GOVERNMENT OF MALAWI

NATIONAL INFECTION PREVENTION AND CONTROL POLICY

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NATIONAL INFECTION PREVENTION AND CONTROL POLICY

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FOREWORD

Healthcare-associated infections (HAIs) pose a significant threat to patients and their guardians, visitors, and healthcare workers, jeopardising their safety and straining healthcare resources. Implementing effective infection prevention and control (IPC) measures is paramount in creating a safe and healthy environment for all and, hence, contributing to public health security.

This National Infection Prevention and Control (IPC) Policy 2024 for Malawi aligns with the Ministry of Health's strategic aspirations as are embodied in the Health Sector Strategic Plan III and Malawi Vision 2063 and talks to the World Health Organization's (WHO) recommendations of the core components of IPC programmes. The policy is a crucial pillar of health services delivery as it assures the delivery of high-quality universal health services in this country. This policy further clarifies our commitment to IPC principles as it empowers healthcare workers and stakeholders to engage meaningfully to support public safety and health security at all levels of healthcare delivery across the country.

This document reflects our unwavering commitment to strengthening IPC practices across all healthcare settings in Malawi. It outlines a comprehensive framework for promoting hand hygiene, environmental hygiene, proper waste management, and all other standard precautions. Adhering to these guidelines can significantly reduce the risk of HAIs and antimicrobial resistance (AMR), improve patient outcomes, and optimise healthcare resource utilisation.

The success of this policy hinges on a collaborative effort. We call upon healthcare leadership, healthcare workers at all levels, and patients, guardians, and visitors alike to actively uphold these IPC principles.

I commend the tireless efforts of the Quality Management Directorate (QMD), the IPC technical experts and all stakeholders who have contributed to this document. Let us embrace this policy document and work together to ensure a healthier future for all Malawians.

Hon Khumbize Kandodo Chiponda MP

Minister of Health

PREFACE

This revised National Infection Prevention and Control (IPC) Policy 2024 for Malawi outlines a comprehensive strategy for strengthening these practices within our healthcare system by addressing the challenges of healthcare-associated infections (HAIs) and threats of antimicrobial resistance (AMR) to contribute to the realisation of the provisions of section 13(c) of the Constitution of the Republic of Malawi:

...to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care...

With the background of limited resources, ever-increasing staff training needs, and isolated behavioural constraints for effective IPC implementation and adherence, the policy leverages existing initiatives and infrastructure to enhance IPC practices whilst optimising alignment with national and international recommendations. The policy speaks to the pillars of the Health Sector Strategic Plan III (HSSP III) implementation framework, and it assures us of enhanced quality of healthcare delivery for improved patient safety and healthcare outcomes, reduced burden on the healthcare system by minimising HAIs and the threats of AMR, and an enhanced and meaningful mutual stakeholder engagement.

The process of developing this work was consultative and engaged various ministries, departments, and government agents, local and international IPC, and WASH partners, with a focus on national obligations and international commitments such as the Sustainable Development Goals and International Health Regulations, just to mention two.

Dr Samson Mndolo

Secretary for Health

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome.
AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
CDC	Centres for Disease Control and Prevention
CHAM	Christian Health Association of Malawi
CMST	Central Medical Stores Trust
COHSASA	The Council for Health Service Accreditation of Southern Africa
COVID-19	Coronavirus Disease 2019
EPI	Expanded Programme on Immunisation
HAI	Health-care Associated Infections
HSDTWG	Health Service Delivery Technical Working Group
HIV	Human Immunodeficiency Virus
HSSP III	The Third Health Sector Strategic Plan
IEC	Information, Education and Communication
IHR	International Health Regulations
IPC	Infection Prevention and Control
IV	Intravenous
KAP	Knowledge, Attitude, and Practice
KPI	Key Performance Indicators
MCM	Medical Council of Malawi
MDA	Ministries, Departments, and Agencies
MNCH	Maternal Neonatal and Child Health
MoH	Ministry of Health
MP	Member of Parliament
NGO	Non-Governmental Organisation
NMCM	Nurses and Midwives Council of Malawi
PPE	Personal Protective Equipment
QI	Quality Improvement
QMD	Quality Management Directorate
QMTWG	Quality Management Technical Working Group
QoC	Quality of Care
RHD	Reproductive Health Directorate
SDG	Sustainable Development Goals
SOP	Standard Operating Procedure
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

GLOSSARY

Key WHO Definitions [Consider keeping only terms that are mentioned in the document]

Key Term	Description or Definition
Antibiotics	These are medicines used to prevent and treat infectious diseases in humans, animals, and plants.
Antimicrobial agents	These are medicines used to prevent and treat infectious diseases in humans, animals, and plants. They include antibiotics, antivirals, antifungals, and antiparasitics.
Antimicrobial Resistance (AMR)	Antimicrobial Resistance (AMR) is a phenomenon in which bacteria, viruses, fungi, and parasites no longer respond to antimicrobial medicines.
Community-acquired resistance	This refers to a phenomenon where microorganisms develop resistance to antimicrobials outside healthcare settings.
Disinfection	A process of eliminating or reducing harmful microorganisms from inanimate objects and surfaces to a level that is not harmful to health.
Healthcare worker	A professional who provides medical services, support, and care to patients in various settings such as hospitals, clinics, community health centres and nursing homes.
Healthcare-associated infections	Any infection that develops during healthcare, from which the patient was not suffering or incubating at the time of admission, after 48 hours of being in the hospital. This includes infections acquired in the healthcare facility but appearing within 90 days after discharge and infections acquired by healthcare workers during service delivery.
Patient safety	The prevention of harm to patients in the system of care delivery that prevents errors and is built on a culture of safety that involves healthcare professionals.
Policy	A law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions.
Sterilisation	The process that effectively kills or eliminates all forms of microbial life from an object or surface.

Waste Management	The process of collecting, treating, recycling, and disposing of different waste materials to reduce the environmental impact of waste.
Alcohol-based hand rub	An alcohol-based preparation designed for application to the hands to inactivate microorganisms and/or temporarily suppress their growth.
Antimicrobial stewardship	A coherent set of actions which promote the responsible use of antimicrobials.
Cleaners	Also known as environmental cleaning staff, these individuals are responsible for performing environmental cleaning in healthcare facilities and play a key role in maintaining a clean and/or hygienic environment that facilitates practices related to the prevention and control of HAI.
Cohorting	Grouping of patients who are colonised or infected with the same resistant organism with the aim to confine their care to one area and prevent contact with other susceptible patients
Decontamination of medical devices	Removal of dirt and pathogenic microorganisms from objects so they are safe to handle, subject to further processing, use or discard.
Hand hygiene	The action of hand cleansing is for the purpose of mechanically removing dirt, organic material, and/or microorganisms.
Healthcare-Associated Infections	An infection acquired in a health facility or healthcare setting by a patient who was admitted or sought healthcare services for a reason other than that infection. An infection occurring in a patient in a hospital or other health care facility in whom the infection was not present or incubating at the time of admission. This includes infections acquired in the hospital but appearing after discharge, and occupational infections among staff of the facility
Improved sanitation facilities	Improved sanitation facilities are defined as those that hygienically separate human waste from human contact. Improved sanitation includes flush or pour-flush to piped sewer system, septic tank pit latrines, ventilated-improved pit latrines, or pit latrines with slab or composting toilets
Improved water source	Water source that by its nature of construction adequately protects the source from outside contamination, particularly faecal matter.

Infection prevention and control (IPC) minimum requirements	IPC standards that should be in place at both national and health facility level to provide minimum protection and safety to patients, health care workers and visitors, based on the WHO core components for IPC programmes.
IPC committee	A multidisciplinary group of experts with interest across the facility, which interacts with and advises the IPC team.
IPC focal point	Professional (nurse, doctor, or other) appointed to oversee IPC at the national or facility level who has a specific professional background, that is, formal postgraduate training in IPC leading to the successful achievement of a certificate or diploma.
IPC process indicators	Measurement of compliance with IPC activities currently used within the facility and the presence of IPC policies, procedures, and protocols. Hand hygiene is an essential process indicator to be monitored.
IPC professional	Health care professionals trained in a certified postgraduate IPC course or a nationally recognized course.
IPC structural indicators	Appropriate clean and hygienic environment, water, sanitation and hygiene services and availability of materials and equipment for IPC, in particular for hand hygiene, including financial, human and information resources compatible with standards set out by government authorities or other bodies responsible for the control and prevention of health care-associated infections.
Multimodal strategy	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 and changing behaviour.
Patient zone	Refers to the immediate patient surrounding at least 1 metre around all sides of the bed. This typically includes the intact skin of the patient and all inanimate surfaces that are touched by or in direct physical contact with the patient, such as the bed rails, bedside table, bed linen, infusion tubing and other medical equipment. It also includes surfaces frequently touched by healthcare workers while caring for the patient, such as monitors, knobs, and buttons, and other 'high frequency' touch surfaces.
Personal protective equipment	Specialised clothing or equipment worn to protect the health care worker or any other person from infection. This is one of the of standard precautions

