What Makes Infection Prevention and Control Work?
Julie Storr, S3 Global
Broadcast live from the 2017 Infection Prevention Society conference

Live broadcast from Infection Prevention 2017

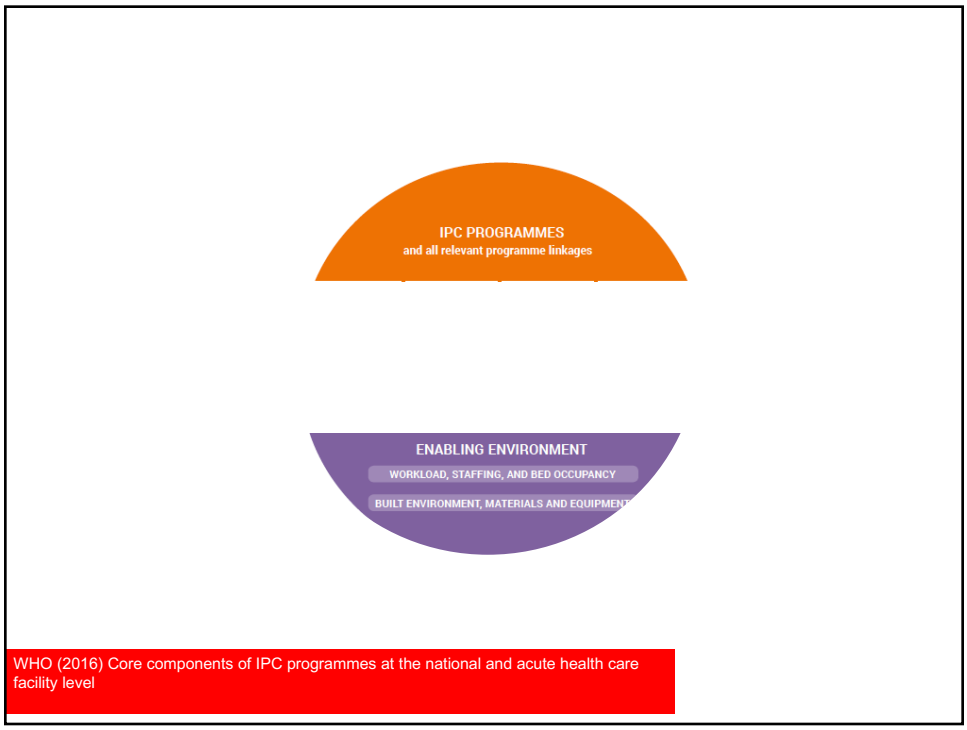
What makes infection prevention and control work?

Julie Storr
Director and Consultant, S3 Global,
Contracted by World Health Organization

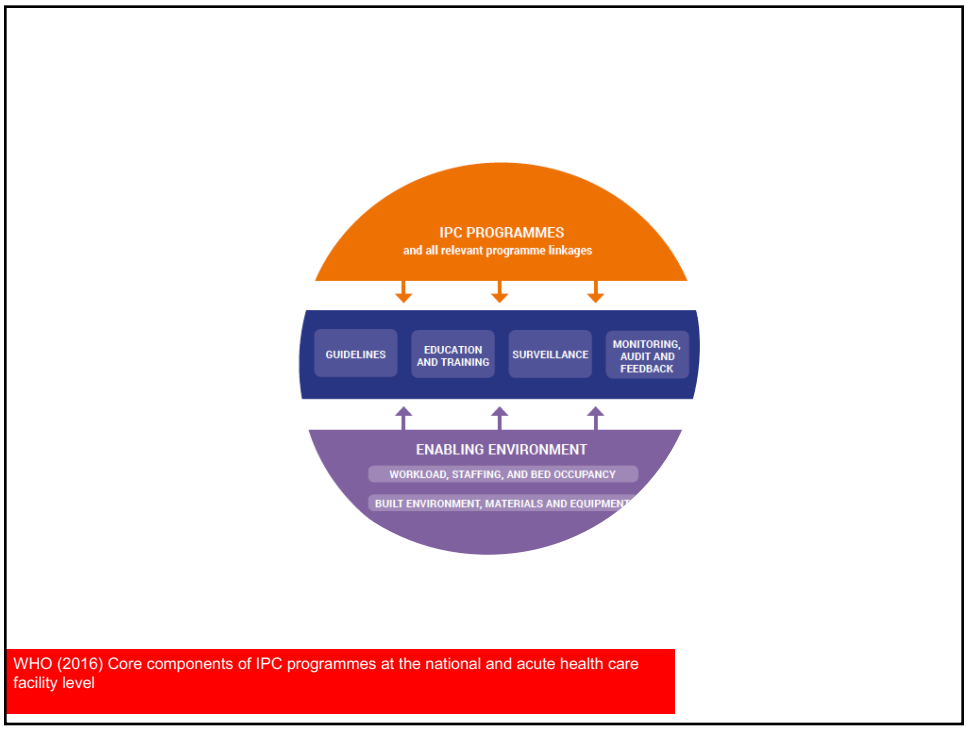
www.webbertraining.com **September 18, 2017**

