

Pacific Infection Prevention and Control Network Meeting

MEETING REPORT



Pacific Infection Prevention and Control Network (PICNet) Meeting

Nadi, Fiji
24 – 26 May 2023

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Pacific
Community
Communauté
du Pacifique

Dr Ana Mahe, PICNet Chair


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2023 PACIFIC INFECTION PREVENTION AND CONTROL NETWORK (PICNet) MEETING

24–26 May 2023, Nadi, Fiji

Meeting papers and presentations are available at <https://phd.spc.int/2023-pacific-infection-control-network-meeting>. PICNet recommendations are in Annex 1. The list of participants is in Annex 2.

Meeting objectives

1. The main objectives of the inaugural PICNet meeting were to discuss, provide updates and share lessons learnt from the COVID-19 pandemic, and make recommendations on priority Infection Prevention and Control (IPC) issues in the region on the following:
 - Global Report and Strategy on Infection Prevention and Control
 - Finalisation of PICNet Terms of Reference
 - IPC education and research
 - Progress on regional IPC activities in the Pacific
 - Lessons learned from the COVID-19 pandemic
 - Strengthening health-care associated infection (HAI) surveillance in the Pacific
 - Role of IPC in antimicrobial resistance (AMR) prevention
 - Hand hygiene programme

Opening

2. PICNet Chair, Dr Ana Mahe, Tonga, welcomed delegates and organisations following the prayer by Fiji.

Keynote address: [Global Report and Strategy on Infection Prevention and Control](#)
Dr Nuha Mahmoud (Team Coordinator Pacific Health Security and Communicable Disease, Division of Pacific Technical Support, WHO, Suva)

3. Dr Mahmoud briefly reviewed the Global IPC Report 2022, including data on HAI:
 - Out of every 100 patients in acute-care hospitals, 7 patients in high-income countries and 15 in low- and middle-income countries will acquire at least one HAI.
 - 162 countries submitted data to a global self-assessment survey on AMR. Only 34% of countries had implemented a nationwide IPC programme (54% had plans but no, or only partial implementation).
4. A draft Global Strategy on IPC (GSIPC) was discussed by the WHO Executive Board in 2022 and also by a meeting of G7 health ministers. The strategy was developed following wide consultation with expert groups and WHO member states. Comments by member states on the draft strategy included the need for political commitment, international cooperation, training, adequate resources, and data. The next step for the strategy is adoption by the World Health Assembly (WHA) and Executive Board. An action plan and monitoring framework will then be developed.
5. The guiding principles of the GSIPC include implementation of IPC across the health system and recognition that clean and safe care is a human right. Its objectives are to:



- Prevent infection in health care
 - Act to ensure IPC programmes are in place and implemented
 - Coordinate IPC activities with other areas and vice-versa
6. IPC capacity building and training plans include curriculum content for pre- and post-graduate health care workers, in-service training, and development of career pathways for IPC professionals.
 7. Implementation of national IPC plans should include advocacy and communication, research and development, and partnerships. Dr Mahmoud asked delegates to read the draft strategy in preparation for developing or reviewing their own IPC plans.

Remarks from the Secretariat

Dr Berlin Kafoa, Director of the Public Health Division, SPC (*online*)

8. Dr Kafoa welcomed country representatives and all meeting participants. He said PICNet is a service of the Pacific Public Health Surveillance Network (PPHSN), which is supported by AFD, DFAT, MFAT and the EU.¹ SPC is committed to more regular meetings of PICNet to give Pacific Island countries and territories (PICTs) opportunities to share information and learn.
9. Dr Kafoa acknowledged the work of Margaret Leong (SPC's IPC Advisor) in developing IPC training and planning in the region, including the 2021 publication of updated IPC guidelines.² He also highlighted the 11-module foundation course on IPC provided by the Australian College for Infection Prevention and Control (<https://www.acipc.org.au/education/>). (It is a level 8 course that recognises prior learning.)
10. He looked forward to seeing tangible outcomes from the meeting that PICTs can implement to improve IPC. Noting that the Pacific leads the world in regional monitoring (e.g. the MANA dashboard for monitoring the NCD roadmap), Dr Kafoa said he would like to see an accessible regional portal showing IPC status for each country.

Regional IPC activities and updates

Margaret Leong, IPC Advisor, SPC

11. Ms Leong thanked IPC focal points for responding to the survey assessing eight core components of IPC. They are all essential and will enhance IPC, AMR prevention, and emergency preparation. The results of the assessment help to identify gaps and strengths and assist planning.
12. All 15 countries responded to the survey, using self-reported data.
 - 67% of PICTs have IPC plans (close to global averages)
 - 6 PICTs have a dedicated budget for IPC
 - Only 20% of PICTs have IPC training programmes
 - Capacity for HAI surveillance is limited
 - Improved infrastructure for hand hygiene is required

¹ Agence française de développement (AFD); Australian Department of Foreign Affairs and Trade (DFAT); New Zealand Ministry of Foreign Affairs and Trade (MFAT); European Union (EU).

² Pacific Community. 2021. Pacific Public Health Surveillance Network (PPHSN) Infection prevention and control guidelines 2021. Suva, Fiji: Pacific Community (SPC). 173 pages. (<https://www.pphsn.net/resources/pphsn-infection-prevention-and-control-guidelines-2021/>)

13. The following dashboard (from the presentation) summarises the results of the assessment.

PICTs' Achievement of IPC Core Components

Key

No

In progress/under development

Yes

Core Component	Indicator	Cook Islands	Fiji	FSM	Kiribati	Marshall Islands	Nauru	Niue	Palau	PNG	Samoa	Solomon Islands	Tokelau	Tonga	Tuvalu	Vanuatu
IPC Programmes	National IPC Programme	Red	Red	Red	Green	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green
	IPC focal point	Green	Red	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green
	Dedicated budget	Green	Red	Red	Red	Red	Red	Green	Red	Red	Green	Green	Green	Green	Green	Red
National and Facility level IPC guidelines	Updated national IPC guidelines	Green	Green	Red	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green
	Guidelines adapted and implemented	Orange	Green	Orange	Orange	Orange	Green	Orange	Green	Green	Green	Green	Green	Green	Green	Red
IPC education and training	Mandatory in-service training provided to healthcare workers	Orange	Orange	Orange	Orange	Red	Green	Red	Orange	Orange	Green	Green	Orange	Orange	Orange	Red
	HAI defined component of national IPC program	Orange	Green	Red	Green	Red	Green	Red	Green	Green	Green	Red	Red	Green	Green	Green
HAI surveillance	Surveillance and monitoring procedures implemented	Green	Orange	Red	Orange	Red	Orange	Orange	Orange	Orange	Green	Red	Orange	Orange	Red	Red
	Multimodal strategies for IPC activities	Green	Green	Orange	Green	Red	Orange	Orange	Orange	Orange	Green	Red	Green	Green	Orange	Red
IPC monitoring and feedback	Monitoring/audit of IPC practices	Green	Green	Red	Green	Red	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green
	Built environment, materials and equipment	Accessible records of daily environment cleaning	Red	Green	Green	Red	Red	Green	Red	Red	Green	Red	Red	Red	Red	Red
Waste management plan		Green	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green	Red

14. Good IPC reduces HAI by 70%. COVID-19 exposed the critical role of IPC and highlighted the need for enhanced IPC across the region. Immediate issues were lack of supplies and poor practices. Improvements since then include more staffing and training – the momentum must be sustained.

