment annual reporting tool. Geneva: World Health Organization; 2022 (https://extranet.who.int/e-spar, accessed 24 October 2023).
[4] International Health Regulations (2005): state party self-assessment annual reporting tool, 2nd ed. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/350218, accessed 24 October 2023).

Develop the national financial investment case aligned with the global business case for IPC.	health institute and academic institutions.			
Key action #4 Establish a dedicated IPC budget to fund the national IPC programme and action plan.	National IPC focal points working with government officials, political and health care leaders and policy-makers at ministries of health (and other relevant ministries and entities providing health care delivery), ministries of finance, labour, environment, and education; accreditation and health regulatory bodies; and senior managers and administrators responsible for planning and budgets.	1. Dedicated (in line with the IPC national action plan) budget allocated to the IPC national programme, identified and available. 2. Proportion of health care facilities with adequate dedicated budget funding for IPC	WHO IPC global portal[1] eSPAR[3]	IPCAT2[2] – 1.7: there is an identified, protected and dedicated budget allocated according to planned activity. IPCAT-MR[5] – 1.4: there is an identified, protected and dedicated budget allocated to the IPC programme, according to planned activity. SPAR[4] 9.1: IPC programmes. IPCAF[6] – 1.9: Does the senior facility leadership show clear commitment and support for the IPC programme by an allocated budget specifically for the IPC programme (that is, covering IPC activities, including salaries)?
Key action #5 Demonstrate evidence of investment by national authorities in water, sanitation and hygiene (WASH), health care waste and cleaning infrastructure services and staffing to ensure that all health care facilities have safely	Political and government and health care leaders; WASH and IPC and other focal points/leaders; key stakeholders and donors.	1. Dedicated and sufficient funding allocated at the national level for WASH services and activities.	GLAAS[7].	Sufficient funding to reach the national target.

[5] Assessment tool of the minimum requirements for infection prevention and control programmes at the national level. Geneva: World Health Organization; 2021 (https://www.who.int/publications/m/item/assessment-tool-of-the-minimum-requirements-for-infection-prevention-and-control-programmes-at-the-national-level, accessed 24 October 2023).

[6] Infection prevention and control assessment framework at the facility level. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/330072, accessed 24 October 2023).

[7] United Nations-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) – 2021/2022 cycle. Geneva: World Health Organization; 2022 (https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health/monitoring-and-evidence/wash-systems-monitoring/un-water-global-analysis-and-assessment-of-sanitation-and-drinking-water/2021-2022-cycle, accessed 24 October 2023).

managed WASH services to enable IPC practices.				
Key action #6 Establish a national IPC committee actively functioning with a dedicated role (regulatory authority) to support implementation of the IPC action plan at the national and facility level.	Political and government and health care leaders; IPC and other focal points/leaders working with focal points responsible for patient safety and quality of care, antimicrobial resistance (AMR), occupational health, WASH, IHR, and One Health	1. National IPC committee established and functioning (2026) 2. Proportion of countries with a national IPC committee established and functioning.	WHO IPC global portal[1].	IPCAT2[2] – 1.1.8: an official multidisciplinary group/committee or equivalent structure is established to support the IPC team at the national level (for example, national IPC committee).
Key action #7 Introduce IPC indicators in line with the WHO IPC core components and minimum requirements in the national quality assurance systems for health care facilities (such as licensing and accreditation systems or similar), if existing.	National IPC focal points working with government and health care leaders and accreditation and health regulatory bodies.	1. IPC requirements included as indicators in national licensing and accreditation (or similar) systems for health care facilities, if existing (2028).	WHO IPC global portal[1].	IPCAT2[2]– 6.1.2: IPC indicators integrated within national monitoring systems, for example, health management information systems.
Key action #8 Establish adequate staffing levels including IPC professionals according to local needs and using standardized tools.	Political, government and health care leaders and policy- makers at ministries of health (and other relevant ministries and entities providing health care delivery), ministries of finance, labour, environment, and education; accreditation and health regulatory bodies; and senior managers and administrators responsible for planning and budgets; IPC and other focal points/leaders; unions.	1. Adequate staffing levels met as per IPC core components (CC) requirements (CC1 for IPC professionals and CC7 for health and care workers) (2030).	WHO IPC global portal[1].	IPCAT2[2] – 1.1.2 (and IPCAT-MR[3] – 1.2): an appointed infection preventionist(s) in charge of the programme can be identified. IPCAT2[2] – 1.1.5 (and IPCAT-MR[3] – 1.5): the appointed infection preventionist(s) has dedicated time for the tasks (at least one full-time person). IPCAF[8] – 1.3: at least one full-time (1:250 beds) IPC professional or equivalent available. IPCAF – 7.1: are appropriate staffing levels assessed in your facility according to patient workload using national standards or a standard staffing needs assessment tool, such as the WHO

[8] Infection prevention and control assessment framework at the facility level. Geneva: World Health Organization; 2018 (https://iris.who.int/bitstream/handle/10665/330072/WHO-HIS-SDS-2018.9-eng.pdf, accessed 24 October 2023).