WHO (2016) Core components of IPC programmes at the national and acute health care facility level

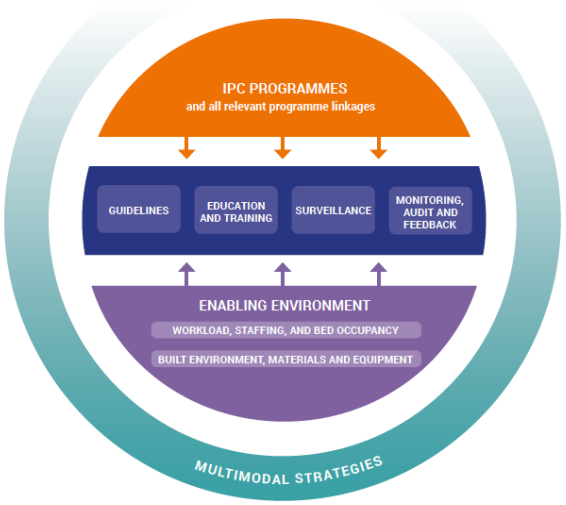
A Webber Training Teleclass
www.webbertraining.com



WHO (2016) Core components of IPC programmes at the national and acute health care facility level



WHO (2016) Core components of IPC programmes at the national and acute health care facility level



WHO (2016) Core components of IPC programmes at the national and acute health care facility level

WHO (2016) Core components of IPC programmes at the national and acute health care facility level

Two questions

1. What do you expect of people in leadership roles?
2. Why do you think we're sometimes disappointed in our leaders?

Gundlach AM (2017) Johns Hopkins School of Public Health. Foundations of Organizational Leadership.

Most common answers

Expectations
- Integrity
- Visionary
- Inspirational
- Decisive
- Team builder

Disappointments
- Don't walk the talk
- Self-centered
- Non-participative
- Poor communication
- Dishonest

Center for Creative Leadership 2011

"The vision thing"

Roy Lilley (2017) The Vision Thing. NHS Managers.Net
http://myemail.constantcontact.com/The-vision-thing.html?soid=1102665899193&aid=Y5yv0aevPII