15. WHO has produced several reports on IPC including the *Global report on infection prevention and control* (<https://www.who.int/publications/i/item/9789240051164>) and *Minimum requirements for infection prevention and control* (<https://www.who.int/publications/i/item/9789241516945>). The global report has no representation from Pacific countries and little from low/middle income countries.

16. Recommendations and next steps

- Support countries in red and orange areas (see dashboard).
- Continue monitoring on a bi-annual basis to track progress and developments (in line with annual workplans).
- Undertake further assessment and surveys (split between national programmatic and facilities level for further detailed monitoring).
- Develop a regional dashboard system (including external review and audit processes) that will allow countries to visualise their progress towards the minimum requirements for IPC.

These steps will be part of ongoing work with countries to finalise and implement National IPC Workplans and Guidelines (including monitoring).

17. Key priorities

- Political commitment and policies (financing, legal frameworks and accreditation systems).

- IPC capacity building and creation of IPC expertise in both clinical and public health settings.
- Development of systems to monitor, report and act, including HAI surveillance and monitoring of IPC indicators.

Discussion

18. Dr Kafoa stressed the importance of ensuring self-reported data is accurate: 'If it's not 'green' don't say it is.' Red and amber give partners action points; green areas will not get resources. All PICTs should have an IPC plan with costed activities
19. French Polynesia: How much budget is needed for IPC and has SPC been able to show that IPC can save on HAI costs?
New Caledonia: Given current budget restrictions, information on the savings available from implementing IPC would be helpful in requesting resources.
20. Dr Mahmoud: Many studies show IPC-associated savings, including prevention of prolonged admission.
21. Margaret Leong: SPC hasn't assessed individual budgets for countries. IPC budgets are usually in country medical supplies budgets. Not all PICTs have an IPC plan.
22. Fiji thanked SPC for support on its National Action Plan and asked about operationalising training and national policies and programmes at local level. An issue for Fiji is lack of control over private health providers. Fiji requested support on setting up a resource database that will let people at national level see which areas require focus.
23. Papua New Guinea (PNG): PNG's first IPC policy is currently being approved. DFAT provided training on IPC during the pandemic. PNG appreciated the IPC guidelines produced by SPC. The dashboard will be useful in understanding how PICTs are addressing IPC in the Pacific.
24. The Chair asked delegates to approve the dashboard.
25. Palau, Fiji, Solomon Islands and Vanuatu all agreed the dashboard would be helpful in assessing progress and identifying gaps.
26. Vanuatu agreed with Dr Kafoa's comment on 'green', and requested more assistance on knowing what to assess, which would help with accurate reporting and planning, noting the need for more funds.

Session 2 – IPC Education and Research

Opportunities for IPC: Education and research

Dr Peta-Anne Zimmerman, Program Advisor, Graduate IPC, Griffith University, and Board Director, Australasian College for Infection Prevention and Control (ACIPC)

27. Dr Zimmerman noted that the WHO Global IPC Report identified member states' gaps and challenges, including non-implementation of an IPC plan or no IPC plan. Primary requirements

for IPC therefore include development of implementation plans and capacity building, and consideration of succession plans.

28. WHO core competencies for IPC professionals include:

- establishing or supporting an organizational structure to prevent HAI, reduce AMR, and improve the safety of patients, health workers and visitors;
- integrating IPC principles in service delivery, and collaborating with all medical staff (including microbiology, epidemiology and occupational health) and partners, e.g. WASH;³
- acting as a role model and advocating for IPC, quality of care and patient and health worker safety, communicating risks, and recommending evidence-based IPC practices.

29. Listing the credentials of IPC professionals, from primary to senior levels, Dr Zimmerman asked delegates to assess themselves and their staff according to the table. The Pacific has made progress on IPC implementation, with achievements including the appointment of IPC focal points in PICTs; programme evaluations; revitalisation of PICNet; production of SPC IPC guidelines; and country workplans.

30. Numerous IPC courses are available through WHO. A Graduate Certificate in IPC is offered by James Cook University, Griffith University, and the University of Adelaide (nurses only). Some public health courses include IPC. SPC offers specific IPC training for PICTs.

31. There is very little Pacific research on IPC, although a paper from PNG was published recently. There is other research going on, but it is not yet published. The Pacific has data that can be used for research. There is also informal mentoring happening.

32. Challenges for IPC include clinical governance, the often low profile of IPC, and lack of recognition of expertise. Research opportunities may be foregone because of lack of time and funding, and the requirement to leave the country to take up a scholarship (as required by Griffith University).

33. On the positive side, the profile of IPC in PICTs is being raised through PICNet. Accreditation and legislation will also help.

34. Future directions include improving the status of IPC; education and research partnerships; mentorship; and donor support.

Discussion

35. New Caledonia: Hand hygiene courses are provided, but practices are not updated or assessed.

36. Solomon Islands: There is limited knowledge on undertaking research and collaboration would be welcome.

³ Water, sanitation and hygiene (WASH).



37. Palau: There are challenges in getting papers to the final stage, e.g. funding, editing.
38. Tuvalu: There is inadequate knowledge of IPC in Tuvalu and assistance is required on collection and analysis of data. Internet access is an issue.
39. Niue noted a lack of technical assistance. Power surges were also a problem.
40. PNG: Research has to start with the nursing curriculum. PNG has basic nursing training then a bachelor degree at Pacific Adventist University. The degree programme provides modules on research. It would be good to have a regional standard for research.
41. RMI collects data manually. A dashboard would be helpful.
42. Dr Zimmerman responded as follows:
- PICTs need to proceed step by step ('doesn't all need to happen tomorrow').
 - Researchers must consider ethical issues and obtain permission to release data.
 - At Griffith, WhatsApp is one of the apps used for communication.
 - Agreed with embedding research in nursing curriculums.