				Workload indicators of staffing need (WISN) method? IPCAF – 7.3: is a system in place in your facility to act on the results of the WISN assessments when staffing levels are deemed to be too low?
		2. Proportion of facilities that meet pre-defined national standards for staffing levels.	The global health observatory[9].	Indicators for Sustainable Development Goal (SDG) 3.c: 1. nursing personnel (proportion); 2. nursing and midwifery personnel (proportion); 3. nursing and midwifery personnel (per 10 000 population).
Facility level				
Key action #1 Demonstrate facility senior managers' commitment and support to IPC through sufficient dedicated budget allocation to the IPC programme and team, including implementation of. the annual action plan.	Facility senior managers including the director-general, medical and nursing directors; IPC focal points/leaders.	1. Adequate dedicated budget for IPC available, that is, to fund the IPC programme and team and the annual action plan, including equipment for IPC practices.	eSPAR[3] WHO IPC global portal[1]	SPAR[4] 9.1: IPC programmes. IPCAF – 1.9: Does the senior facility leadership show clear commitment and support for the IPC programme by an allocated budget specifically for the IPC programme (that is, covering IPC activities, including salaries)?

[9] SDG Target 3.c. Health workforce: substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states. Geneva: World Health Organization; 2023 (https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/sdg-target-3.c-health-workforce, accessed 24 October 2023).

Strategic direction #2. Active IPC programmes

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Establish a national IPC programme and demonstrate evidence of improvement of IPC programmes, including WASH (that is, meet WHO minimum requirements at national and facility level).	Political, government and health care leaders; IPC focal points, leaders at public health and other national institutes, including key stakeholders and donors. IPC focal points in WHO regional offices and country offices.	1. All WHO IPC minimum requirements at national level are met.	WHO IPC global portal[1].	IPCAT-MR[5] – all indicators (national level).
		2. Proportion of health facilities meeting all WHO IPC minimum requirements at facility level.		IPCAF-MR - all indicators (tools for primary[10], secondary and tertiary care facilities).
		3. Proportion of health care facilities with (1) basic water, (2) sanitation, (3) hygiene, and (4) waste services.	WHO/United Nations Children's Fund (UNICEF) Joint Monitoring Programme data on service levels (WASH and health care waste).	Basic water is defined as water available from an improved source on premises, but basic sanitation is a more comprehensive definition. Thus, for the purposes of this global action plan, the sanitation target will be met if facilities have toilets, which are improved and useable, with one dedicated for staff and one for patients; if basic hand hygiene is a functional hand hygiene facility (with soap and water and/or alcohol-based handrub) available at points of care and within 5 metres of toilets; if basic health care waste is waste that is safely segregated into at least three bins and sharps and infectious waste are treated and disposed of separately.
Key action #2	Political, government and health care leaders; IPC and other focal	1. Proportion of tertiary/secondary care health	eSPAR[3]	SPAR[4] C9.1: IPC programmes.

[10] Assessment tool on infection prevention and control minimum requirements for primary health care facilities. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/367505, accessed 24 October 2023).

Ensure the establishment of active IPC programmes (that is, with objectives and an action plan supported by dedicated human resources and financing) at least in tertiary/secondary care facilities, and with an IPC link person in each primary care facility, within broader health services development.	points, leaders at public health and other national institutes; key stakeholders and donors; facility senior managers including the director-general, medical and nursing directors.	facilities with an active IPC programme.	WHO IPC global portal[1].	IPCAF – 1.1-1.4 and 1.8-1.9 :
		2. Proportion of primary care facilities with an IPC link person.	WHO IPC global portal[1].	IPCAF-MR – CC1 indicator 1.1 (primary care facilities[10]).
Key action #3 Support the implementation of multimodal improvement strategies (MMIS) to reduce HAIs in health care facilities at all levels, according to local priorities	Political, government and health care leaders; IPC and other focal points, leaders at public health and other national institutes, professional and scientific organizations, key stakeholders and donors; facility senior managers including the director-general, medical and nursing directors.	1. Proportion of facilities with implemented multimodal implementation strategies to reduce specific HAIs according to local priorities.	WHO IPC global portal[1].	IPCAT2[2] – 5.1.1 (and IPCAT-MR[3] – 5.1): trained national IPC team, competent in implementation science and multimodal behaviour change strategies.
				IPCAT2[2] – 5.1.2: promotion of multimodal strategies through the inclusion of the approach in the development of IPC guidelines, education and training.
				IPCAT-MR[5] – 5.2: the national IPC focal point coordinates/supports local implementation of IPC improvement interventions.
				IPCAT-MR[5] – 5.3: multimodal strategies are included as the best approach for the implementation of IPC guidelines and IPC education and training programmes.
Key action #4 Develop national IPC guidelines, including policies for an enabling environment for IPC, infrastructure, supplies, and infection prevention among health and care workers at facility level.	Political, government and health care leaders; IPC and other focal points/leaders; educational institutions and professional and scientific organizations, societies, unions; key stakeholders and donors.	1. Evidence-based IPC guidelines and policies available at the national level.	WHO IPC global portal[1].	All indicators in CC2 in IPCAT2[2] (and IPCAT-MR[5]).

Facility level				
Key action #1 Establish an active IPC programme in tertiary/secondary care facilities (that is, with objectives and annual action plan, supported by dedicated human resources and budget) and ensure that there is an IPC link person in each primary care facility, within broader health services development.	Local political, government and health care leaders; facility senior managers including the director-general, medical and nursing directors; local IPC leaders and teams; key stakeholders and donors.	1. Active IPC programme established (that is, with objectives and annual action plan supported by dedicated human resources and adequate funding) (2026).	eSPAR[3]	SPAR C9.1: IPC programmes.
			WHO IPC global portal[1]	IPCAF-MR: all indicators in CC1 (tools for secondary/tertiary care facilities). IPCAF – 1.1-1.4 + 1.8-1.9:
Key action #2 Make, fund and implement IPC improvement plans in order to achieve the WHO minimum requirements for IPC according to the facility level, including an appropriate facility infrastructure.	Local political, government and health care leaders; facility senior managers including the director-general, medical and nursing directors; local IPC leaders and teams; key stakeholders and donors.	1. WHO IPC minimum requirements in the health care facility are met according to the facility level.	WHO IPC global portal[1]	IPCAF-MR: all indicators (tools for primary[10], secondary and tertiary care facilities).
		2. Percentage of WHO IPC minimum requirements met in the health care facility, according to the facility level.		