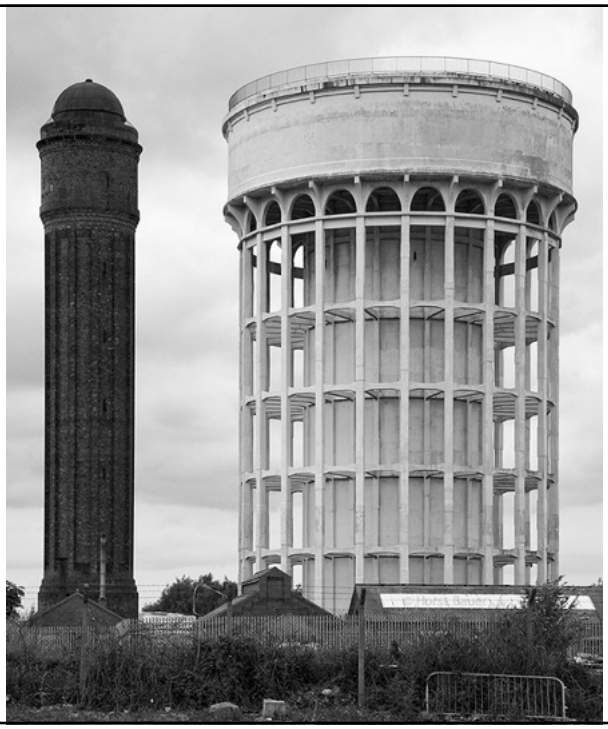
Assumptions

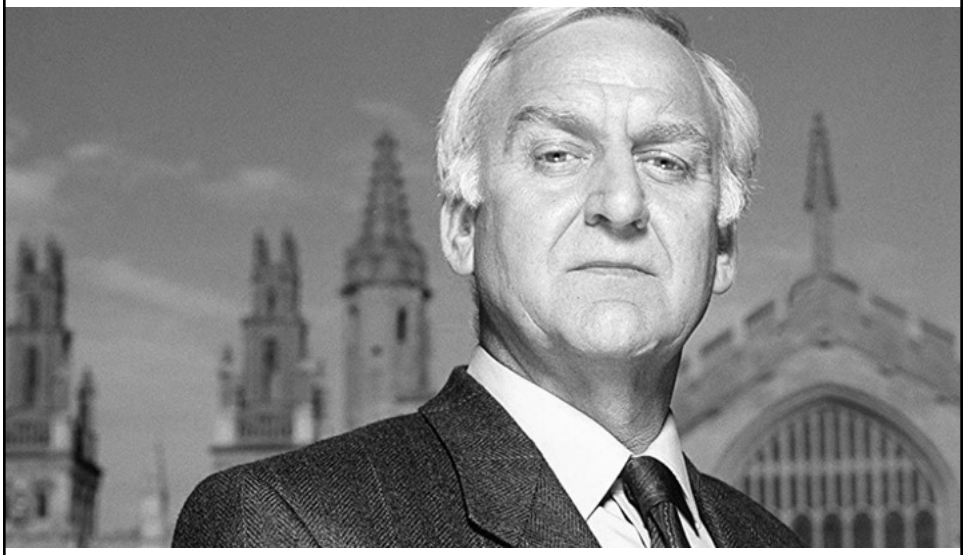
- Leaders think differently to non-leaders
- Leaders commitment and passion are not mechanical – they must be authentic
- "Felt" leadership is essential especially in times of uncertainty and change
- The only leadership is ethical leadership – our integrity defines us
- Every leader has a story – what's yours???

Gundlach AM (2017) Johns Hopkins School of Public Health. Foundations of Organizational Leadership.