Foundations of IPC International

Jackie Miley, Education Manager, ACIPC

43. The Foundations of IPC International is a course that addresses the basic principles of IPC. It is a self-paced course over 6 months and is delivered online with live (Zoom) tutorials. Content is updated often and is applicable to all settings. Students come from all over the world, with numbers greatly increasing since the pandemic began.
44. The course, which is a level 8 course under the Australian Qualifications Framework, has 11 modules:
1. Microbiology and immunology
 2. Exploring the concepts and science of HAI prevention
 3. Audit and surveillance
 4. Cleaning, decontamination and sterilization
 5. Outbreak management
 6. Multi-resistant organisms and antimicrobial stewardship
 7. Aseptic technique and invasive devices
 8. Clinical governance
 9. Theories of leadership and motivation
 10. Employee health – vaccination, sharps safety, pregnancy
 11. IPC in specific settings.
45. Learning outcomes include a comprehensive understanding of IPC practice; ability to formulate a programme; and effective communication with multi-disciplinary teams. Course resources include regional and international guidelines, a textbook, and recorded lectures.
46. Student support includes a Q&A forum, live tutorials, and feedback on draft essays before final submission. Assessment includes quizzes, key questions, and a written assignment.

47. Other courses available include Academic writing, IPC in aged care settings, Blood-borne virus testing, and IPC industry masterclass.

Discussion

48. Dr Mahmoud confirmed that the WHO IPC short courses are available in all UN languages.
49. Niue students have to use their own data but are not reimbursed by the government. Niue is open to support on research.
50. Fiji, Federated States of Micronesia (FSM) and Cook Islands all expressed support for the course and research. Cook Islands said the course will also help in succession planning with new graduates coming through.
51. The Chair declared that PICNet endorsed the course.

Session 3 Health Emergencies – COVID-19 and lessons learned

Samoa's experience: Responding to IPC requirements during COVID-19 quarantine
Joyce Roache-Levaai, Principal Officer, Quality Assurance and Infection Control Div., MOH, Samoa

52. Samoa was still recovering from the measles epidemic and associated loss of life when COVID-19 struck. Border control measures were implemented before WHO declared COVID as an international emergency. A national lockdown was put in place after eight cases were detected in Samoa. Repatriation flights (several chartered) arrived from New Zealand, Australia, Fiji, USA and Vanuatu.
53. Key roles and responsibilities included preparation of IPC and logistics, and establishment of quarantine facilities and requirements, including training staff and investigating breaches. Multimedia awareness programs were developed and delivered.
54. Achievements included recruitment of four Senior IPC Officers in November 2021, and full support for IPC by management, the Health Emergency Operating Centre and the National Emergency Operating Centre.
55. Challenges included the spread of false information, non-compliance with training, procurement delays, and staff illness and stress.
56. Future directions:
- Develop IPC outbreak preparedness, readiness and response plan.
 - Provide moral and psychosocial support, therapeutic and counselling services for health-care workers.
 - Improve supply management for public health emergency response.
 - Deliver ongoing IPC training, support and capacity building for IPC staff.

Fiji's experience: Role of IPC in the successful management of a hospital outbreak of COVID (Delta variant)

Yvette Samisoni, IPC Supervisor, Lautoka Hospital, Fiji



57. Lautoka Hospital, Fiji, underwent a 21-day lockdown after several staff and patients tested positive for COVID-19.
58. IPC was essential in containing the outbreak, with measures including a screening station, correct PPE use, hand hygiene, management support and inclusion of the IPC team in all discussions. This support was empowering for the IPC team.
59. Immediate control steps included full PPE with respirator masks; monitoring staff compliance; and pre-engagement orientation for COVID wards.
60. Challenges included IPC-led testing, maintaining IPC protocols, and managing data, which was done manually by ophthalmologists (who had spare capacity during the lockdown).
61. Future directions:
 - Strengthening IPC outbreak preparation, readiness and response action plans including drills and desktop exercises.
 - Strengthening implementation of the minimum requirements for IPC programmes.
 - Investing more in IPC education for IPC focal points.
62. The IPC team (the 'real heroes') and SPC were acknowledged for their support.

Panel discussion: Opportunities, challenges, and lessons from COVID-19

Panellists: French Polynesia, Fiji, Tuvalu and Samoa

63. Question: What was your first thought on responding to COVID?

- a. Fiji: We had to understand a new virus and plan how to address it. IPC was at the forefront. Everyone saw how important it was. It was an opportunity to present the basics of IPC to all staff.
- b. French Polynesia: COVID was a chance to show how essential IPC is. I wanted to help professionals who were frightened of the disease. I had already trained staff in PPE wearing in France. I then went to French Polynesia and had to answer questions about COVID from the MOH. It was difficult to apply the IPC programme, but we were able to implement IPC procedures thanks to COVID. All PICTs have the same problems and fears.
- c. Tuvalu: It was a struggle. I'm a physiotherapist. Tuvalu had no IPC resources or staffing. SPC helped us and we also received an IPC advisor from Australia and recruited a nurse to the IPC team. We gave training, but when staff asked questions, I had to look up the answers. I didn't know about audits and monitoring. I've learnt a lot.

64. Question to Samoa: What would have helped you in responding to COVID-19?

- a. Samoa: It would have helped if IPC staff were recruited before the outbreak not after. I was working in public health rather than in a clinical setting. WHO members sat in Health Emergency meetings and WHO provided an IPC consultant who went straight to training clinical staff.

65. Question: What were the challenges and opportunities?

- a. Fiji: It was a chance to assess our infrastructure and launch our IPC guidelines. On the negative side – we need to set up a resource database (PPE, pharmaceuticals etc.).
- b. Tuvalu: We established the position of IPC officer at Princess Margaret Hospital. We now have a budget for the position but are yet to recruit. SPC helped us with our draft IPC guideline. The training course from Griffith University will be much appreciated. On the negative side – we’re part-time IPC practitioners.
- c. Samoa: Positives included revival of the IPC committee; recruitment of IPC staff; and receiving copies of IPC guidelines from SPC. A negative was lack of training for new IPC staff, many of whom had no clinical background.

66. *Question: Looking back, what would you tell yourself?*

- a. Fiji: We did well thanks to all the support received. I would say have an emergency action plan.
- b. French Polynesia: Training is essential. It’s critical to be prepared. IPC should be part of medical training.
- c. Tuvalu thanked the Government of Tuvalu and all organisations that supported Tuvalu, and acknowledged the assistance provided by nurses from Fiji.
- d. Samoa: Ask for help. Samoa now needs help in training our staff – we’d like all four team members to join the new course.