Point of care	The place where three elements come together: the patient, the health care worker, and the environment where care or treatment is being provided.
Positive pressure mechanical ventilation system	A mechanical ventilation system in which the supply airflow rate is greater than the exhaust airflow rate. The room will be at a higher pressure than the surrounding areas.
Primary health care facilities	These are facilities including health centres and community hospital that provide outpatient, maternal, neonatal and child services to population of 10,000. The latter is larger than health centres and service package extends to inpatient services and minor operations and may offer other selected secondary level services.
Protocol	Detailed plan of a scientific or medical experiment, treatment, or procedure.
Safe water	Water that meets national and/or WHO water quality guidelines, including zero Escherichia coli or thermotolerant coliform bacteria in any 100-millilitre sample of drinking water.
Secondary-level hospital	These are facilities that provide primary health care facility services plus in patient care and emergency care
Standard operating procedure	Set of step-by-step instructions compiled by an organisation to help workers carry out routine operations in the most effective manner.
Standard precautions	A set of activities designed to prevent the transmission of organisms between patients/staff for the prevention of health care-associated infection. They must be applied to ALL patients who require health care, by ALL health workers in ALL health settings. They include hand hygiene; use of personal protective equipment; handling and disposal of waste and sharps; handling and management of clean and used linen; environmental cleaning; and decontamination of equipment.
Tertiary-level hospital	These provide primary and secondary level hospital care with highly specialised services.
Transmission-based precautions	Additional measures focused on the particular mode of transmission of the microorganism and always used in addition to standard precautions.
Water quality	The water quality refers to the chemical physical and biological characteristics of water based on the standards as appropriate for its use. Water in health care facilities should not present a risk to health from pathogens and should be protected from contamination inside the health care setting itself. Water for drinking, cooking, personal hygiene, medical activities, cleaning, and laundry must be safe for the purpose intended.

CHAPTER ONE: INTRODUCTION

1.1. OVERVIEW OF INFECTION PREVENTION AND CONTROL IN MALAWI

This Infection Prevention and Control Policy outlines the guidelines and protocols for managing and preventing infections in a healthcare setting. The policy draws from the lessons learned during the implementation of the preceding policies and guidelines. Several factors were considered in formulating the new IPC policy, including the incorporation of existing and emerging issues for its relevance. Harmonising the policy with other IPC documents, national and international, like the WHO IPC core components, IPC minimum requirements, IPC legal framework, National IPC Operational Plan, and National Antimicrobial Implementation Plan has ensured that the document retains relevance and aligns with other efforts towards improvement of IPC implementation. This policy advocates for evidence-based practices in the implementation of IPC activities across the country.

Infection Prevention and Control (IPC) is crucial for ensuring patient safety and delivering high-quality healthcare. It is a practical approach supported by evidence that safeguards patients, their guardians and visitors, and healthcare workers from preventable infections. Effective IPC programs significantly decrease the risk of healthcare-associated infections (HAIs), leading to better patient outcomes and reduced mortality rates, hence attaining overall improved quality of healthcare delivery, as patients are less susceptible to hospital-acquired infections. By preventing infections, patients and their guardians are protected from incurring costs due to prolonged hospital stay and loss of productivity. Healthcare systems save resources and time on treating hospital-acquired illnesses, hence utilising these resources for other diseases and ailments. Implementing IPC measures shields healthcare professionals from infectious diseases, minimising absenteeism and ensuring a productive, healthy workforce.

1.2. BACKGROUND

The World Health Organisation (WHO) emphasises a comprehensive approach to IPC programming that includes implementation of the eight core components. These core components are the IPC program, IPC guidelines, IPC training and education, HAI surveillance, multimodal strategies, monitoring of IPC practices and feedback, workload, staffing, and bed occupancy, and built environment and equipment for IPC. The guidelines on the core components should be used when implementing the standard precautions (hand hygiene, personal protective equipment, environmental cleaning, waste management, etc) and transmission-based precautions (airborne, droplet, and contact). (WHO, Improving infection prevention and control at the health facility, 2018).

In the 2000s there were heightened interests to strengthen the implementation of infection prevention and control practices across the public, Christian Health Association of Malawi (CHAM), and private health facilities. Furthermore, the development of IPC standards guidelines instilled the motivation to make health institutions safe. This later culminated in the development of the 2006 National IPC Policy. The policy aimed to create a framework to guide IPC activities in Malawi. Whilst the framework was based on best practices then, no significant reviews have led to its revision to reflect the new developments in medicine and science and the ever-evolving social issues in the past two decades of its implementation. Therefore, This policy is an update that reinforces the previous policy direction, emphasising reorganisation and realignment of the policy document with evidence-based national and international best practices.

Infection Prevention and Control (IPC) is part of a comprehensive approach to improving health outcomes. Establishing IPC policy and strategy provides a framework to develop and implement guidelines and standard operating procedures (SOPs) to establish a safety culture in healthcare facilities. The evolving landscape

of emerging infectious diseases necessitates increased awareness and attention to IPC, which will equip governments and communities to respond to manage outbreaks and prevent the spread of infectious diseases. The COVID-19 pandemic has accelerated efforts to strengthen health systems in Malawi.

Malawi's healthcare system is organised into three levels: primary, secondary, and tertiary. Health services are delivered mainly by public health facilities. However, other important facilities are owned and managed by faith-based institutions, non-governmental organisations (NGOs), private-not-for-profit entities, and private-for-profit providers. Within the decentralisation framework, the primary and secondary health facilities fall under the local district and city councils, and the tertiary facilities are currently under the central government control. Guided by the National Decentralisation Policy of 1998, the district councils oversee the management, planning, execution, and evaluation of the district health services and budgets. The 1998 National Decentralization Policy that operationalises the Local Government Act (1998) bestows the Ministry of Health (MoH) with the mandate to provide oversight to the health sector in Malawi by specifically providing national strategic planning, policymaking, standards setting, technical support, monitoring and evaluation, quality assurance, resource mobilisation, and international representation for the health sector (Republic of Malawi, 1998). MoH is also responsible for the oversight of tertiary hospitals even though these hospitals gradually transition into autonomous statutory corporations, with Zomba and Mzuzu Central Hospitals being already made semi-autonomous. The Ministry of Health's central government expands to the health zones, five of which are Northern, Central-Eastern, Central-Western, South-Eastern, and South-Western Health Zones. Whereas the national government sets policies, plans for, and monitors health delivery in the country, the local governments, like district and city councils, manage healthcare services at the district hospital level down to the community level (Malawi Ministry of Health, 2023).

1.3. GOVERNANCE AND LEADERSHIP

The Ministry of Health (MoH) develops, adopts, and implements policies and legislation aimed at achieving health goals and social determinants of health as enshrined in section 13(c) of The Constitution of the Republic of Malawi, which directs that the state will "... provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care" (Republic of Malawi, 1994).

The IPC Program falls under the guidance of the Quality Management Directorate (QMD) and is responsible for coordinating and facilitating IPC program implementation in Malawi. The QMD collaborates with the key stakeholders in IPC through the Quality Management Technical Working Group (QMTWG), which reports to the Health Services Delivery TWG, which then finally reports to the Senior Management of the MoH comprising of directors from various programs and central hospital leadership (Malawi Ministry of Health, 2017).

The current IPC Policy for Malawi is almost twenty years old since its publication in 2006. The policy seeks firstly to provide an overarching framework for the development of IPC learning, training, and reference materials, and secondly advocate for regulatory enforcement of IPC practices in Malawi, contributing to the constitutional provision of aiding in keeping the Malawi citizenry healthy (Malawi Ministry of Health, 2006). Despite that, the policy advocates for evidence-based IPC practices, and it has not been reviewed to reflect any advances in medicine that have taken shape since its publication, despite it being expressly indicated in the policy that it will be reviewed periodically. The 2006 IPC Policy established a National IPC program with a national focal point and several structures at various strata of the health administration in Malawi. Under the guidance of the National IPC officer, the policy established five satellite IPC officers domiciled at the Zonal Health Officers, working in tandem with central hospital IPC officers to oversee district IPC coordinators within their respective health zones. These governance and leadership structures were replicated at the health facility

within all public health facilities, CHAM, and private and quasi-private institutions (Malawi Ministry of Health, 2006). Though the 2006 National IPC Policy aspired to establish the National IPC Programme, there is no specific legal instrument to legislate the implementation of IPC across the health sector. The IPC Programme structures should be capacitated and reflected in the functional structure of the MoH and should have duly established posts.

1.4. THE CURRENT STATUS

1.4.1. Health Facility IPC Standards

The Ministry of Health is responsible for the general oversight of IPC implementation and standards development. Through their IPC committees, the healthcare facilities conduct the planning, coordination, implementation, and monitoring of the IPC Program at the facility level. Malawi has developed a National Quality of Care (QOC) Standards guidance by aligning them with already existing standards in Malawi, such as the Safe Care, COHSASA, IPC and MNCH QOC standards to ensure there is consistency in the provision of quality of health services across the country. In addition, the Infection Prevention and WASH Guidelines for Malawi (Malawi Ministry of Health, 2020) and Infection, Prevention and Control Standard Operating Procedures (in COVID-19 Contexts) (Malawi Ministry of Health, 2021) provide health facility guidelines and standards in IPC implementations.