Strategic direction #3. IPC integration and coordination

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Ensure inclusion of IPC principles, standards and indicators within strategies and documents of other complementary national programmes[11].	IPC team and focal points in other programmes at the ministry of health and WHO country office.	1. Desk review and situational analysis of IPC integration within other programmes completed (2028).	WHO IPC global portal[1.]	IPCAT2[2]: all indicators in section 1.3, that is, clear linkages (including routine communications) between IPC and other programmes and professional organizations.
		2. Key existing IPC principles, standards and indicators identified and appropriately included and cross-referenced within other national complementary programmes (2030).		IPCAT2[2] – 6.1.2: IPC indicators integrated within national monitoring systems, for example, health management information system.
Key action #2 Ensure that the IPC programme is aligned with and contributes to other complementary national programme strategies and documents.	IPC team and focal points in other programmes at the ministry of health and WHO country office.	1. Desk review and situational analysis of integration of other complementary programmes within the IPC programme. completed (2028).	WHO IPC global portal[1.]	IPCAT2[2]: all indicators in section 1.3, that is, clear linkages (including routine communications) between IPC and other programmes and professional organizations.
		2. Key existing policies, principles, standards and indicators from other complementary programmes identified and appropriately included and cross-referenced within IPC documents and programmes (2030).		
Key action #3 Ensure that IPC clinical practices and appropriate antimicrobial	Health care leaders; IPC and other focal points/leaders; senior	1. Clinical packages (for example, policies, standard operating protocols) available,	*No current existing indicators or systems.*	

[11] Programmes/areas of work complementary to IPC programmes, such as AMR, occupational health, patient safety, public health emergencies, quality of care, WASH and health care waste, specific infectious diseases' programmes (for example, human immunodeficiency virus, tuberculosis) and others.

prescribing (that is, antimicrobial stewardship) become embedded in policies related to patient care pathways/ programmes at the national, sub-national and facility levels for tertiary, secondary and primary health care.	managers at the sub-national and facility level.	which integrate IPC and appropriate antimicrobial prescribing within clinical care (for example, surgery, maternal and neonatal care, etc.) (2028).		
Key action #4 Ensure inclusion of IPC principles, strategies and standards in AMR policies, national action plans and implementation projects.	Political, government and health care leaders; AMR and IPC focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); key stakeholders and donors.	1. AMR policies, national action plans and implementation projects including IPC available (2026).	TrACSS[12].	Component 3.5: IPC in human health.
		2. Modified SDG 3.d.2 indicator in inpatients: proportion of bloodstream infections due to methicillin-resistant *Staphylococcus aureus* (MRSA), *Acinetobacter* spp, *Klebsiella* spp, and *Pseudomonas* spp resistant to carbapenems.	Elements of the modified SDG 3.d.2 indicator can be collected through GLASS[13].	
Key action #5 Ensure IPC is included as a component of the national preparedness, readiness, and response plan within the context of public health emergencies.	Political and government and health care leaders; IPC and public health emergencies focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); key stakeholders and donors.	1. IPC section including budget, personnel, and supplies included in the national preparedness, readiness, and response plan.	WHO IPC global portal[1].	IPCAT2[2] – 1.3.2: Priority public health programmes including integration of IPC with IHR and preparedness relating to public health emergencies.

[12] Global database for Tracking Antimicrobial Resistance Country Self- Assessment Survey (TrACSS) (https://amrcountryprogress.org/#/map-view, accessed 30 October 2023).
[13] Global Antimicrobial Resistance and Use Surveillance System (GLASS). Geneva: World Health Organization; 2015 (https://www.who.int/initiatives/glass, accessed 24 October 2023).

Key action #6 Develop and cost national plans for WASH in health care facilities.	Political and government and health care leaders; WASH and IPC focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); key stakeholders and donors.	1. Costed road maps (that is, national plans) available for WASH in health care facilities, which include IPC elements.	WASH country progress tracker[7].	National coordination and roadmaps.
		2. Standards available for WASH, cleaning and health care waste in health care facilities.	Country tracker. eSPAR[3].	Standards for WASH and health care waste. SPAR[4] C9.3: built environment.
Key action #7 Ensure IPC is included as a component of national occupational health and safety programmes for health workers, including plans for prevention, reporting and follow-up of occupational infections.	Political and government and health care leaders; occupational health and safety and IPC focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); ; and professional and scientific organizations, societies, unions.	1. National plans available for the prevention, reporting and follow-up of occupational infections, including a policy for health and care workers vaccination.	The global health observatory[14].	Existence of national policy instruments for occupational health and safety for health and care workers.
		2. Proportion of countries having a national policy for occupational health and safety for health and workers (indicator for global reporting).		
		3. Proportion of countries with a vaccination programme for health and care workers (indicator for global reporting).		