Discussion

- 67. Tokelau: WHO has declared the pandemic is over, but Tokelau is still implementing measures, including quarantining all incoming people. Last week we had a positive case in a village. The challenge is that our three islands each have a powerful community council and all advice has to go through the council. Thanks to SPC for sponsoring eight retired nurses to come to Tokelau to help.
- 68. The Chair asked if there were any recommendations on preparedness, in addition to the panel’s recommendations.
- 69. Niue does not have an IPC officer and has to establish all the IPC structures that have been discussed. However, Niue established an emergency response plan for COVID and SPC assisted with draft IPC guidelines. It is hoped that Margaret Leong will come to Niue to help implement its guidelines and preparation for the next pandemic.
- 70. Fiji: Timelines between pandemics are shortening. Both IPC readiness and strengthening of IPC guidelines should be treated with urgency.
- 71. PNG: COVID had a huge impact in PNG, including loss of health staff, fear and law and order problems. We emphasised the role of IPC in arresting the cycle of transmission. PNG has almost 10 million people and it’s essential to appeal to common interests. PNG appreciated the work of SPC in bringing PICTs together.

72. Chair: Do we agree on the need for an IPC preparedness plan?
73. FSM agreed, noting that FSM was one of the last PICTs to open its border. It also had a preparedness plan. Palau also agreed, noting that the meeting would help refine Palau's procedures.
74. Solomon Islands: There was little IPC at national level till COVID came. Its importance is now recognised in public health and other ministries. A health emergency response requires IPC and PICTs must have plans in place.

Session 4 Improving the safety climate - Hand hygiene

Introducing WHO guidance – Responding to outbreaks of antimicrobial-resistant (AMR) pathogens in health-care facilities

Dr Takeshi Nishijima and Dr Sophie Dennis (AMR) Essential Medicines and Health Technologies, Division of Health Systems and Services, WHO Regional Office for the Western Pacific Region (WPR)

75. Between 2020 and 2030, it is estimated that AMR will cause over 5.2 million excess deaths in the WPR and incur USD 148 billion in economic costs. AMR is a priority for the WPR requiring national action plans; improved surveillance; and strengthened capacity.
76. The 2014 Action Agenda for AMR in the WPR included three regional priorities:
1. Strengthen development and implementation of comprehensive national plans to contain AMR and raise awareness in multi-sector actions to contain AMR.
 2. Improve surveillance of AMR and monitoring of antimicrobial use.
 3. Strengthen health system capacity to contain AMR.
77. The 2019 Regional AMR Framework provides a systems approach to tackling AMR that includes training, stewardship and response. Regional guidance published in 2022 calls for the earliest possible detection and control of AMR pathogens, and a step-by-step response to outbreaks in health-care facilities in low- and middle-income countries. The guidance should be used by health-care workers including clinicians and management, and also by public health professionals and policy-makers.
78. AMR preparedness and prevention includes IPC/WASH precautions, antimicrobial stewardship, training and surveillance.
79. WPRO has supported train-the-trainer workshops including simulation exercises.
80. Potential support for PICTs is likely to include:
- review of AMR surveillance system, using a step-by-step approach, and recommendations on gaps, etc.;
 - support for capacity building for AMR outbreak response in hospital settings (e.g. a train-the-trainer workshop if there is a need);
 - technical assistance for developing or updating AMR outbreak response documents.

Building a standardised hand hygiene programme

Kate Ryan, Hand Hygiene Australia (HHA)

81. A paper published in Lancet by Pittet et al. (2000) found that the promotion of bedside alcohol-based handrubs was key to increased compliance with hand hygiene (HH) protocols.
82. A HHA initiative reported on after 2 years' implementation found that compliance with protocols was highest for nurses and lowest for medical staff. After 8 years, for every 10% increase in HH compliance, the incidence of healthcare-associated *Staphylococcus aureus* bacteraemia decreased by 15%.⁴
83. HHA aims are to implement a standardised HH culture-change programme to improve compliance among Australian health-care workers, and to establish a system for auditing compliance that would allow local, national, and international benchmarking.
84. HHA developed a standardised programme based on the WHO five moments for HH:
1. Before touching a patient
 2. Before a procedure
 3. After a procedure or risk of exposure to body fluid
 4. After touching a patient
 5. After touching a patient's surroundings
85. The presentation includes a detailed description of implementing a HH programme and evaluating the results, including auditor training and annual auditor validation.
86. Keys to a successful HH programme:
- HH product available at point of care
 - HH included in all educational activities
 - Auditing in all areas of the health service
 - Visibility of auditors
 - Timely feedback
 - Wards responsible for their own results
 - Innovative interventions and promotions
 - Active support from hospital leadership
 - Rewards for achievement
87. Recommendations to the Pacific Community for implementing a Pacific-wide HH Programme include:
- managing expectations (baseline compliance may be very low)
 - measuring performance
 - recognising that a HH programme is a continuous quality initiative
 - providing results and feedback.

Progress on implementing a hand hygiene programme in Vanuatu

Agnes Mathias, National IPC Coordinator, MOH, Vanuatu

88. SPC and the HHA programme provided HH audit training for Vila Central Hospital (VCH) focal points. The training aligned with the WHO five moments for HH (para. 84 above).
89. Vanuatu volunteered to act as a pilot country for training five participants from its IPC team as Gold Standard HH auditors.

⁴ [https://doi.org/10.1016/S1473-3099\(18\)30491-2](https://doi.org/10.1016/S1473-3099(18)30491-2)



90. Three VCH wards (Surgical, Medical and Neonatal Intensive Care) were pilot sites for HH auditing. After 8 hours of online training, a baseline audit of the three wards was carried out in June/July 2022 with follow-up audits in November 2022.

91. Results to date:

- The baseline HH compliance was 23%.
- By the second audit, HH compliance had increased substantially, from 23% to 50%.

92. Challenges:

- Lack of funds makes it difficult to install appropriate HH stations.
- Inadequate HH supplies.

93. Future directions

- Raising awareness of the critical role of HH in preventing infections and generating savings in health care costs.
- Investing in HH to improve compliance in acute care settings.
- Reviewing processes to ensure efficient management of HH supplies.
- Building IPC capacity and expertise through training and continuous education.
- Establishing HH compliance as a national key indicator.

Implementing a hand hygiene programme in Federated States of Micronesia (FSM)

Amanda Lih Abello, IPC focal point, FSM

94. After two FSM staff were trained as Gold Standard HH auditors, they conducted a baseline audit of all areas of Pohnpei Hospital in September-November 2022 and then developed an action plan to improve compliance. The plan included installing HH equipment in all wards, plus posters.

95. A follow-up survey in March-April 2023 showed compliance increased from 7% to 9%.

- Surgical ward – noted that doctors and nurses washed their hands after seeing a patient, not before. This improved in follow up.
- Emergency ward – low compliance improved after training, which included emphasizing that gloves are not a substitute for hand washing.
- Pediatric ward – the baseline of 5% increased to 8%.