The National IPC program can implement IPC standards, but there is no legislative structure that mandates government and healthcare facilities to adhere to these standards. Moreover, no law specifies a minimum interval for reviewing and revising National IPC Standards or that local authorities have the power to adopt sub-national IPC Standards, nor is there any provision to ensure a dedicated budget is made for effective IPC implementation despite this being a significant challenge in IPC practices across the country. It is also unclear whether sub-national IPC Standards can be stricter than the National IPC Standards. Additionally, there is no legal requirement for the National IPC Program to incorporate available evidence into the National IPC Standards

1.4.2. IPC Education and Training

This domain is key to setting foundation of capacity building for health care workers and other professionals in IPC knowledge and skills. The Medical Practitioners and Dentist Act establishes the Medical Council of Malawi (MCM) and mandates the council to guide, direct, and regulate the training in medicine, dentistry and allied health professionals and it approves training institutions and their curricula. The Nurses and Midwives Act on the other hand establishes the Nurses and Midwives Council of Malawi (NMCM) to oversee education and practice of nurses and midwives in Malawi. The MCM working in collaboration with the NMCM have significantly contributed to developing the National IPC WASH Training Curriculum for pre-service training. This is yet to be rolled into all health training institutions. The post-service IPC monitoring and training by the regulatory bodies is limited. The IPC National Operation Plan 2023-2030 is another tool that promotes IPC education and training at all levels.

1.4.3. Healthcare Associated Infections (HAIs) and Antimicrobial Resistance (AMR) Surveillance

Africa has the highest mortality rate from AMR infections in the world, with 27.3 deaths per 100,000 attributable to AMR. Tadesse and colleagues in 2017 reported that 42.6% of African countries do not have up-to-date data on AMR. Of those that report, they have high (34.0%) microbial resistance of Haemophilus influenza to amoxicillin, with that of Escherichia coli to amoxicillin, trimethoprim, and gentamicin being 88.1%, 80.7%, and 29.8%, respectively.

Although few studies have assessed knowledge, attitudes, and practices (KAP) regarding antimicrobial use (AMU) and AMR among key stakeholder groups, several AMR awareness and educational campaigns have been organized by both government and non-government stakeholders. AMR was recently incorporated into in-service training at the hospital level as part of broader IPC training. Additionally, there are plans to develop and include AMR topics in future curricula at the primary, secondary, and higher education level. An estimated 40% of hospital laboratories in Malawi have the capacity to isolate and identify bacterial infections as well as to perform antimicrobial susceptibility testing (AST). However, healthcare workers do not always use laboratory services to inform diagnosis or treatment despite these available capacities. Malawi has implemented AMR surveillance in 15 human health laboratories and three animal health laboratories. Since April 2020, AMR surveillance data have been stored at a national data warehouse and are regularly analysed. However, there is no national surveillance or reporting mechanism for HAIs.

The national AMR burden in Malawi is not fully known, although some data suggests that resistance of common pathogens to various antimicrobials has increased since the early 2000s. A total of 29 183 pathogens were isolated from 194 539 blood cultures from adult and paediatric patients admitted between 1998 and 2016 with fever or suspicion of sepsis in a hospital surveillance study conducted at Queen Elizabeth Central Hospital, a large, government-run tertiary healthcare facility in Blantyre. Despite an overall decrease in the incidence of bloodstream infections between 1998 and 2016, the study showed an increase in AMR, especially among Gram-negative organisms. There were indications of emerging methicillin resistance in Staphylococcus aureus and an increasing trend in multidrug resistance in three out of six commonly identified pathogens (Klebsiella spp., Enterococcus spp. and Streptococcus spp.). Data from the Queen Elizabeth Central Hospital survey and surveillance data reported to WHO's Global AMR and Use Surveillance System (GLASS) in 2017 indicated an increase in resistance rates. The findings should be interpreted with caution because they are derived from one or two hospitals and, therefore, do not represent national estimates. Additionally, AMR surveillance data from larger facilities in low-resource settings may not represent routine AMR surveillance data, as many patients included in the surveys may be suspected of having severe infections.

Malawi faces challenges in addressing AMR due to limited prioritisation of sepsis and a lack of local evidence and policies (2023). Kawale et al. have reported that efforts to combat AMR include evaluating vaccination impact on reducing resistant Streptococcus pneumoniae and extended-spectrum B-lactamase-producing Escherichia coli and Klebsiella species carriage. Malawi's antibiotic use practices in food animals, especially in small-scale intensive farming, contribute to AMR growth, emphasising the need for holistic interventions like improving access to veterinary services and regulatory enhancements. Furthermore, understanding the dynamics of human colonisation with AMR bacteria in households in Malawi is crucial, highlighting the role of water sources and behaviours in transmission and suggesting targeted interventions at the household level. These insights underscore the importance of tailored policies focusing on evidence generation, antimicrobial stewardship, and infection prevention and control to combat AMR effectively in Malawi.

It is from recognising the AMR threat that Malawi established the Antimicrobial Stewardship Programme (AMS), which led to the development of the first-ever Antimicrobial Resistance Strategy of 2017-2022, following which Malawi participated in the 2019 WHO Feasibility Study on Practical Toolkit for AMS implementation in Low Middle-Income Countries. Malawi has dedicated itself to AMS in recent years, albeit with a limited national budget to address AMR through the development and implementation of an operational plan for IPC that includes AMR activities and the development of the National Antimicrobial Stewardship

Programme Guidelines for Healthcare setting in Malawi. Malawi further seeks to strengthen national IPC policy and efforts designed to reduce AMR in human and animal health sectors by supporting these efforts to review the National IPC Policy.

1.5. PROBLEM STATEMENT

The 2006 National IPC Policy is outdated. The policy assessment has shown several weaknesses, albeit there are some strengths too. The policy is not fully in tandem with the most current guidance from WHO and certainly not fully aligned with the Health Sector Strategic Plan III, including some challenges with the current proposed Public Health Bill of 2023 whereby health care worker training in safe handling of infectious materials in a health care setting. Furthermore, the policy has fifty policy statements, many of which address the same domains of practice, with some framed as activities.

Furthermore, the situation analysis that informed the development of this policy document noted that the respondents (administrators and healthcare staff) performed fairly well on infection prevention and control knowledge, though there were significant differences between cadres. However, most respondents self-reported weaknesses in their attitudes and IPC practices across the country. The respondents were, however, satisfied with the IPC structures at the health facility level, though they expressed concerns over the availability and access to equipment, supplies, and infrastructure for IPC, including low opportunities for training in IPC.

The IPC and WASH partners are not uniformly distributed across the districts. Some districts have about four times the number of partners compared to others. Despite the WASH pillar having the greatest number of partners in the country, most of the respondents also complained of challenges with water availability at some point around the year. The need for improved maintenance of infrastructure equipment has persistently been expressed across the districts.

1.6. PURPOSE OF THE POLICY

The purpose of the 2024 National IPC policy is to provide a guiding framework for implementing IPC/WASH practices to reduce Healthcare-Associated Infections and Antimicrobial Resistance and to provide guidance on emerging and re-emerging infectious disease responses.

1.7. LINKAGES TO LAWS AND OTHER POLICIES IN MALAWI

1.7. Linkages of IPC Policy with the Laws of Malawi

The following are some of the legal provisions that guide the implementation of infection prevention and control in Malawi.

1.7.1.1 Control and Diseases of Animals Act 1967 (Cap. 66:02)

The Control and Diseases of Animals Act makes provision for the control of diseases of domestic animals and provides that all diseased animals should be separated, and notification of the disease should be brought to the nearest inspector or police officer. Further, the minister has the power to make rules regarding the prevention and control of diseases of animals. Under part XIII of the Act, the minister has the power to make rules regarding, among other things, the removal of animals suspected of being diseased or unwholesome for the purpose of human consumption. Similarly, under part IX of the act, the minister has the power to make rules regarding the keeping of animals. This would support appropriate built structures for the effective IPC implementation of effective human and animal traffic control within health facilities.

1.7.1.2. Environment Management Act 2016 (Cap. 60:02)

This Act provides for the protection and management of the environment, the conservation and sustainable utilisation of natural resources, and other related matters. It criminalises the improper management of hazardous materials and the emission of pollutants into the environment. This provides a basis for effective healthcare waste management in the context of IPC implementation.

1.7.1.3. Local Government Act 2017 (Cap. 22:01)

The Local Government Act provides for the decentralisation and devolution of certain powers, functions, and services from central government to local government and local authorities. Under the act, a council may make bylaws for the good rule and government of the whole or any part of the local government area or, as the case may be, for effective and appropriate IPC activities within the local government area and for any other purpose.

1.7.1.4. Malawi Bureau of Standards Act 2012 (Cap. 51:02)

The Malawi Bureau of Standards Act provides for standards to be followed by producers and standards of goods imported into Malawi. This would ensure standardised safe equipment and products which are safe and appropriate for use according to IPC standards and guidelines.

1.7.1.5. Medical Practitioners and Dentists Act 1987 (Cap. 36:01)

This act empowers the Medical Council of Malawi, established to regulate the training within Malawi of medical personnel and for the control and regulation of the medical profession and dental practice. This would support that current and evidence-based curriculum on IPC are always taught in pre-service training.

1.7.1.6. Nurses and Midwives Act 1996 (Cap. 36:02)

The Nurses and Midwives Act provides for the establishment of a regulatory body for the nursing profession for the registration and disciplining of nurses, midwives and nursing midwifery technicians, the licensing of private practice, the regulation of education and training of nurses, midwives and nursing midwifery technicians and generally for the control and regulation of the nursing midwifery profession and practice.

1.7.1.7. Occupational Safety, Health, and Welfare Act 1997 (Cap. 55:07)

This law aims to ensure safe and healthy workplaces, protect the health and well-being of workers, establish responsibilities for workplace safety, maintain adequate staffing in healthcare facilities, and promote effective infection prevention and control (IPC) practices.