[14] Existence of national policy instruments for occupational health and safety for health workers. Geneva: World Health Organization; 2023 (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/existence-of-national-policy-instruments-for-occupational-health-and-safety-for-health-workers, accessed 24 October 2023).

Key action #8 Integrate IPC supplies in the national lists of essential medicines and priority medical devices and identify those essential for emergencies	Political and government and health care leaders; IPC and other focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes).	1. Agreed list of essential IPC supplies available (that is, alcohol-based handrub products, personal protective equipment, disinfectants, etc.) (2026). 2. Assessment completed of which IPC supplies are included in the national lists of essential medicines and priority medical devices (2028). 3. Agreed list of essential IPC supplies included in lists of essential medicines and priority medical devices (2030).	The global health observatory[15]. WHO IPC global portal[1].	SDG 3.b.3: proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. IPCAT2[2] – 1.2.7: assurance of national procurement of adequate supplies for IPC practices, including access to essential infrastructures, materials and equipment necessary for safe IPC practice.
Facility level				
Key action #1 Establish an IPC committee ensuring strong representation of and collaborative activities with other complementary programmes (for tertiary/secondary care facilities).	Focal points/leaders for IPC and other complementary programmes; senior managers at the sub-national and facility level, including the director-general, medical and nursing directors and local IPC leads.	1. IPC committee established with representation of and collaborative activities with other complementary programmes (2026).	WHO IPC global portal[1].	IPCAF – 1.6: do you have an IPC committee5 actively supporting the IPC team? IPCAF – 1.7: are any of the following professional groups represented/included in the IPC committee?
Key action #2 Ensure both IPC clinical practices and appropriate antimicrobial prescribing are embedded in all patient care pathways/wards.	Local IPC and clinical care focal points/leaders; senior managers at the sub-national and facility level, including the director-general, medical and nursing directors	1. Standard operating protocols available integrating IPC and appropriate antimicrobial prescribing within clinical care (for example, surgery,	*No current existing indicators or systems.*	

[15] Indicator 3.b.3: Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. Geneva: World Health Organization; 2023 (https://www.who.int/data/gho/indicator-metadata-registry/imr-details/5559, accessed 24 October 2023).

		maternal and neonatal care, etc.) (2028).	
		2. Demonstrate increased compliance with IPC practices in specific wards and among specialized professionals (for example, injection safety, hand hygiene, waste management and others in surgical wards, operating room and critical care units) (2030).	
		3. Demonstrate increased compliance with appropriate antimicrobial prescribing (for example, at least one annual audit).	

Strategic direction #4. IPC knowledge among health and care workers and career pathways for IPC professionals

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Develop a national curriculum for IPC professionals aligned with the WHO IPC core competencies or endorse an international curriculum.	IPC and other focal points/leaders; educational institutions and professional and scientific organizations, societies, unions.	1. Curriculum for IPC professionals developed or an international curriculum endorsed and in use (2028).	IPCAT2[2] – 3.2.1- 3.2.3	
		2. Proportion of countries with a curriculum for IPC professionals developed and in use (indicator for global target).		
Key action #2 Establish a national postgraduate[16] IPC certificate[17] programme (including training courses on emergency preparedness on specific situations) for IPC professionals that are aligned with existing international standards, or require existing certificates.	Political and government and health care leaders; IPC and other focal points/leaders; educational institutions and professional and scientific organizations, societies, unions.	1. Postgraduate IPC certification programme established or requirement for an existing certificate (2030).	*No current existing indicators or systems.*	
		2. Proportion of countries with an IPC certificate programme or equivalent or requiring existing certificates (indicator for global target).		

[16] Postgraduate: a type of qualification that is completed after a relevant undergraduate degree or diploma. Postgraduate degrees encompass a range of qualifications, including master's degrees, postgraduate diplomas and certificates, and PhDs.
[17] A certificate is awarded following the completion of a course or series of courses that provides education and training around an intended learning outcome.

Key action #3 Develop (or adopt an international one) and establish a national IPC curriculum for pre-graduate[18] training and education for all relevant health care disciplines (for example, medical, nursing and midwifery schools), endorsed by the appropriate national or International body, and integrate it within health educational curricula, with embedded evaluation mechanisms.	Political and government and health care leaders; IPC and other focal points/leaders; educational institutions and professional and scientific organizations, societies, unions	1. IPC pre-graduate curriculum for all relevant health care disciplines developed and endorsed by the appropriate national or international body ensuring that quality and standards are met (national/International) (2028).	WHO IPC global portal[1].	IPCAT2[2] – 3.2.1: national IPC curricula, developed (or under development) in collaboration with local academic institutions are available for pre-graduate courses. IPCAT-MR CC3.1-3.4; 5.1; 6.4
		2. IPC pre-graduate curriculum integrated within health educational curricula, with embedded evaluation mechanisms (2030).	*No current existing indicators or systems.*	
Key action #4 Develop a national in-service[19] IPC curriculum for all frontline clinical, cleaning and management staff (or adopt an international one) and create a national (or sub-national) training programme to support in-service IPC training.	Political and government and health care leaders; IPC and other focal points/leaders; educational institutions and professional and scientific organizations, societies, unions.	1. National in-service IPC curriculum developed (2026).	WHO IPC global portal[1].	IPCAT2[2] – 3.2.4; 3.2.5 IPCAT-MR[5] – CC3.1-3.4; 6.4
		2. National (or sub-national) IPC training programme to support in-service training created (2028), rolled-out and regularly updated (2030).		
		3. Proportion of countries with a national IPC in-service curriculum (indicator for global target).		