96. Challenges

- Providing HH equipment at point of care. The action plan included placing equipment in wards, etc.
- Educating and training staff, including new staff, on IPC.
- Reinforcing a culture of responsibility and accountability.

97. Future directions

- Establish a database to support HH data input and analysis.
- Make HH compliance a national indicator and include WASH in healthcare facilities.
- Support surveillance of HAIs.
- Improve resource availability and build the infrastructure required to improve IPC practices.
- Ensure political commitment to implementing the core components of an IPC programme.
- Build IPC capacity through training and ensuring career pathways for IPC professionals.

Hand hygiene auditing project – Palau (Belau) National Hospital, Ministry of Health and Human Services

Belinda Eungel, Infection Control Coordinator, Bureau of Hospital Services, Palau

98. Palau has an 80-bed capacity hospital and 100% availability of HH products. Following training to Gold Standard auditor level by HHA, staff were provided with training on the '5 moments of HH'. A baseline audit showed 48% compliance/52% non-compliance with HH protocols. A recent follow-up after implementation of a multi-modal plan showed a 40% increase in HH compliance.

99. The multi-modal plan included:

- system change (infrastructure and material and supplies for HH)
- education (staff of the pilot wards were trained in HH 5 moments)
- monitoring and feedback (results of HH Audits posted in wards and clinics, and incentives for improvements identified)
- reminders in the workplace ('5 moments' posters in patient care areas)
- support for institutional safety (funding and technical assistance received from MOH and SPC).

100. Future directions

- Support for infrastructure – resources, materials and equipment – to perform HH at the point of care.
- HH monitoring and feedback becomes a national indicator in all PICTs.
- Support for establishment of a HH database including education materials.
- Continued training and support for primary health-care facilities with WASH infrastructure.
- Implementation of the minimum requirements of an IPC programme at national and primary health-care facility level.

Discussion

101. Nauru emphasised that IPC training is not just for IPC staff but for all health-care workers.

102. Fiji: HH is already a national indicator. In Fiji, behaviour is an issue. We need to see that HH is normal and to make it part of the culture. Having hand rub beside each bed during COVID was a start.

103. PNG, Palau and Vanuatu supported making HH a national key indicator.

104. Kate Ryan, HHA, expressed doubt about making HH a national indicator immediately. In Australia, a target of 70% was set to begin with. She suggested first setting requirements, e.g. hand rub, education, auditing.

105. The Chair noted that a HH indicator was well supported.

106. Fiji suggested setting a hospital-level indicator. RMI agreed.

Presentation of draft recommendations for Day 1

107. The Chair presented the draft recommendations for comment.

108. While generally agreeing with the recommendations, participants suggested:



- HH education in schools (noting that UNICEF has a hand washing program in schools through WASH)
- the importance of continued IPC training, and sufficient IPC staff
- integration of WASH and IPC.

Launch of Foundation Course

109. The Foundation Course was officially launched at an evening gathering. Professor Philip Russo described the background of the course and Jackie Wiley introduced a video outlining the course content, which is online.

Keynote address: The importance of surveillance in health-care settings

Associate Professor Philip Russo, Immediate Past President, Australasian College for Infection Prevention & Control (ACIPC); Director Nursing Research, Monash University Nursing and Midwifery; Director Nursing Research, Cabrini Health; Adjunct A/Professor, Avondale University

110. Definition of surveillance –

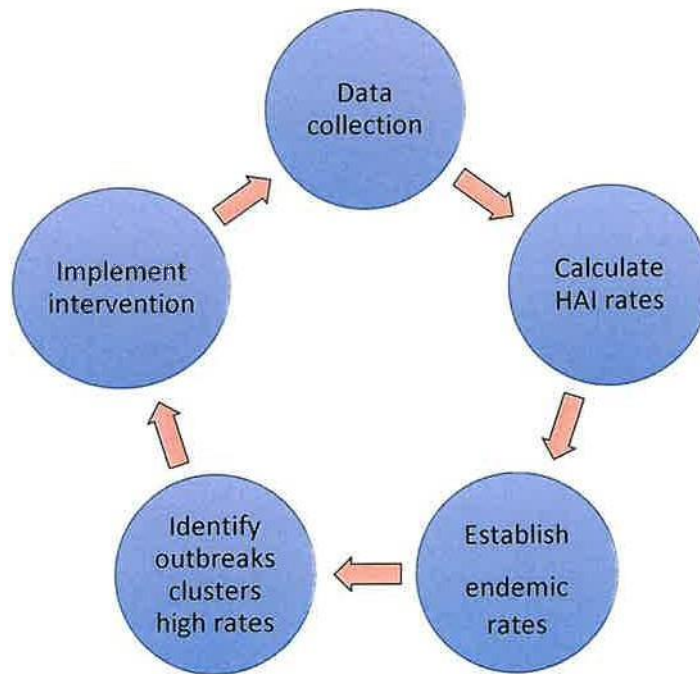
‘The ongoing, systematic collection, analysis and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of the data to those who need to know’ (Allen-Bridson 2012).

111. Purposes of surveillance

- Establish baseline/endemic rates
- Detect clustering/potential outbreaks
- Assess effectiveness of interventions (i.e. baseline, intervene, re-assess)
- Generate hypotheses/research
- Quality improvement
- Guide treatment and prevention strategies
- Meet regulatory requirements
- Benchmark
- Reduce the incidence of preventable infection

112. Critical to have standard definitions of surveillance to allow comparability (surveillance is resource intensive):

1. Standard definitions and protocols
2. Defined populations at high risk (e.g., intensive care, surgical patients)
3. Site-specific, risk-adjusted infection rates comparable across institutions
4. Adequate numbers of trained IPC practitioners
5. Dissemination of data to health-care providers
6. A link between monitored rates and prevention efforts
7. Timely feedback



Hospital surveillance programme

113. Only collect data that will be used. For example, to assess the Caesarean section infection rate:

- Generate infection rate
 - Surgical site infection rate in May = 5%
- Is this good, bad, expected?
 - Make a comparison with previous months, other hospitals
 - Benchmark
- Share the data – give feedback to those who need to know
- Why is the infection rate high?
- Share the information with
 - Surgeons, hospital executive staff, operating room staff, ward staff
- Are the patients higher risk?
- Are the infections deep, organ or superficial?

114. Professor Russo described a hospital-based scenario on reducing SSI after hip surgery. Baseline observations included doors left open, IPC breeches and a crowded OR. Remedial action included an education programme for all staff, e.g. on wound care, mask compliance, cleaning, and compliance with the hospital's prophylactic antibiotics policy. The results showed the SSI rate was more than halved.