1.7.1.8. Physical Planning Act (No. 17 of 2016)

The law supports safe building of structures which includes sanitary structures amongst many other provisions.

1.7.1.9. Public Health Act 1948 and 2023 Public Health Bill

Malawi Public Health Act of 1948 is the main legislation that regulates public health in Malawi. It seeks to safeguard the general public's health. IPC legal framework in Malawi has been extensively assessed and key recommendations therefore include the amendment of the Public Health Act which was already in motion at the time of review. However, the review proposed that the act should establish a regulators agency for IPC, development of comprehensive IPC regulations to address the gaps and areas of weaknesses identified across the domains of IPC. The 2023 Public Health Bill has sufficient grounds that would effectively support the implementation of IPC activities in Malawi, though does not reflect all the recommendations from the review.

1.7.1.10. Waterworks Act 1996

This act guides on the provision of safe water in the facilities and makes provisions for proper sanitation and hygiene including healthcare waste management in facilities.

1.7.1.11. Water Resources Act 2013

This act provides for the management, conservation, use and control of water resources. The act seeks inter alia to promote the safe storage, treatment, discharge and disposal of waste and effluents which may pollute water or otherwise harm the environment and human health.

1.7.1.12. Public Procurement and Disposal of Assets Act 2017

Public Procurement and Disposal of Assets Act (2017) is a legal instrument which regulates all procedures and processes on procurement of goods, services, and consultancy. This is key to management of the supply chain of all commodities including IPC materials and facilities. It will support procurement entities in the local authorities to undertake IPC commodities within the acceptable legal context in Malawi.

1.6.1.13. Pharmacy and Medicines Regulatory Authority Act (No. 9 of 2019)

The Act amongst others regulates the registration of medicines and allied substances including those used in infection prevention and control within the health facilities.

1.7.2. Linkages with other national policy frameworks for Infection Prevention and Control in Malawi

The Ministry of Health and other ministries and government agents have over the years developed various policy instruments to address matters of public health which may have a bearing on IPC practices. The following are some of the policies:

1.7.2.1. Health Information System: National Policy and Strategy, 2003

The policy was developed with the aim of documenting the integral part and importance of health information in the national health system. This would support implementation of HAIs surveillance and the monitoring and auditing of IPC practices.

1.7.2.2. Infection Prevention and Control Policy, 2006

The policy outlines the broad principles of infection prevention and control for healthcare facilities. It was developed in accordance with international evidence-based information at the time to protect patients, staff and the public from infections acquired from a healthcare facility. However, with the new advances in science and the evolution of the practices, several issues need to be addressed.

1.7.2.3. National Care of the Carer HIV and AIDS Workplace Policy, 2005

This policy specifically aims at preventing the transmission of HIV and other infectious diseases in the healthcare setting just like the Infection prevention and Control Policy. However, the policy further guides on how to provide support to healthcare workers caring for AIDS patients; providing care and support for health workers infected with HIV; and assisting informal health workers to prevent contracting HIV during home or hospital care of relatives suffering from AIDS related illnesses and delivery of HIV infected pregnant women in the home.

1.7.2.4. Quality Management Policy for the Health Sector, 2017

The Quality Management Policy for the Health Sector provides a framework for integrating and coordinating quality assurance and quality improvement initiatives in service delivery within the health sector.

1.7.2.5. Decentralisation Policy of 1998

This addresses how the previous functions of the MoH are decentralised to the Local Government authorities to ensure efficient provision of quality healthcare to all people living in Malawi.

1.7.2.6. The International Health Regulations (IHR) 2005

The aim of the IHR is disease prevention with an international cross-border public health risk while, at the same time, avoiding unnecessary interference with international trade and travel. Infection Prevention and Control core best practices are a pivotal package to ensure there is control of spread of infectious diseases of international concern.

1.7.2.7. Sustainable Development Goals (SDGs)

Infection Prevention and Control programs help to prevent health care-associated infections, which are often caused by multidrug-resistant organisms. These infections can lead to outbreaks in health care facilities and spread to community settings. Specifically IPC contributes to achieving some of the SDG targets Reducing maternal mortality (SDG 3.1), ending preventable deaths of newborns and children under 5 (SDG 3.2), combating communicable diseases (SDG 3.3), achieving universal health coverage (SDG 3.8), reducing antimicrobial resistance (SDG indicator 3.d.2), and ensuring clean water and sanitation (SDG 6) amongst others.

1.7.2.7. National Sanitation and Hygiene Policy 2018-2024

The National Sanitation and Hygiene Policy aims to improve availability, accessibility and utilisation of proper sanitation facilities and hygiene practices in Malawi.

1.7.2.8. National Health Policy 2018

This policy provides direction on key issues that are central to the development and functioning of the health system in Malawi. Among other objectives, it seeks to promote preventive health at all levels of the health care system, reduce risk factors and address social determinants of health. This policy will support implementation of prevention and management of infectious diseases in health care settings.

1.7.2.9. National Water Policy 2005

This policy advocates for sustainable management and utilization of water resources so that water of acceptable and sufficient quantities is made available to Malawians. It also advocates for availability of efficient and effective water and sanitation services as a basic need for every Malawian.

1.7.2.10. Environmental Health Policy 2018

This policy amongst many others aims to prevent and control the transmission of communicable diseases and improve water quality, sanitation and hygiene at household level, public and private institutions.

CHAPTER TWO: BROAD POLICY DIRECTION

2.1. POLICY GOAL

The goal of this policy is to have a healthy and productive Malawian population by ensuring the health and safety of healthcare workers, patients and their guardians and visitors, and communities through the reduction and prevention of the emergence of healthcare-associated infections and antimicrobial resistance. The policy seeks to empower health facilities to deliver safe and high-quality health services for all people in Malawi so they can contribute to national development - a pillar of the Health Sector Strategic Plan III.

2.2. POLICY OUTCOMES

The expected outcomes of implementation of the policy by 2030

i. Reduction of incidences of HAIs and AMRs
ii. Systems and structures for IPC implementation are supported at all levels.
iii. Improved financing and utilisation of resources for IPC at all levels
iv. Improved coordination among all IPC stakeholders
v. Collaborative research and use of up-to-date IPC guidelines
vi. Improved knowledge, attitudes, and skills in prevention and control of infections
vii. Effective management and response to outbreaks and emergencies

2.3. POLICY OBJECTIVES

2.3.1. Main Objective

The policy's objective is to reduce the occurrence of healthcare-associated infections (HAIs) and the emergence of antimicrobial resistance (AMR) in Malawi.

2.3.2. Specific Objectives

i. Establish and support all requisite structures and systems for the effective implementation of IPC activities across all levels of health service delivery, according to national and international best practices.
ii. Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.
iii. Support generation and use of evidence in IPC implementation.
iv. Maintaining healthcare worker and patient safety, community engagement, and outbreak preparedness and response.

2.4. GUIDING PRINCIPLES

The following are the principles that the National IPC Policy will be guided by the following:

2.4.1. Equality and Equity

The implementation of IPC activities shall respect the individual and protect the individual's fundamental rights. All stakeholders shall reciprocate with adherence their responsibilities in line with IPC best practices to maximise the greatest good. The principle will be realised by ensuring that all people are protected from infections without distinction of ethnicity, gender, age, disability, and religion.

2.4.2. Inclusiveness

Gender mainstreaming issues will be considered in the planning, implementation, monitoring, and evaluation of IPC interventions. Community participation will be central in the planning, management, and delivery of IPC interventions. IPC interventions will be planned and implemented at all levels of the health delivery system. By providing user-friendly materials, all people from all races and those with disabilities will be protected from infections.

2.4.3. Sustainability

The design of IPC programmes and associated structures will ensure efficiency in use of available resources to achieve the desired goals. IPC program will be sustained through on job training, integration of IPC interventions, supervision and mentorship, and community engagement.

2.4.4. Coordination and collaboration

There shall be strengthened collaboration between ministries, departments and agencies, private and civil society organisations in the development and implementation of IPC interventions. The adopted IPC interventions will align with national and international policies and obligations. Multisectoral collaboration will be encouraged and strengthened to address determinants of IPC issues. The IPC program shall be integrated with ministries, departments, agencies, and partners.

2.4.5. Ethical and scientific soundness

Confidentiality, safety, and efficacy in IPC will be adhered to and respected for every Malawian citizen.

2.4.6. Integration

All IPC activities should be integrated with other programs and interventions for successful implementation of the policy.

2.4.7. Effectiveness and Efficiency

All stakeholders shall be expected to use available resources for health efficiency and effectiveness to maximise health gains.

CHAPTER THREE: PRIORITY AREAS

These priority areas reflect the key pillars of a functional and effective implementation of infection prevention and control and are aligned to the WHO guidelines. The following are the priority areas for the 2024 National Infection Prevention and Control:

i. Infection prevention and control programme.

ii. Evidence based IPC guidelines.

iii. Infection prevention and control education and training

iv. Health care-associated infection surveillance

v. Multimodal strategies for implementing infection prevention and control activities.

vi. Monitoring/audit of infection prevention and control practices/activities and feedback

vii. Workload, staffing, and bed occupancy at the facility level.

viii. Built environment, materials, and equipment for IPC at the facility level.