[18] Pre-graduate: a person taking an academic course (for example, diploma or degree programme), but who has not yet graduated.

[19] In-service: training that is given to employees during the course of employment, carried out by an institution or agency. It includes orientation programmes.

Key action #5 Mandate that all health and care workers, in particular frontline clinical, cleaning, and management staff, receive education and training in IPC standard operating protocols upon employment and regularly (for example, annually).	Political and government and health care leaders; IPC and other focal points/leaders; key stakeholders and partners; senior managers including medical and nursing directors.	1. Legal mechanism or well-defined strategies established to mandate IPC in-service training (2028).	*No current existing indicators or systems.*	
		2. Proportion of facilities providing and/or requiring mandatory training for all frontline clinical, and cleaning staff upon employment and annually, as well as for managers upon employment.	WHO IPC global portal[1].	IPCAF – 3.3-4: health and care workers receive IPC training upon employment, regularly and is mandatory.
				IPCAF-MR (tools for primary[10], secondary and tertiary care facilities) – indicators 3.1-2.
		3. Proportion of facilities achieving all WHO minimum requirements for IPC training and education according to the facility level (IPCAF-MR).	WHO IPC global portal[1].	IPCAF-MR (tools for primary[10], secondary and tertiary care facilities) – all CC3 indicators.
		4. Proportion of countries with a national (or sub-national) IPC training programme (indicator for global target).	*No current existing indicators or systems.*	
Key action #6 Create a career pathway for IPC professionals.	Political and government and health care leaders; policy and decision makers in the ministries of health and education, educational institutions and organizations; IPC focal points and	1. Framework available that outlines the steps that create a career pathway for IPC professionals (2028).	*No current existing indicators or systems.*	

	leaders; professional and scientific organizations and societies.	2. Specific positions for IPC professionals/focal points created in the national health care system.		
		3. Proportion of hospitals with at least one full-time IPC professional per 250 beds.	WHO IPC global portal[1].	IPCAF – 1.3: does the IPC team have at least one full-time IPC professional or equivalent (nurse or doctor working 100% in IPC) available per ≤250 beds? IPCAF-MR – 1.1 (tool for secondary care facilities); 1.2 (tool for tertiary care facilities).
Facility level				
Key action #1 Make implementation plans and provide resources (human and financial) to achieve all WHO minimum requirements for IPC training and education and to progressively achieve all requirements of CC 3.	Local political and government and health care leaders; IPC and other focal points/leaders; educational institutions and professional and scientific organizations, societies, unions; senior managers including the director-general, medical and nursing directors.	1. All WHO minimum requirements for IPC training and education met, according to the facility level, (2030). All WHO minimum requirements for IPC training and education met, according to the facility level, (2030).	WHO IPC global portal[1].	IPCAF-MR: all indicators in CC3 (tools for primary[10], secondary and tertiary care facilities).

Strategic direction #5. Data for action

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Establish/strengthen the national IPC monitoring system and ensure that health care facilities participate in the national IPC monitoring networks.	Political, government and health care leaders; IPC and other focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); educational institutions and professional and scientific organizations, societies	1. National strategic plan for IPC monitoring in place, including an integrated IPC monitoring system for the collection, analysis and feedback of data.	WHO IPC global portal[1].	IPCAT2[2] – 6.1.1 + 6.1.2 + 6.1.6 + 6.3.6
				IPCAT-MR[5] – 6.2 + 6.5
			eSPAR[3].	SPAR[4] C.9.2: HAI surveillance.
		2. Proportion of tertiary/secondary care facilities having an IPC monitoring system for collection, analysis and feedback of data	WHO IPC global portal[1].	IPCAF-MR (tools for secondary/tertiary care facilities) – 6.2-6.4.
		3. Proportion of countries with a national IPC monitoring system (indicator for global reporting).		
Key action #2 Establish/strengthen a national HAI and related AMR surveillance system, including for early warning to detect epidemics and pandemic-prone pathogens, and for monitoring antimicrobial consumption, and ensure that tertiary/secondary health care facilities (at least referral centres) participate in the national or international HAI and AMR surveillance networks (for	Political and government and health care leaders; IPC and other focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); educational institutions and scientific societies	1. National strategic plan for HAI and related AMR surveillance (with a focus on priority infections based on the local context) developed by a multidisciplinary technical group (2026).	WHO IPC global portal[1].	IPCAT2[2] – all indicators in CC4. IPCAT-MR[5] – all indicators in CC4. IPCAF-MR (tools for secondary/tertiary care facilities) – all indicators in CC4.
		2. National/sub-national HAI and related AMR surveillance system (including for early warning to detect epidemic- and pandemic-prone pathogens causing HAIs),	eSPAR[3].	SPAR C9.2: HAI surveillance

example, GLASS, European AMR Surveillance Network, HAINet).		established and supported (including financially) by government and national/sub-national authorities (2028).		
		3. Proportion of tertiary/secondary health care facilities participating in the national/sub-national or international HAI and related AMR surveillance network.		
		4. Proportion of tertiary/secondary health care facilities having an HAI and related AMR surveillance system, including for early warning to detect outbreaks, epidemics and pandemic-prone pathogens.		
Key action #3 Establish/strengthen a system for monitoring hand hygiene in health care as a key national indicator.	Political, government and health care leaders; IPC and other focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); professional and scientific societies.	1. Hand hygiene compliance monitoring and feedback established as a key national indicator, at the very least for reference hospitals (2026).	WHO IPC global portal[1]	IPCAT2[2] – 6.2.1 (IPCAT-MR[5] 6.5) + 6.3.3. IPCAF[8] – 6.5. IPCAF-MR (tools for secondary/tertiary care facilities) – 6.3. HHSAF[20] (all indicators for evaluating a hand hygiene programme). WHO hand hygiene observation form[21] and data analysis tool.
		2. National programme for improving hand hygiene compliance in place (2026).		
		3. National hand hygiene monitoring system (compliance or product consumption) established and implemented (2028).		
		4. Proportion of health care		