115. Conclusion

- Timely feedback of data
- Benchmarking and comparing data – with other hospitals or with the literature
- Sharing data and interventions
- Increased awareness of clinicians, hospital executive, health department, consumers

116. Future directions

Internationally there is increasing use of electronic medical records, the introduction of algorithms to identify patients at high risk of infection, and experimentation with AI. These elements will reduce the burden and improve the accuracy of surveillance and influence how HAI surveillance is done in future.

**'Surveillance alone will not reduce healthcare associated infections.
It must be used to drive action and interventions.'**

Discussion

117. Solomon Islands: Surveillance is lacking in Solomon Islands. Does IPC include a system for tracking HAI?
118. Margaret Leong: In the past year, SPC has worked with the Doherty Institute to build a standard methodology for SSI. PICTs now need to develop their SOPs so they can adopt the methodology. They should start small. SPC will be providing more support for addressing HAI, which is a weak area of the core components.
119. Donna Cameron (Doherty Institute) noted that training materials have been rolled out. In response to a comment by PNG, she stressed that surveillance can be carried out without a microbiology lab, even though microbiology is important.
120. Samoa and Palau both requested further training in HAI. Palau also asked for technical assistance.
121. French Polynesia: If a health-care worker doesn't alert clinicians to an anomaly, it can't be investigated. HAI surveillance means maintaining good communication, visiting wards, etc. and asking to be informed of anomalies. Infections are not necessarily someone's fault – they may be due to patient flora.

Session 5 Health-care Associated Infection Surveillance

Surgical site infection surveillance (SSI) – country updates

IPC Focal points: Solomon Islands, RMI, Kiribati

Update on SSI surveillance – Caesarean sections

Solomon Islands

122. A study on SSI in Caesarean sections was carried out at the National Referral Hospital from September 2022 to March 2023.
- Total 441 Caesarean sections: Elective 39, emergency 402
 - Infection rates for elective – 0%, and for emergency – 4%
 - There was an increase in SSI in December 2022. Only 4% SSI were detected during the study.
123. Challenges:
- Knowledge and skills gap on SOP for SSI surveillance
 - Difficult to follow up patients for 30 days post discharge
 - Inconsistent reporting mechanism from facility to national level (manual reporting)

- Inadequate resources for IPC team (computer hardware, consumables for printing forms) to support completeness of reporting.

124. Future directions

- Establishment of online surveillance system for SSI – this could be a database.
- Support for resources (including computer hardware) for effective implementation of HAI surveillance.
- Good coordination with provincial IPC staff to support post-discharge surveillance.
- IPC capacity building on SSI surveillance tools.
- Ongoing training in epidemiology surveillance (training currently provided by SPC).
- Engagement and collaboration with senior leadership, physician champions, infection preventionists, and multidisciplinary teams.
- Patients' clear understanding of wound care requirements prior to discharge from the hospital. Some are from remote areas where hygiene is limited.

SSI surveillance in RMI

RMI

125. SSI surveillance started in January 2022 on the following cases:

- Total abdominal hysterectomy and bilateral salpingo-oophorectomy: 6 cases
- Elective C-section: 32 cases
- Herniorrhaphy: 8 cases
- Colostomy: 7 cases
- Cholecystectomy (1 infection – *E. coli*)

IPC continues to monitor and follow up SSI cases.

126. Study of Ebeye Hospital

- SPC conducted virtual training on SSI surveillance on 5 August 2022.
- Ebeye Hospital was represented by 13 participants.
- Training included the SOP for SSI surveillance, with the SOP to be adapted to the facility.
- Surveillance tools.
- Data was collected throughout the surveillance period.
- Results: 43 surgeries, 2 infections.

127. Future directions

RMI needs:

- support with an SSI database/software to assist data analysis.
- support to strengthen antimicrobial stewardship in RMI.
- follow-up training on SSI surveillance from SPC.
- continuation of reporting/feedback via email to the leadership team, and bulletin board postings for all physicians and nursing staff
- potentially, a disease/procedure specific guideline in relation to AMS in RMI.

SSI surveillance in Kiribati

Toata Titaake, Ministry of Health and Medical Services, Kiribati

128. Kiribati has four main hospitals – Betio, Nowerewere, Kiritimati Island, and North Tarawa. SSI surveillance began in Nowerewere Hospital with elective Caesarean cases only following training by the Doherty Institute in partnership with SPC. The new SOP and data collection tools (denominator and numerator forms) were used.

129. Surveillance procedure: Patients were followed for 30 days via phone call, which required teamwork between health-care workers. Results: 90 Caesareans, 5 infections (6.4%).

130. Benefits:

- The SSI surveillance programme benefits patients because surgical wounds are well monitored during the 30-day period.
- The data is useful in highlighting the importance of
 - hand hygiene practice
 - health-care workers use of aseptic technique for wound dressing
 - patients' understanding of wound care.

131. Challenges for IPC staff

- Poor communication between IPC team and ward nurses on wound review.
- Unable to do follow-up on SSI cases reviewed in community clinics.
- Unable to use the hospital landline phone to contact/follow-up SSI cases as it is always busy.

132. Challenges for patients

- Some patients have no contact information
- Unable to communicate with public health nurses to report back on SSI cases who visit their clinics
- Transportation
- Missed appointments
- Ownership of SSI surveillance

133. Future directions

- Continue support by SPC for training and awareness of SSI surveillance
- Improve education and communication on SSI surveillance to increase compliance
- Strengthen the network with public health nurses for post-discharge follow-up of SSI patients
- Establish links with public case workers to ensure continuum of care of SSI cases in the community
- Increase funding
- Provide feedback to the surgical team, obstetrics team and technical leadership team on the surveillance and requirement for support

Discussion

134. FSM does not yet have HAI/SSI surveillance in place. The information provided by the presentations is the first step. FSM requested inclusion in SPC's training for SSI surveillance.

135. PNG, Palau and Niue also requested training.

136. Solomon Islands asked what other SSI indicators should be looked at.

137. Margaret Leong: We'd like all PICTs to implement surveillance. Those PICTs that reported need to improve their adherence to the SOPs/methodology. We're also going to study healthcare-associated bloodstream infection, but with a few PICTs this year.

138. Tokelau provides only basic surgery and is developing a referral hospital. It would like the Pacific Islands Operating Room Nursing Association (PIORNA) Samoa to assist.

139. Samoa asked SPC to share the SSI surveillance SOP and tools before providing training.

140. Vanuatu noted the need for frequent refresher training.
141. French Polynesia: Hospitals that don't perform surgery can still train nurses, e.g. to avoid catheter infection. French Polynesia has three hospitals that don't perform surgery, but they do carry out HAI surveillance.
142. Nauru has challenges with SSI, including prophylaxis.
143. Fiji: Surveillance requires persistence, especially after high-profile outbreaks. Teamwork is essential. Fiji has good lab support, nurses are trained in the basics of microbiology, and links are being built with epidemiology. Some research was carried out with a local university lecturer on nosocomial infection. It is important to build a collaborative clinical services network and to have data based on definitions. Digitisation will enable sharing of data.
144. The Chair noted the support for an SSI database and the requests to SPC for more training.