3.1. PRIORITY AREA 1: INFECTION PREVENTION AND CONTROL PROGRAMME.

This priority area seeks to achieve efficient and effective implementation of IPC activities at all levels, particularly reduction of HAIs and AMR in the country through a dedicated and well-trained multidisciplinary IPC team led by a full-time officer guided by clear IPC program objectives. The program should have established a framework for assessments, costed work plans, appropriate and adequate infrastructure, equipment, and resources at each level of the health care system. This priority area will ensure that there are trained multidisciplinary IPC teams at all levels of care; to support the effective and efficient implementation of IPC activities so the health facilities can deliver safe and quality health care services. The IPC teams are responsible for the development of operational plans and the monitoring and evaluation of IPC activities.

3.1.1. Policy Statements.

The government will ensure well-functioning IPC structures and designated full-time personnel leading and managing IPC at the health facility with an adequately funded budget.

3.1.2. Strategies

Establishment and recruitment of IPC officer posts at all levels of health care delivery.

Establishment of multidisciplinary IPC Committees at all levels of health care delivery.

a. Integrate IPC activities in routine health service delivery at all health system levels.

b. Capacity building of IPC Committees at all levels of the health system

c. Develop and finance implementation plans at the national and subnational levels.

3.2. PRIORITY AREA 2: EVIDENCE-BASED GUIDELINES

This priority area seeks to address the development and adaptation of up-to-date, evidence-based IPC guidelines at national and subnational levels and advocate for the generation of sound evidence locally. The successful realisation of this area will ensure safety for patients, guardians, healthcare workers, and visitors at

all times. Everyone in healthcare facilities deserves protection from infections. Clear and accessible guidelines for infection control are essential. Training all staff and raising awareness among patients and visitors creates a safer environment for all citizens.

3.2.1. Policy Statement

The government will ensure the availability of evidence-based guidelines at all levels of health care delivery.

3.2.2. Strategies

i. IPC committees at national and subnational levels develop and or adapt and advocate for the use of evidence-based guidelines at all levels.

ii. Regular reviews of IPC guidelines and theme specific SOPs.

iii. Ensure readily availability of guidelines and SOPs for infection prevention and control (IPC) and antimicrobial stewardship (AMS) at all healthcare system levels.

iv. Raising awareness and adherence to IPC practices among all stakeholders, including healthcare workers, patients, guardians, and visitors.

v. Quarterly supportive supervision on adherence to IPC evidence-based guidelines.

vi. Support and encourage research for the generation of evidence-based IPC guidelines.

vii. Standardise skills and competencies of healthcare workers across all health system levels.

3.3. PRIORITY AREA 3: EDUCATION AND TRAINING

Pre-service and in-service training in IPC, up-to-date college curricula in IPC, universal in-service and pre-service education and training of healthcare workers in IPC are fundamentally pivotal in successfully implementing infection prevention and control.

This priority area highlights the importance of proper Infection Prevention and Control (IPC) training for both healthcare students and professionals. Academic institutions should include comprehensive IPC training in their curriculum to equip future healthcare workers with the necessary skills to implement effective infection control measures. Ongoing education and training programs are crucial to ensure healthcare workers stay updated on the latest IPC guidelines and best practices, ultimately reducing the risk of infections, and improving patient outcomes.

3.3.1. Policy Statements

The government will ensure that the healthcare workers and students in training have adequate and up-to-date knowledge and skills in infection prevention and control.

3.3.2. Strategies

i. Availability of up to date pre-service and in-service course content for students and health care workers at all times.

ii. Adequate national capacity to train all healthcare workers in current evidence-based IPC practices.

iii. Ensuring that all healthcare workers have the requisite knowledge and skills in current evidence-based IPC practices.

iv. Periodic review of training guidelines, IPC SOPs, and health facility training materials.

v. Advocacy in continued professional development for IPC in diverse platforms.

3.4. PRIORITY AREA 4: SURVEILLANCE OF HEALTHCARE-ASSOCIATED INFECTION

This component should address early detection of healthcare-associated infections (HAIs) and antimicrobial resistance (AMR) cases and their timely reporting whilst ensuring that staff are well trained and there is adequate availability of laboratories, equipment, reagents, and consumables at all times. A surveillance of HAI and AMR is essential to understanding the impact of the National IPC programme in Malawi. The HAI surveillance aims to systematically collect data on the incidence of HAI to recognise problems and implement appropriate changes. MOH will set the priorities for the surveillance of infections and pathogens in Malawi, which will be included in their respective SOPs. Standardised case definitions for active surveillance methods will be developed so that consistent data is collected across healthcare facilities. Facility-based surveillance should be integrated, and active and passive HAI surveillance should be conducted to support the development of baseline data on HAI and guide AMR intervention. The detection of healthcare-associated infections (HAIs) is a critical policy issue, requiring robust surveillance systems and diagnostic capabilities within healthcare facilities. Effective detection involves timely identification and reporting of infections that patients acquire while receiving treatment for other conditions. Establishing standardised protocols for HAI detection and ensuring that healthcare workers are trained in these protocols are essential steps. Improved detection helps implement immediate control measures, reduce the spread of infections, and enhance patient safety.

3.4.1. Policy Statement

The government will ensure the availability of robust HAIs and AMR surveillance systems integrated into the existing disease surveillance at all levels.

3.4.2. Strategies

i. Capacity building in prevention, early detection, reporting, and response to emergence of HAIs and AMR

ii. Development of appropriate reporting tools for HAIs and AMR and their integration into the routine disease surveillance in the country

iii. Procurement of infrastructure and equipment for HAI and AMR surveillance for all healthcare levels nationwide.

iv. Availability of laboratories, equipment, reagents, and consumables for detection of HAIs and AMR at all times

v. Raising awareness of healthcare-associated infections (HAIs) and MAR among health workers, guardians, visitors, and patients.

vi. Strengthen the comprehensive capacity of IPC Committees and their officers in implementing science methods for multimodal designing, implementing, and evaluating IPC practices at all levels of the healthcare delivery system.

vii. Coordination of IPC activities with complementary areas such as wash and antimicrobial stewardship programs.

3.5. PRIORITY AREA 5: MULTIMODAL STRATEGIES FOR IMPLEMENTING INFECTION PREVENTION AND CONTROL ACTIVITIES.

WHO recommends combining approaches to improve infection control practices in healthcare facilities. These strategies aim to change healthcare workers' attitudes and practices towards the reduction of HAIs and AMR. In practice, this means using multiple approaches in combination to influence healthcare workers' behaviour and effect the necessary improvements. These methods address five main areas: system change, training and education of the proposed change, monitoring the implementation and progress of the change, use of reminders and effective social and behavioural communication for change, and cultural changes. Implementing IPC multimodal strategies must be linked to quality improvement programmes at the national and sub-national levels (including health facilities). There are five core elements for the implementation of multimodal implementation strategies. These are system change - making sure the right equipment and supplies are available; education and training - teaching healthcare workers and managers about infection control; monitoring - tracking infection control practices and results; reminders - providing ongoing communication about infection control; and culture change - creating a safe environment that prioritizes infection control.

3.5.1. Policy Statement

The government will ensure that national, subnational, and facility committees are multidisciplinary and advocate for multimodal approaches to IPC implementation as appropriate.

3.5.2. Strategies

i. Comprehensive capacity of IPC Committees and their officers in implementation science methods for multimodal designing, implementation, and evaluation of IPC practices at all levels of the healthcare delivery system.

ii. Coordinate IPC activities with complementary areas such as wash and antimicrobial stewardship programs.

iii. Develop and implement communication strategies to influence the adoption of multiplatform information, education, and communication materials for behavioural change.

iv. Design specific IPC interventions for implementation using multimodal implementation strategies at all health service delivery system levels.

v. Provision of adequate resources for IPC activities

vi. Ensuring the equitable engagement of all healthcare workers and stakeholders in IPC practices across the country

vii. Bridging the knowledge gap in IPC guidelines

3.6. PRIORITY AREA 6: MONITORING AND EVALUATION

This area emphasizes the importance of monitoring and evaluation (M&E) for the national IPC program. It outlines strategies to regularly monitor healthcare-associated infections (HAIs) and antimicrobial resistance (AMR). This comprehensive approach allows for data-driven decision-making, identification of trends and outbreaks, and ultimately improved patient safety and outcomes.

This policy ensures that the national IPC programme is monitored and evaluated continuously to confirm that facility and national-level indicators are being captured, recorded, and reported and to ensure ongoing quality

improvement. Facility IPC officers will perform periodic routine assessments and report on IPC practices and systems as described.

3.6.1. Policy Statement

The government will ensure that all health facilities conduct regular audits of IPC implementation according to national and local guidelines and shall provide feedback to the people directly involved in the areas being audited.

3.6.2. Strategies

i. Develop a budgeted IPC operational plan with an implementation and M&E framework.

ii. Develop standardised M&E and auditing tools and protocols leveraging contemporary technologies.

iii. Integrate monitoring and evaluation tools for healthcare-associated infections (HAIs) and antimicrobial resistance (AMR) into the MoH's routine M&E framework and incorporate HAI and AMR indicators into the national indicators matrix.

iv. Enhancing knowledge of HAI and AMR surveillance among healthcare workers

v. Integrating functional HAI and AMR surveillance into the routine disease surveillance system.