[20] Hand Hygiene Self-Assessment Framework (HHSAF). Geneva: World Health Organization; 2010 (https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/hand-hygiene/monitoring/hhsa-framework-october-2010.pdf, accessed 24 October 2023).

[21] Hand hygiene. Geneva: World Health Organization; 2023 (https://www.who.int/teams/integrated-health-services/infection-prevention-control/hand-hygiene/monitoring-tools, accessed 26 October 2023).

		facilities at all levels monitoring hand hygiene and providing data through the national system.		
Key action #4 Integrate IPC and HAI indicators and data in national health information and accreditation systems and/or other relevant quality improvement activity	Political, government and health care leaders; accreditation bodies and/or other relevant quality improvement bodies; IPC and other focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes).	1. IPC and HAI data included as key criteria into national health care accreditation systems and/or other relevant quality improvement activity (2028).	*No current existing indicators or systems.*	
		2. IPC and HAI data included into health management information systems (2028).		
Key action #5 Ensure training and expertise in data collection, analysis interpretation and reporting to maximize data accuracy and quality.	Political, government and health care leaders; IPC and other focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); educational institutions and scientific societies.	1. Training programme established for IPC/HAI/antimicrobial consumption data collection, analysis interpretation and reporting (2026).	*No current existing indicators or systems.*	
		2. National training courses regularly organized (2028).		

Key action #6 Support health care facility activities related to IPC/HAI/antimicrobial consumption data analysis, reporting/feedback and interpretation to facilitate the development and update of local improvement plans.	Political, government and health care leaders; IPC, AMR and antimicrobial stewardship focal points/leaders (ministry of health; national IPC committee; leaders at public health and other national institutes); professional and scientific societies.	1. Regular reports of IPC/HAI/antimicrobial consumption data produced and shared with health and care workers and administrators (2026)	WHO IPC global portal[1].	IPCAT2[2] – all indicators in CC6, section 6.3 (includes IPCAT-MR[5] 6.2).
		2. Local action plans regularly developed/updated in the light of reported data (2028).		IPCAF[8] – 6.5-6.7
Facility level				
Key action #1 Make implementation plans and provide resources (human and financial) to achieve all WHO minimum requirements for HAI surveillance according to the facility level, and to progressively achieve all requirements of CC4.	Local political, government and health care leaders; IPC and infectious diseases surveillance focal points/leaders; senior managers including the director-general, medical and nursing directors.	1. Percentage of WHO minimum requirements for HAI surveillance met (only tertiary and secondary care facilities).	WHO IPC global portal[1].	IPCAF-MR (tools for secondary/ tertiary care facilities): all indicators in CC4. IPCAF – indicators 4.1-15.
Key action #2 Make implementation plans and provide resources (human and financial) to achieve all WHO minimum requirements for IPC monitoring and feedback according to the facility level, and to progressively achieve all requirements of CC6.	Political, government and health care leaders; IPC and health information systems focal points/leaders; senior managers including the director- general, medical and nursing directors.	1. Percentage of WHO minimum requirements for IPC monitoring and feedback met.		IPCAF – indicators 6.1-8.

Strategic direction #6. Advocacy and communications

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Develop and implement a national IPC advocacy and communications strategy and implementation plan (as a stand-alone or a part of wider strategies, for example, on AMR, patient safety or WASH), aligned for consistency with the WHO global strategy and including engaging local champions and the community.	Media and communication professionals and bodies; IPC and other focal points/leaders and teams; civil society, patient and family advocacy groups.	1. National advocacy strategy and implementation plan, including the identification of local experts/champions, developed and implemented (2026).	*No current existing indicators or systems.*	
Key action #2 Establish an advocacy and risk communication and community engagement training programme for IPC professionals and champions.	Government and health care leaders and decision- makers; IPC and other focal points/leaders; media and communication professionals and bodies; educational institutions and professional and scientific organizations, societies; civil society, patient and family advocacy groups.	1. National IPC advocacy and communications training programme established (2028).	*No current existing indicators or systems.*	
Key action #3 Organize national communication campaigns on IPC priority topics and participate in the WHO World Hand Hygiene Day (WHHD).	Government and health care leaders and decision makers; IPC and other focal points/leaders; media and communication professionals and bodies; educational institutions and	1. National campaigns on IPC priority topics organized annually. 2. National initiative to participate in the WHHD organized annually.	*No current existing indicators or systems.*	

	professional and scientific organizations, societies; civil society, patient and family advocacy groups.	3. Proportion of facilities participating in the WHO WHHD.	*WHO SAVE LIVES – Clean your hands* campaign registration system[22].	Proportion of facilities participating in the WHO WHHD.
Facility level				
***Key action* #1** Organize events/communications and campaigns on IPC priority topics (for example, hand hygiene, AMR, WASH).	Senior managers, including the director- general, medical and nursing directors; local IPC and other leaders and teams; communication professionals and teams.	1. At least one event/communications per year organized.	*No current existing indicators or systems.*	
Key action #2 Participate in the WHO WHHD.	Senior managers, including the director- general, medical and nursing directors; local IPC focal points and other leaders and teams; communication professionals and teams.	1. Activities organized for WHHD every year.	*No current existing indicators or systems.*	

[22] *SAVE LIVES – Clean your hands* registration update. Geneva: World Health Organization; 2023 (https://www.who.int/campaigns/world-hand-hygiene-day/registration-update, accessed 26 October 2023).