Session 6: Role of IPC in antimicrobial resistance (AMR) prevention

Role of microbiology in AMR prevention

Dr Eka Buadromo, Team Leader, PHD, SPC

145. Microbiology is the study of the biology of micro-organisms. It requires lab resources and expertise in
- bacteriology
 - virology
 - parasitology
 - mycology
 - culture, identification and sensitivity testing.
146. Microbiology is fundamental to AMR prevention. Good relationships between microbiology laboratory staff and IPC staff are important in managing multi-resistant organisms (MRO), especially in hospital settings.
- An accurate and efficient microbiology service enables:
- early detection and notification of MRO
 - early implementation of IPC measures
 - reduced risk of MRO spread.
- PHD and other partners are trying to strengthen this approach through training.
147. Facilities in PICTs
- Basic microbiology testing is available in >80% of PICTs
 - Some countries have the automated VITEK⁵ identification and sensitivity testing system
 - A smaller number of countries use GeneXpert MRO cartridges
 - Samples can be referred to the WHO regional collaboration centre for PCR and whole genome sequencing (Dr Eka acknowledged WHO's support.)
147. SPC is working with Tuvalu to establish microbiology testing and also has to support other small countries, e.g. Niue and Nauru.

⁵ Automated system that performs bacterial identification and antibiotic susceptibility testing.

148. The One Health approach includes trying to minimise antibiotic use in animals, given that resistance builds very quickly.
Training will be provided for PICTs in the second half of 2023.

149. AMR challenges in PICTs

- Lack of microbiology testing supplies (SPC brings its own supplies for training so as not to use PICT supplies)
- No microbiology services in some countries
- Lack of antibiograms based on Excel (WHONET⁶ is available free online but PICTs are struggling with it)
- Weak antimicrobial stewardship (lack of implementation of pharmacy regulations in PICTs)
- Lack of MRO surveillance
- Requirement for further training on One Health approach

150. Future directions

- Strengthen microbiology testing (basic and molecular technology) (IPC teams to ask for more resources for microbiology laboratories).
- Implement use of real-time antibiogram to support AMR surveillance
- Strengthen relationships between IPC staff, clinicians and microbiologists.
- Improve planning and support for screening – need molecular testing to see where organisms are coming from.
- Establish an AMS committee and strengthen AMS activities in all PICTs (only Fiji has AMS guidelines). Partners can support AMS development.
- Strengthen the One Health approach to AMR.

One Health and AMR - Harmonizing IPC, AMS and AMR Surveillance

Dr Sala Saketa, Senior Laboratory Advisor, SPC

(Dr Sala acknowledged support from Massey University and PHD colleagues, who advocate One Health.)

One Health building blocks

Communication, collaboration, coordination, capacity building

151. One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems.

- It recognizes that the health of humans, domestic and wild animals, plants, and the wider environment (including ecosystems) are closely linked and inter-dependent.
- The approach mobilises multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems, while addressing the collective need for clean water, energy and air, safe and nutritious food, action on climate change, and sustainable development.

152. Operationalising One Health requires:

- common goals, perspective and strategies across sectors
- building on existing structures, including through
 - gaps and needs analysis
 - mapping

⁶ Windows application for the management and analysis of microbiology laboratory data.

- true trans-disciplinary approaches
- coordination, collaboration and communication

153. Dr Eric Rafai, Fiji, SPC's new One Health Coordinator, is based with the Animal Health Programme. Fiji's implementation of One Health includes the following steps:

- Governance structure
- NARC: National Antimicrobial Committee
- Supra-national actors identified (FNU, animal sector, etc.)
 - COMBAT: support for cross-sector collaboration
 - CSIRO (EMAR): support for cross-sector collaboration, training
- Research to support surveillance
- Control activities
 - Regulations
 - Awareness
 - NARC
- Surveillance activities – still developing the best approach

154. Barriers to implementing One Health:

- Commitment, including fitting in with daily workloads
- Identifying the right person to approach
- Lack of harmony on policies, including on spending.

155. Factors for success:

- Communication/relationships
- Information sharing
- Willingness to collaborate
- Funding

156. Conclusion

Although there have been advances in addressing AMR using the One Health approach in PICTs, there is still much work to be done.

PICNet, as a service network of PPHSN, is well placed to operationalise the One Health approach as it helps in harmonisation of strategies such as IPC, AMS, and AMR surveillance to accelerate prevention and control of AMR in the region.

157. Way forward

- Scale up intersectoral and cross-sector capacity building
- Develop policies and strategies
- Provide support for sustainable veterinary microbiology services (some resources available post-pandemic)
- Strengthen IPC and AMS services
- Develop the environment sector
- Encourage data sharing

Scenario-based exercise to test preparedness for critical antimicrobial resistant organisms

Ms Donna Cameron, IPC Consultant, Peter Doherty Institute for Infection and Immunity, University of Melbourne

158. A scenario-based tabletop exercise was used to test the preparedness of CWM, Fiji's major referral hospital. The exercise included understanding the current situation and determining responses.
The scenario involved a patient in a four-bed ward. *Klebsiella pneumoniae* resistant to meropenem was isolated from a urine sample. Contact tracing found three other cases. Workshop participants looked at protocols to guide staff, and policies/guidelines/procedures, before identifying the next steps and an action plan.
159. As a result of the exercise, a plan was developed to address the issues identified and build local capacity to manage critical AMR organisms.
160. The training was supported by COMBAT-AMR, a One Health programme that aims to strengthen capacity to mitigate AMR in humans and animals in Fiji, Samoa, Solomon Islands and PNG. COMBAT-AMR is funded by the Australian government.
161. WHO has developed a useful resource (available free online) 'Responding to Outbreaks of Antimicrobial-resistant Pathogens in Health-care Facilities: Guidance for the Western Pacific Region.'⁷

Discussion

162. Jackie Miley (ACIPC): We have gathered world experts so we can put together a course that should be available by September. The One Health approach is already in the Foundations of IPC course.
163. Vanuatu needs more support on AMR. Fiji is providing support for setting up a national AMR strategy.
164. Solomon Islands now has a clearer understanding of One Health and AMR and the role of IPC.
165. Dr Eric Rafai, SPC: One Health has been on the agenda of Pacific leaders for many years. In addition to AMR, there are also problems with zoonotic diseases and plant disease control. A One Health symposium is planned for 23 and 24 August. Participants are asked to advise SPC if they are interested in submitting an abstract.