3.7. PRIORITY AREA 7: WORKLOAD, STAFFING AND BED OCCUPANCY AT THE FACILITY LEVEL.

This section prioritizes workload, staffing, and bed occupancy at the facility level to ensure effective infection control in healthcare facilities. It highlights the importance of sufficient qualified staff, low vacancy rates, appropriate bed occupancy, proper infrastructure, and adequate space for staff and patients. These factors all contribute to reducing the risk of infections and improving patient safety.

3.7.1. Policy Statement

The government will ensure that all hospitals in Malawi adhere to the IPC guidelines on bed occupancy, workload, and staffing levels.

3.7.2. Strategies

i. Recruitment, deployment, retention, and development of human resources for health commensurate with workload and space in health facilities.

ii. Expansion, upgrading, and maintenance of equipment and infrastructure are requisites for IPC implementation, commensurate with workload and space in health facilities.

3.8. PRIORITY AREA 8: BUILT ENVIRONMENT, MATERIALS, AND EQUIPMENT FOR IPC AT THE FACILITY LEVEL.

This pillar seeks to link access to high-quality PPE and hand washing facilities, isolation structures in health facilities, adherence to standard operating procedures (SOPs), and healthcare waste management to effective IPC implementation. This is critical for effective infection control. All Health facilities should provide healthcare workers with adequate and appropriate PPE, including gloves, masks, gowns, and face shields, to protect them from infection risks. Additionally, installing and maintaining accessible hand washing facilities throughout healthcare facilities promotes proper hand hygiene practices. Access to high-quality PPE and hand-washing

facilities is essential for reducing the risk of healthcare-associated infections (HAIs) and protecting healthcare workers and patients. Establishing isolation structures in health facilities is crucial for preventing infection spread, particularly in highly contagious diseases. Isolation rooms or wards should be designed to minimise the risk of cross-contamination, with appropriate ventilation systems, designated staff, and strict infection control protocols. These structures allow for the safe management and treatment of infected patients while protecting other patients and healthcare workers. Investing in isolation structures enhances the capacity of healthcare facilities to respond to infectious disease outbreaks and maintain effective infection control.

3.8.1. Policy Statements

The government will ensure that all health facilities have adequate and correctly placed infrastructure, equipment, and supplies that promote the implementation of IPC best practices.

3.8.2. Strategies

i. Construction, rehabilitation, and maintenance of equipment and infrastructure for IPC implementation.

ii. Health education on the proper use of health facility equipment and infrastructure.

iii. Ensuring that infrastructural and administrative engineering in health facilities supports the reduction of healthcare-associated infections (HAIs) and the emergence and spread of antimicrobial resistance (AMR) at all levels of health service delivery.

iv. Leverage technological advancement in infrastructure, setup, and materials in IPC.

CHAPTER FOUR – IMPLEMENTATION ARRANGEMENTS

4.1. INSTITUTIONAL ARRANGEMENTS

The following are the roles and responsibilities of key IPC & Wash stakeholders.

4.1.1. Ministry of Health

The Ministry of Health, through Directorates such as QMD, RHD, EPI, Public Hospitals, Health Education and Promotion Services, National Health Sciences Research Committee, and Public Health Institute of Malawi for instance, working with the public, CHAM, IHAM, and Private Hospitals will:

a. Develop, review, and monitor Infection Prevention and Control (IPC) policies and guidelines while providing resources for their implementation.

b. Guide training programs for healthcare providers and institutions and oversee IPC activities across all health facilities.

c. Conduct IPC awareness campaigns, develop educational materials, and promote social behaviour changes for better IPC practices.

d. Manage research regulation on IPC and coordinate technical working groups at national and sub-national levels.

4.1.2. Ministry of Water and Sanitation

a. Formulate policies and guidelines for safe water and sanitation, ensure their implementation, and monitor adherence.

b. Secure and allocate resources to support safe water provision and sanitation initiatives across the country.

4.1.3. Ministry of Education

a. Promote hygiene practices and social behaviour change and communication on IPC.

b. Collaborate with MOH and other MDAs on IPC related activities including public health emergencies.

4.1.4. Health Regulatory Bodies

Health regulators bodies (Medical Council of Malawi, Nurses and Midwifery Council, and Pharmacy and Medicines Regulatory Authority) will:

a. Review and accredit the IPC curriculum and IPC guidelines and enforce IPC training.

b. Monitor and evaluate IPC policies, as well as accredit and licence institutions and practitioners.

c. Support and encourage dissemination of IPC research findings in studies done in Malawi as part of continuous professional development.

d. Participate in the development of IPC Policy and Guidelines.

4.1.5. Other Regulatory Bodies

Other professional regulatory bodies (Malawi Environmental Protection Authority, Malawi Bureau of

Standards, National Water Regulatory Authority etc) will:

a. Licence institutions, accredit courses and modules in WASH, waste management and IPC activities.

b. Monitor, evaluate, inspect, and enforce IPC and WASH regulations quality and compliance to the same.

4.1.6. Department of Environmental Affairs

a. Formulation of policy and guidelines on waste disposal and management

b. Provide policy guide on waste and hazardous material disposal and management.

c. Monitoring and evaluation of waste disposal and management

d. Conduct environmental assessments and research to identify potential health risks.

e. Encourage sustainable practices and environmental conservation to reduce the spread of diseases.

f. Develop policies and guidelines on healthcare waste and hazardous materials disposal and management.

g. Monitor waste disposal practices and conduct environmental health risk research.

h. Promote sustainable practices to prevent disease spread.

4.1.7. Non-Governmental Organisations

4.1.7.1. International NGOs

a. Provision of technical guidance and support on IPC policy

b. Assist in capacity building of institutions and providers on IPC.

c. Provision of financial assistance and budgetary support in IPC

d. Assist in coordination of technical working groups on IPC at national and sub-national level.

4.1.7.1. Implementing Partners

a. Implementation of IPC activities

b. Provide technical support on IPC activities at all levels (national and sub-national)

c. Provision of supervisory role in IPC activities at local authority level

d. Support local authorities with IPC materials and other resources.

e. Support monitoring and evaluation of IPC at local authorities i.e. support review meetings.

4.1.8. Health Teaching Institutions

a. Involved in and provide education and training of health providers and institutions.

b. Conduct research and development in IPC.

c. Involved in curriculum development in IPC.

d. Provide technical expertise and support (i.e. through consultancy) on IPC to other stakeholders.

4.1.9. Ministry of Local Government

The District Councils, City Councils, District Health Offices, District Water Office, and District Environment Office will:

a. Provide policy guidance on IPC to stakeholders at the local level.

b. Enforce and implement IPC policy and guidelines at the local authority.

c. Ensure service providers adhere to IPC standards and guidelines.

d. Conduct awareness campaigns on IPC-related activities.

e. Monitoring and evaluation of implementation of IPC activities

f. Promotion of social behaviour change and communication on IPC.

g. Lobbying for and providing resources for the implementation of IPC activities

4.1.10. Pharmaceutical Companies and Stakeholders (CMST, wholesale and retail pharmacies)

a. Provision of high-quality IPC commodities and supplies that comply with acceptable standards of manufacturing, packaging, storage, and distribution.

b. Conduct routine evidence generation for improved commodities and products suitable IPC practices in Malawi.

4.1.11. Health Profession Associations

a. Advocate for prudent prescribing practices amongst their membership.

b. Human resources for health development

c. Bridging the knowledge gap between and within professionals

4.2. IMPLEMENTATION PLAN

Annex 1: Implementation Plan for the 2024 IPC Policy

Priority Area	**Priority Area 1: Infection Prevention and Control Programme.**		
Policy Statement	**The government will ensure well-functioning IPC structures and designated full-time personnel leading and managing IPC at the health facility with an adequately funded budget.**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	Establishment and recruitment of IPC officer posts at all levels of health care delivery.	MoH, CHAM, IHAM, Private Sector	2024-2026
	Strengthening of multidisciplinary IPC Committees at all levels of health care delivery.	MoH, CHAM, IHAM, Private Sector	2024-2030
	Integrate IPC activities in routine health service delivery at all levels of the health care system	MoH, CHAM, IHAM, Private Sector	2024-2026
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Develop and finance implementation plans at the national and subnational levels	MoH, CHAM, IHAM, Private Sector	2024-2030
Priority Area	**Priority Area 2: Evidence-based guidelines**		
Policy Statement	**The government will ensure the availability of evidence-based guidelines at all levels of health care delivery.**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Support generation and use of evidence in IPC implementation.	Conduct regular reviews of IPC guidelines and theme-specific SOPs	MoH and Partners	2024-2030
	Support and encourage research for the generation of evidence-based IPC guidelines	MoH, Research Institutions, CHAM, IHAM, Private Sectors, and Partners	2024-2030

Maintain operational readiness for outbreak preparedness and response.	Ensure the availability of strategies/ action plans for disease outbreak preparedness at all levels of health service delivery.	MoH	2024-2030
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	Raise awareness and ensure adherence to IPC practices among all stakeholders, including healthcare workers, patients, guardians, and visitors	MoH, CHAM, IHAM, Private Sector	2024-2030
	Standardise IPC skills and competencies of healthcare workers across all levels of the health system	MoH, CHAM, IHAM, Private Sector	2024-2030
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Conduct quarterly supportive supervision on adherence to IPC evidence-based guidelines	MoH	2024-2030
	IPC committees at national and subnational levels develop and or adapt and advocate for the use of evidence-based guidelines at all levels - 2024-2030.	MOH, CHAM, IHAM, Private Sector	2024-2030
Priority Area	**Priority Area 3: Education and Training**		
Policy Statement	**The government will ensure that the healthcare workers and students in training have adequate and up-to-date knowledge and skills in infection prevention and control.**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Maintain operational readiness for outbreak preparedness and response.	Availability of up-to-date pre-service and in-service course content for students and healthcare workers at all times.	MoH, Health Workers Training Institutions, Professional Associations, and Regulatory Bodies	2024-2030
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	Adequate national capacity to train all health care workers in current evidence-based IPC practices.	MoH, Health Workers Training Institutions	2024-2030