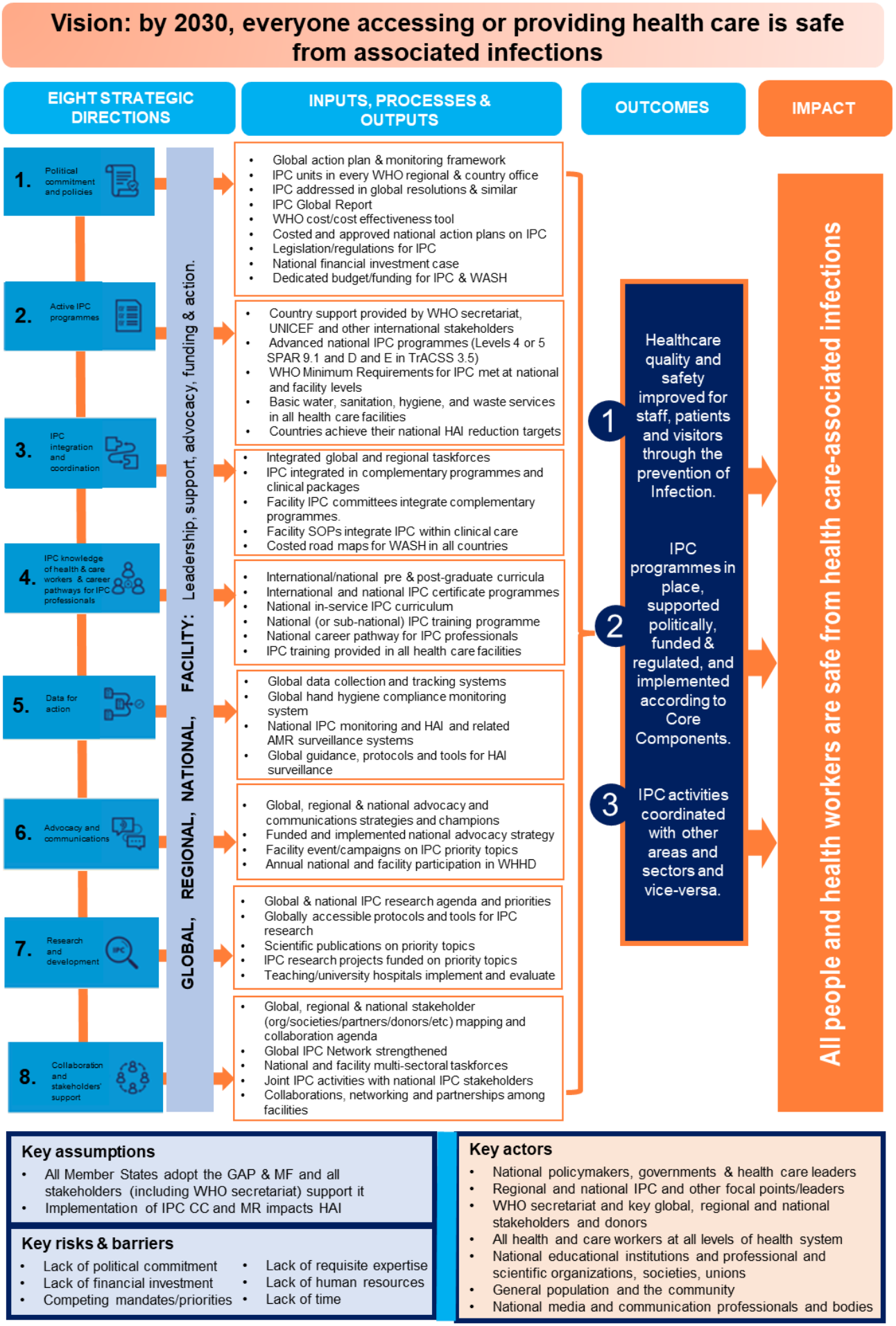
Strategic direction #7. Research and development

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Develop a country-specific national IPC research agenda and priorities (as a stand-alone or as a part of wider strategies, for example, on AMR, patient safety or WASH), adapted from the global research agenda and including a multisectoral and multidisciplinary approach.	Research for health, IPC and other focal points/leaders and teams; professional and scientific organizations and societies; key partners and donors.	1. National IPC research agenda and priorities developed (2028).	*No current existing indicators or systems.*	
Key action #2 Prioritize, fund and implement research projects on IPC in selected facilities, according to the local priorities.	Research for health, IPC and other focal points/leaders; ministry of health and of research and university; research institutions; professional and scientific organizations and societies; key partners and donors.	1. Biennial number of scientific publications/ publicly available reports of research results on priority IPC topics.		
Facility level				
Key action #1 Seek research funds for projects on IPC, according to the facility priorities.	Local IPC and other focal points/leaders and teams; medical and nursing directors.	1. Grant proposals for IPC research projects submitted.	*No current existing indicators or systems.*	
Key action #2 Implement research projects on IPC and report on the results	Local IPC and other focal points/leaders and teams			