Session 7 PICNet Terms of Reference (TOR)

PPHSN and PICNet

Christelle Lepers, Surveillance Information and Communication Officer, PHD, SPC

166. PICNet is one of the six services of the Pacific Public Health Surveillance Network (PPHSN). It was developed following the SARS outbreak, which indicated a need to address infection control issues at facility, national and regional levels. In 2004, PPHSN members recommended 'reviewing and improving on the infection control measures in PICTs by establishing and formalising the Pacific regional infection control network under the umbrella of the PPHSN'.

⁷ <https://www.who.int/publications/i/item/9789290619970>

167. PICNet was officially launched in 2006 at an IPC meeting and training workshop. Progress since then has included the appointment of an IPC Advisor, extensive training in PICTs, and updating of PPHSN's IPC guidelines in 2021 (originally published in 2010).
168. PICNet's role in COVID responses included specific IPC guidance and procedures for using PPE.
169. A PICNet discussion list, similar to PacNet (PPHSN's alert and communication list), was developed to enable exchange of information and experiences between Pacific IPC professionals but was used very little. It could be reactivated, or the PPHSN website (pphsn.net) could also be used to share information, documents and experiences.

Draft PICNet Terms of Reference

Margaret Leong IPC Advisor, PHD, SPC

170. The current PICNet TOR is due for review, with draft changes made by Margaret. Participants were asked to look at the draft changes to the TOR and comment before they are finalised and endorsed.
SPC advised that the TOR should be simple and practical.
171. Meeting chair and frequency of meetings
- The Chair of the PICNet meeting will be from the next PICT host of PHMM. The Deputy Chair will be from the PICT that last hosted PHMM.
 - Face-to-face PICNet meetings will be held every two years. Online meetings will occur in between.
 - The steering committee could meet twice a year.
 - Membership (core and allied) remains the same as in the 2006 TOR. Member countries are core participants. Allied membership is open to all partners.
 - SPC provides secretariat support.

Comments

- Add 'research agenda' and align the TOR with those of other programmes
- Expand the introduction
- TOR responsibilities lack mention of a mechanism for monitoring IPC assessments and progress
- Include raising the profile of IPC
- Steering committee membership could be rotated (2006 nominations were Fiji, Kiribati, Palau, PNG, Samoa and Solomon Islands). Other PICTs could be nominated.
- Call the steering committee a technical working group (TWG) to match other PPHSN groups
- TWG – the TWG's role is to provide technical advice for PICNet. Reduce the number of PICT members to three, with one to be Chair and another Deputy Chair. TWG meetings could be held twice a year, and more frequently depending on priorities. TWG meetings may be virtual.
- PIHOA stressed that microbiology is essential for surveillance. Should this be mentioned in the TOR? PIHOA has applied for US funding to strengthen microbiology in the North Pacific.
- Add a reference to coordination with the other five pillars of PPHSN, e.g. 'PICNet to collaborate and coordinate with LabNet, etc. in areas where they can strengthen each other'.

- The initial TOR had strategies. Perhaps this could be the first subject for the TWG.
- IPC focal points are new in the role and may have a problem contributing to the TWG.

172. Margaret Leong: One of the TWG's tasks will be to take the recommendations of this meeting and put them into strategies that they will disseminate to you.

173. The majority of PICTs agreed there should be three PICT members of the TWG. Vanuatu nominated Fiji, and Fiji agreed.

174. Conclusion

- PICTs agreed that SPC will update the draft TOR based on the meeting's comments and will then send representatives the revised draft for further input.
- PICTs were asked to consider renewing the PICNet logo.

Session 8: Discussion of the draft recommendations

Key decision points and recommendations

Chair, PICTs PICNet (This session of the meeting was open only to PICT representatives.)

175. The Chair presented the draft recommendations.

176. Comments included strengthening the point on IPC's role in AMR prevention and adding 'surge capacity' under 'National level'.

Presentation of recommendations

Dr Ana Mahe Chair, Tonga

177. The Chair presented the recommendations to the plenary meeting, which accepted them.

Close of meeting

178. The Chair thanked everyone for their guidance, especially Dr Kafoa, Margaret Leong and Dr Mahmoud, and acknowledged all partners and guest speakers.

She thanked PICT delegates for sharing their experiences and achievements.

"It has been a valuable meeting – we know what we have to do."

179. Tokelau said the closing prayer.

Slido evaluation

180. Participants completed a Slido evaluation of the meeting.

Statement

Pacific Island governments realise and acknowledge the importance of IPC, recognising the vital role of IPC in supporting quality of care, preventing antimicrobial resistance, and contributing to universal health care for all Pacific people.

At the regional level

- i. Develop a Regional IPC Monitoring Dashboard that will allow countries to visualise their progress towards the minimum requirements for IPC.
- ii. Support IPC programmes with development and implementation of annual plans and dedicated budgets at the national and facility level, to ensure the sustainability of IPC and WASH (water, sanitation and hygiene) infrastructure and resources.
- iii. Advocate for governments to dedicate national budgets for IPC.
- iv. Provide advocacy and support to ensure all PICTs prioritise the IPC minimum requirements, including political commitment to the development of policies that address financing, legal frameworks and accreditation systems for IPC standards.
- v. Provide IPC capacity building and training for the development of IPC expertise in both clinical and public health settings.
- vi. Support the development of systems to monitor, report and act, including HAI surveillance and monitoring of IPC indicators.

At the national level

- i. Establish/strengthen the minimum requirements of IPC programs at the national and health-care facility level
- ii. Support the development of IPC outbreak preparedness, readiness and response plans, e.g. surge capacity, tools for IPC.
- iii. Strengthen data monitoring and the IPC surveillance database.

Education

- i. Support IPC education for Pacific IPC focal points and other health-care workers.
- ii. Recognise IPC professional specialisation at all levels of health service delivery.
- iii. Strengthen education and capacity in the following areas:
 - hand hygiene, e.g. develop a Pacific hand hygiene programme
 - healthcare-associated infection (HAI) surveillance and antimicrobial resistance
 - collaboration between IPC and WASH in school education programmes and healthcare facilities
 - broader community engagement and behaviour change for IPC.

Data and research (to inform decision-making)

- i. Use data to monitor IPC core components and minimum standards.
- ii. Strengthen data collation and develop a database for:
 - IPC minimum standards
 - HAI surveillance, e.g. Caesarean-sections- surgical site infections
 - AMR prevention
- iii. Promote and actively seek research opportunities and partnerships.
- iv. Endorsement to publish IPC regional data.

Leadership

- i. Strengthen leadership and management in IPC.
- ii. Advocate for and raise the profile of the IPC workforce.
- iii. Support mentoring initiatives.

Development partners

- i. Support and fund IPC education and research.
- ii. Support mentoring initiatives and capacity building attachments.

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