	Ensuring that all healthcare workers have the requisite knowledge and skills in current evidence-based IPC practices.	MoH, CHAM, IHAM, Professional Associations, Private Sector	2024-2030
Support generation and use of evidence in IPC implementation.	Periodic review of training guidelines, IPC SOPs, and health facility training materials.	MoH	2024-2030
	Advocacy in continued professional development for IPC in diverse platforms.	MoH	2024-2030
Priority Area	**Priority Area 4: Surveillance Of Health Care-Associated Infection**		
Policy Statement	**The government will ensure availability of robust HAIs and AMR surveillance systems which are integrated into the routine disease surveillance at all levels**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Maintain operational readiness to outbreak preparedness and response.	Capacity building in prevention, early detection, reporting, and response to emergence of HAIs and AMR	MoH	2024-2030
	Development of appropriate reporting tools for HAIs and AMR and their integration into routine disease surveillance in the country	MoH	2024-2025
	Raising awareness of healthcare-associated infections (HAIs) and MAR among health workers, guardians, visitors, and patients.	MOH & Partners	2024-2030
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Procurement of infrastructure and equipment for HAI and AMR surveillance for all healthcare levels nationwide.	MOH & Partners	2024-2030
	Availability of laboratories, equipment, reagents, and consumables for detection of HAIs and AMR at all times	MOH & Partners	2024-2030

	Availability of laboratories, equipment, reagents, and consumables for detection of HAIs and AMR at all times	MOH & Partners	2024-2030
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	Comprehensive capacity of IPC Committees and their officers in implementation science methods for multimodal designing, implementation, and evaluation of IPC practices at all levels of the healthcare delivery system.	MoH, CHAM, IHAM, Private Sector	2024-2030
	Coordination of IPC activities with complementary areas such as wash and antimicrobial stewardship programs	MoH, CHAM, IHAM, Private Sector	2024-2030
	Integrating functional HAI and AMR surveillance into the routine disease surveillance system.	MoH	2024-2026
Priority Area	**Priority Area 5: Multimodal strategies for implementing Infection Prevention and Control activities.**		
Policy Statement	**The government will ensure that national, subnational, and facility committees are multidisciplinary and advocate for multimodal approaches to IPC implementation as appropriate.**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	Development and implementation of communication strategies for influencing adoption of multiplatform information, education, and communication materials for behavioural change	MOH & Partners	2024-2030
	Bridging the knowledge gap in IPC guidelines	MOH & Partners	2024-2030
Support generation and use of evidence in IPC implementation.	Design specific IPC interventions for implementation using multimodal implementation strategies at all levels of health service delivery system.	MoH	2024-2030
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Provision of adequate resources for IPC activities	MOH & Partners	2024-2030

	Ensuring the equitable engagement of all healthcare workers and stakeholders in IPC practices across the country	MoH, CHAM, IHAM, Private Sector	2024-2030
	Coordination of IPC activities with complementary areas such as wash and antimicrobial stewardship programs		
Priority Area	**Priority Area 6: Monitoring and Evaluation**		
Policy Statement	**The government will ensure that all health facilities conduct regular audits of IPC implementation, HAI Surveillance, and AMS according to national and local guidelines.**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	Develop a budgeted IPC operational plan with implementation and M&E frameworks	MoH, CHAM, IHAM, Private Sector	2024-2030
	Develop standardised M&E and auditing tools and protocols leveraging contemporary technologies	MoH	2024-2025
	Integration of monitoring and evaluation tools for healthcare-associated infections (HAIs) and antimicrobial resistance (AMR) in the routine M&E framework of the MoH and incorporate HAI and AMR indicators into national indicators matrix	MoH, Professional Associations	2024-2026
Priority Area	**Priority Area 7: Workload, staffing, and bed occupancy at the facility level.**		
Policy Statement	**The government will ensure that all hospitals in Malawi adhere to the IPC guidelines on bed occupancy, workload, and staffing levels.**		
Objective	Strategy	Responsibility	Timeframe
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Recruitment, deployment, retention, and development of human resources for health commensurate with workload and space in health facilities.	MoH, CHAM, IHAM, Private Sector	2024-2030

	Expansion, upgrading, maintenance of equipment and infrastructures requisite for IPC implementation commensurate with workload and space in health facilities.	MOH & Partners	2024-2030
Priority Area	**Priority Area 8: Built environment, materials, and equipment for IPC at the facility level.**		
Policy Statement	**The government will ensure that all health facilities have adequate and correctly placed infrastructure, equipment, and supplies that promote implementation of IPC best practices.**		
Objective	**Strategy**	**Responsibility**	**Timeframe**
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Construction, rehabilitation, and maintenance of equipment and infrastructure for IPC implementation.	MOH & Partners	2024-2030
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Health education on proper use of health facility equipment and infrastructure.	MOH & Partners	2024-2030
	Ensuring that infrastructural and administrative engineering in health facilities supports the reduction of healthcare-associated infections (HAIs) and the emergence and spread of antimicrobial resistance (AMR) at all levels of health service delivery.	MoH	2024-2030
	Leverage technological advancement in infrastructure, setup, and materials in IPC.	MOH & Partners	2024-2030

4.3. MONITORING AND EVALUATION FRAMEWORK

Priority Area	**Priority Area 1: Infection Prevention and Control Programme.**					
Policy Statements	**The government will ensure well-functioning IPC structures and designated full-time personnel leading and managing IPC at the health facility with an adequately funded budget.**					
Objective	**Outputs**	**Performance Indicator(s)**	**Baseline**	**Target**	**Source of Verification**	**Assumptions or Risks**
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	IPC Officer posts established	Percentage of officer posts established, and a warrant issued for the same	0	100.00%	Staff Establishment	Leadership and governance support, Infrastructure readiness for the post
	Functional National IPC Steering Committee empanelled	number of quarterly meetings conducted	0	0.00% 24	Meeting minutes and reports	Stakeholders' engagement, M and E systems, cultural and behavioural compliance
	IPC knowledge, attitude, and practices amongst health care workers are improved	Percentage of healthcare facilities scoring at least 80% in standard IPC assessment tools	35%	80.00%	QOC assessment reports	Cultural and behavioural compliance, access to quality training education
	IPC Committee members are trained in updated guidelines and SOPs in infection prevention and control	Percentage of IPC committees trained in updated IPC guidelines and SOPs		0.00%	QOC assessment reports	availability of resources, baseline knowledge and willingness to improve, engagement and motivation of health care workers

Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Implementation plans are developed at all levels of health care delivery system	Percentage of secondary health facilities with IPC implementation plans	0	100.00%	Availability of implementation plans implementation plans	effective resource allocation, capacity for financial and resources management
		Percentage of tertiary health facilities with established IPC Committees		100.00%	Availability of implementation plans	
Priority Area	**Priority Area 2: Evidence based guidelines**					
Policy Statements	**The government will ensure the availability of evidence-based guidelines at all levels of health care delivery**					
Objective	**Outputs**	**Performance Indicator(s)**	**Baseline**	**Target**	**Source of Verification**	**Assumptions or Risks**
Support generation and use of evidence in IPC implementation	IPC guidelines are reviewed	Number of IPC guidelines reviewed within their expected life span in the past 5 years	0	3	IPC guidelines review meeting minutes and reports	access to reliable data, capacity for data analysis and interpretation
	IPC SOPs are reviewed	Number of IPC SOPs reviewed within their expected life span in the past 5 years	2	3	SOP review meeting minutes and report	access to reliable data, capacity for data analysis and interpretation
	Research in IPC are conducted and published	Number of IPC driven research conducted sanctioned by the national level	0	24	IPC research reports	collaborative research environment
Maintain operational readiness to outbreak preparedness and response.	Available IPC emergency response contingency plan	Percentage of facilities with IPC emergency response contingency plan	0	100%	availability of the IPC emergency response contingency plan	adequate resources and infrastructure, skilled and trained workforce

Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery. according to national and international best practices.	HAIs and AMR awareness among health care workers, patients, guardians, and visitors is improved	Percentage of patients, guardians, and patients' visitors scoring over 70% at exit interviews on standard precautions for prevention of HAIs and AMR	0	70%	ombudsman reports, HAIs, and AMR assessments reports	compliance to national and international guidelines
	All health care workers adhere to guidelines and SOPs	Percentage of health facilities scoring 80% and above on standard assessment of minimum requirements for basic IPC implementation	0	% 100%	IPC and QOC assessment reports	health workers training and competence
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Integrated supportive supervision are conducted at all levels of health care delivery system	Percentage of health facilities that are supervised at least quarterly.	0	100%	supervision reports	availability of the resources
Priority Area	**Priority Area 3: Education and Training**					
Policy Statement	**The government will ensure that the health care workers and students in training have adequate and up to date knowledge and skills in infection prevention and control**					
Objective	**Outputs**	**Performance Indicator(s)**	**Baseline**	**Target**	**Source of Verification**	**Assumptions or Risks**
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	IPC Training Program introduced	Number of training institutions offering IPC training courses	0	1	QMD Reports	Delay in approval of content