Strategic direction #8. Collaboration and stakeholder support

Key actions	Key players	Indicator(s)	Existing indicator system	Existing indicator(s)
National level				
Key action #1 Map national partners, professional societies civil society organizations, patient advocacy and community groups, and international organizations relevant for IPC, using a multisectoral and multidisciplinary approach.	Health care leaders; IPC and other focal points/leaders and teams; professional and scientific organizations, societies, unions; key stakeholders and donors. WHO country office leaders.	1. National mapping exercise performed and available (2026) and mechanisms in place for regular updates. 2. National collaborating agenda on IPC developed (2028). 3. Regular updates of profiles of IPC national stakeholders (organizations/societies/partners/donors/etc.) (2030).	*No current existing indicators or systems.*	
Key action #2 Encourage and implement multi-stakeholder activities/initiatives, according to country needs and including data sharing on IPC, HAIs, AMR and WASH.	Health care leaders; IPC and other focal points/leaders and teams; professional and scientific organizations, societies, unions; key stakeholders and donors. WHO country office leaders.	1. Proportion of countries with a multisectoral taskforce that includes a strong focus on IPC/WASH in health care facilities. 2. Number of joint IPC activities with national IPC stakeholders in line with the national plan, local needs and context (2030).	*No current existing indicators or systems.*	
Facility level				
Key action #1 Seek collaborations, networking and partnerships with other health care facilities and national IPC societies (if present) to support IPC implementation.	Local IPC and other leaders and teams; facility senior managers; local educational institutions and professional and scientific organizations and societies, unions; key stakeholders and donors.	1. Proportion of collaborative or multidisciplinary projects, networking events or partnerships established.	*No current existing indicators or systems.*	

Supplementary annex 4. Results chain - a theory of change for the global action plan on infection prevention and control (IPC)


Vision: by 2030, everyone accessing or providing health care is safe from associated infections
EIGHT STRATEGIC DIRECTIONS
INPUTS, PROCESSES & OUTPUTS
OUTCOMES
IMPACT
1. Political commitment and policies
2. Active IPC programmes
3. IPC integration and coordination
4. IPC knowledge of health & care workers & career pathways for IPC professionals
5. Data for action
6. Advocacy and communications
7. Research and development
8. Collaboration and stakeholders' support
GLOBAL, REGIONAL, NATIONAL, FACILITY: Leadership, support, advocacy, funding & action.
• Global action plan & monitoring framework
• IPC units in every WHO regional & country office
• IPC addressed in global resolutions & similar
• IPC Global Report
• WHO cost/cost effectiveness tool
• Costed and approved national action plans on IPC
• Legislation/regulations for IPC
• National financial investment case
• Dedicated budget/funding for IPC & WASH
• Country support provided by WHO secretariat, UNICEF and other international stakeholders
• Advanced national IPC programmes (Levels 4 or 5 SPAR 9.1 and D and E in TrACSS 3.5)
• WHO Minimum Requirements for IPC met at national and facility levels
• Basic water, sanitation, hygiene, and waste services in all health care facilities
• Countries achieve their national HAI reduction targets
• Integrated global and regional taskforces
• IPC integrated in complementary programmes and clinical packages
• Facility IPC committees integrate complementary programmes.
• Facility SOPs integrate IPC within clinical care
• Costed road maps for WASH in all countries
• International/national pre & post-graduate curricula
• International and national IPC certificate programmes
• National in-service IPC curriculum
• National (or sub-national) IPC training programme
• National career pathway for IPC professionals
• IPC training provided in all health care facilities
• Global data collection and tracking systems
• Global hand hygiene compliance monitoring system
• National IPC monitoring and HAI and related AMR surveillance systems
• Global guidance, protocols and tools for HAI surveillance
• Global, regional & national advocacy and communications strategies and champions
• Funded and implemented national advocacy strategy
• Facility event/campaigns on IPC priority topics
• Annual national and facility participation in WHHD
• Global & national IPC research agenda and priorities
• Globally accessible protocols and tools for IPC research
• Scientific publications on priority topics
• IPC research projects funded on priority topics
• Teaching/university hospitals implement and evaluate
• Global, regional & national stakeholder (org/societies/partners/donors/etc) mapping and collaboration agenda
• Global IPC Network strengthened
• National and facility multi-sectoral taskforces
• Joint IPC activities with national IPC stakeholders
• Collaborations, networking and partnerships among facilities
1 Healthcare quality and safety improved for staff, patients and visitors through the prevention of Infection.
2 IPC programmes in place, supported politically, funded & regulated, and implemented according to Core Components.
3 IPC activities coordinated with other areas and sectors and vice-versa.
All people and health workers are safe from health care-associated infections
Key assumptions
• All Member States adopt the GAP & MF and all stakeholders (including WHO secretariat) support it
• Implementation of IPC CC and MR impacts HAI
Key risks & barriers
• Lack of political commitment
• Lack of financial investment
• Competing mandates/priorities
• Lack of requisite expertise
• Lack of human resources
• Lack of time
Key actors
• National policymakers, governments & health care leaders
• Regional and national IPC and other focal points/leaders
• WHO secretariat and key global, regional and national stakeholders and donors
• All health and care workers at all levels of health system
• National educational institutions and professional and scientific organizations, societies, unions
• General population and the community
• National media and communication professionals and bodies