	Updated pre-service course content for IPC training available	Availability of up-to-date pre-service module for IPC for health training programs	5 %	100%	QMD Reports	Delay in approval of content. Costs of starting up an IPC Program can be limiting
	Updated in-service course content for IPC training available	Availability of up-to-date in-service course for IPC	80%	100%	QMD Reports	Delay in approval of content
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	IPC Trainer of trainers are available	Percentage of district hospitals and central hospitals with at least four IPC TOTs.	25%	100%	QMD report	Lack of in country trainers for masters
	All health care workers are trained in up-to-date infection prevention and control practices	Percentage of newly recruited staff who have been trained in up dated IPC guidelines within 3 months of recruitment and deployment percentage of health cares who have undergone training within the past 2 years	30%	80%	QMD report	Lack of funding to achieve the goal Weak reporting system
Support generation and use of evidence in IPC implementation.	**IPC Guidelines and SOPs are reviewed**	**Number of IPC Guidelines and SOPs current and updated within the last two years**	**88%**	**100%**	**QMD report**	**Lack of funding to achieve the goal**

	IPC CPD content developed and accessible	Availability of CPD content and accessible	30%	100%	QMD Report	Delay approval of content
Priority Area	**Priority Area 4: Surveillance of Health Care-Associated Infections**					
Policy Statements	**The government will ensure the availability of robust HAIs and AMR surveillance systems integrated into the existing disease surveillance at all levels.**					
Objective	Outputs	Performance Indicator(s)	Baseline	Target	Source of Verification	Assumptions or Risks
Maintain operational readiness to outbreak preparedness and response.	Health care workers trained in surveillance of HAIs and AMR	Percentage of newly recruited staff who have been trained in up dated IPC guidelines within 3 months of recruitment and deployment	30%	80%	QMD Report	Lack of funding for trainings Expert trainers in HAIs and AMR
		Percentage of serving staff who have been trained in up-to-date guidelines within 2 years				
	Data collection tools for HAIs and AMR surveillance developed	Availability of data collection tools on HAIs and AMR	5%	50%	QMD Report	Lack of funding for trainings Lack of expertise in tool development
	HAIs and AMR awareness among patients, guardians, and visitors is improved	Percentage of patients, guardians, and patients' visitors scoring over 70% at exit interviews on standard precautions for prevention of HAIs and AMR	10%	70%	Ombudsman and pharmacovigilance team	Low literacy from patients and guidance

Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Infrastructure and equipment for HAIs and AMR surveil-lance procured	Percentage of tertiary health facilities with adequate equipment and infrastructure for HAI and AMR surveillance	80%	100%	PHIM and HTSS	
		Percentage of secondary health facilities with adequate equipment and infrastructure for HAI and AMR surveillance	20%	100%	PHIM and HTSS	
	Adequate reagents, and consumables are procured	Percentage of secondary level hospitals with functional lab-oratories, with adequate lab-oratory equip-ment for culture and sensitivity testing, reagents, and consum-ables for AMR surveillance	55%	100%	PHIM and HTSS	-Slow implementa-tion by private sector hospitals due to lack of funds
		Percentage of tertiary level hospitals with functional laboratories, with adequate reagents, and consumables for AMR surveil-lance	100%	100%	PHIM and HTSS	

Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices.	IPC committee members are competent in implementation science for IPC improvement	Percentage of health facilities implementing at least two quality improvement projects within the last 12 months	15%	40%	QMD Report	Poor reporting system Inadequate training in quality improvement methods.
	IPC, WASH, and AMR programs are fully integrated	Number of quarterly Integrated IPC, WASH and AMR supportive supervision conducted	0	4 per year	MoH	Knowledge and willingness to improve
	Full integration of HAI and AMR surveillance in routine surveillance system	Number of facilities conducting HAI and AMR surveillance		100%	Report	Improved stakeholder collaboration Availability of financial resources
Priority Area	**Priority Area 5: Multimodal Strategies for Implementing Infection Prevention and Control Activities.**					
Policy Statements	**The government will ensure that national, subnational, and facility committees are multidisciplinary and advocate for multimodal approaches to IPC implementation as appropriate.**					
Objective	**Outputs**	**Performance Indicator(s)**	**Baseline**	**Target**	**Source of Verification**	**Assumptions or Risks**
Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices	IPC committee members are competent in implementation science for IPC improvement	Percentage of health facilities implementing at least two quality improvement projects within the last 12 months	15%	40%	QMD Report	Poor reporting system Inadequate training in quality improvement methods.

Priority Area	**Priority Area 6: Monitoring and Evaluation**					
Policy Statements	The government will ensure that all health facilities conduct regular audits of IPC implementation, HAI Surveillance, and AMS according to national and local guidelines.					
Objective	Outputs	Performance Indicator(s)	Baseline	Target	Source of Verification	Assumptions or Risks
Support generation and use of evidence in IPC implementation	Budgeted IPC operation plans developed	Percentage of facilities with approved budgeted IPC plans.		100%	HMIS Database	Improved stakeholder collaboration
	Standardised IPC M&E tools are developed.	Number of M & E tools developed	100	100	Documented evidence e.g. reports	WHO adapted tools are used
	IPC M&E tools are digitalised	Number of M&E tools digitised.	0	5	Reports	Availability of financial resources and collaboration of relevant stakeholders
	HAIs and AMR surveillance training among health care workers is conducted	Percentage of healthcare workers trained in HAI and AMR surveillance		100%		
	HAIs and AMR indicators incorporated into the national reporting platforms (DHIS2)	Percentage of health facilities reporting on HAI and AMR in DHIS2		80%	Report	Improved stakeholder collaboration Availability of financial resources
Priority Area	**Priority Area 7: Workload, Staffing and Bed Occupancy at The Facility Level.**					
Policy Statements	The government will ensure that all hospitals in Malawi adhere to the IPC guidelines on bed occupancy, workload, and staffing levels.					
Objective	Outputs	Performance Indicator(s)	Baseline	Target	Source of Verification	Assumptions or Risks

Set up and support all requisite structures and systems for effective implementation of IPC activities across all levels of health service delivery according to national and international best practices	Adequate motivated human resources are deployed	Staff-patient ratio	More than 10 patients per Nurse and More than	Nurses 1: 9 ratio Clinicians 1:	IPC reporting form	A less balanced staff-to-patient ratio will lead to the spread of infection between workers and patients.
	Appropriate patient placement, and traffic control for optimal prevention and control of spread of infections					
	Functional equipment and infrastructure for IPC implementation is available	Bed occupancy rate for primary health facilities	Over 100%	=/- 100%	IPC reporting form	Increases the risk of hospital acquired infections and the spread of AMR.
		Bed occupancy rate for secondary health facilities				
		Bed occupancy rate for tertiary health facilities				
		Percentage of health facilities with reliable water supply all year round				

Priority Area	Priority Area 8: Built environment, materials, and equipment for IPC at the facility level.					
Policy Statements	The government will ensure that all health facilities have adequate and correctly placed infrastructure, equipment, and supplies that promote implementation of IPC best practices.					
Objective	Outputs	Performance Indicator(s)	Baseline	Target	Source of Verification	Assumptions or Risks
Support the mobilisation and prudent utilisation of resources for IPC activities in Malawi.	Functional equipment and infrastructure for IPC implementation is available	Percentage of health facilities with functional sterilization equipment		100%	IPC monthly reporting form	Unsterile equipment transmits pathogens, thereby increasing the rate of healthcare-acquired infections and AMR.
		Percentage of hospitals that have functional laundry machines.		100%	IPC monthly reporting form	Contaminated textiles and fabrics in healthcare facilities can be a source of substantial numbers of pathogenic microorganisms that can potentially infect health workers and patients
		Percentage of health facilities with adequate waste disposal facilities		100%	IPC monthly reporting form	Lack of appropriate waste management facilities can lead to environmental contamination and spreading of pathogens to health workers, patients, and the community
		Percentage of health facilities with adequate improved toilets for staff separated by sex				Lack of toilet facilities will lead to poor hygiene practices, increasing the risk of infections, including hospital acquired infection.
		Percentage of health facilities with hand hygiene facilities				Hand hygiene facilities provide an enabling environment for handwashing which helps to prevent the spread of microorganisms

	Training on proper use of health facility equipment and infrastructure for health care workers is conducted	Percentage of healthcare workers trained in IPC		100%	IPC monthly reporting form	Untrained healthcare workers in IPC leads to noncompliance to IPC practices thereby increasing the rate of infection transmission.
	Infrastructure and equipment are engineered to reduce HAIs and AMR	Percentage of health facilities segregating healthcare waste		100%	IPC monthly reporting form	Segregation of waste facilitates safe and efficient handling of waste in a manner that minimises transmission of infectious agents and environmental contamination
		Percentage of health facilities scoring at least 80% in 5S		100%	IPC monthly reporting form	5S makes the environment clean and organised for efficiency
	New digital solutions and innovations are utilised	Percentage of primary health facilities utilising digital data collection tools for HAIs and AMR surveillance		100%		Absence of new digital solutions and innovations can lead to errors and delays in reporting, resulting in less accurate and timely data. Inadequate surveillance capabilities may lead to delayed detection and response to outbreaks of HAIs and AMR.

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