My story in 60 (ish) seconds

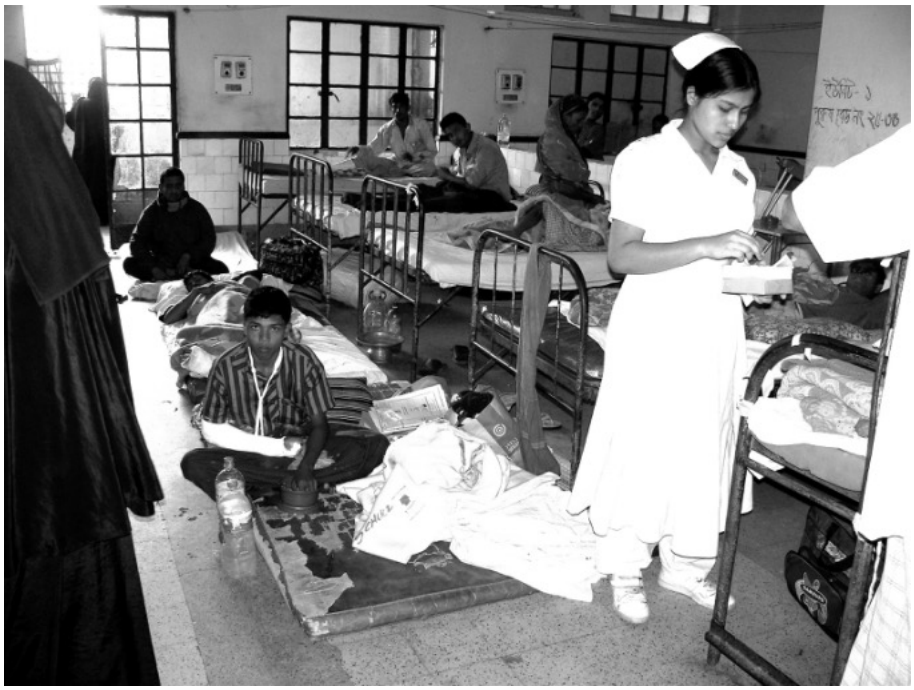

SALFORD LADS CLUB

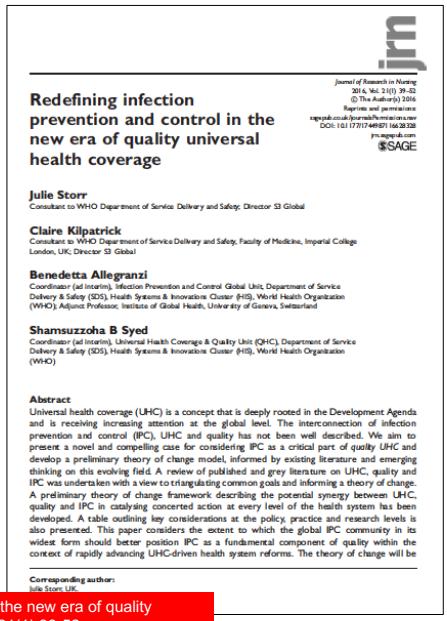




cleanyourhands© campaign


UNITED NATIONS





jrn

Journal of Research in Nursing
2016, Vol. 21(1) 39–52
© The Author(s) 2016
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1744987115622328
jrn.sagepub.com
SAGE

Redefining infection prevention and control in the new era of quality universal health coverage

Julie Storr
Consultant to WHO Department of Service Delivery and Safety; Director S3 Global

Claire Kilpatrick
Consultant to WHO Department of Service Delivery and Safety, Faculty of Medicine, Imperial College London, UK; Director S3 Global

Benedetta Allegranzi
Coordinator (ad interim), Infection Prevention and Control Global Unit, Department of Service Delivery & Safety (SDS), Health Systems & Innovations Cluster (HIS), World Health Organization (WHO); Adjunct Professor, Institute of Global Health, University of Geneva, Switzerland

Shamsuzzoha B Syed
Coordinator (ad interim), Universal Health Coverage & Quality Unit (QHC), Department of Service Delivery & Safety (SDS), Health Systems & Innovations Cluster (HIS), World Health Organization (WHO).

Abstract
Universal health coverage (UHC) is a concept that is deeply rooted in the Development Agenda and is receiving increasing attention at the global level. The interconnection of infection prevention and control (IPC), UHC and quality has not been well described. We aim to present a novel and compelling case for considering IPC as a critical part of quality UHC and develop a preliminary theory of change model, informed by existing literature and emerging thinking on this evolving field. A review of published and grey literature on UHC, quality and IPC was undertaken with a view to triangulating common goals and informing a theory of change. A preliminary theory of change framework describing the potential synergy between UHC, quality and IPC in catalysing concerted action at every level of the health system has been developed. A table outlining key considerations at the policy, practice and research levels is also presented. This paper considers the extent to which the global IPC community in its widest form should better position IPC as a fundamental component of quality within the context of rapidly advancing UHC-driven health system reforms. The theory of change will be

Corresponding author:
Julie Storr, UK.

Storr et al (2016) Redefining infection prevention and control in the new era of quality universal health coverage. Journal of Research in Nursing. Vol 21(1) 39-52

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2010.02662.x
VOLUME 15 NO 12 PP 1407–1412 DECEMBER 2010

Viewpoint

Keeping health facilities safe: one way of strengthening the interaction between disease-specific programmes and health systems

Anthony D. Harries[1,2], Rony Zachariah[3], Katin Taylor-Smith[3], Erik J. Schouten[4,5], Frank Chimbwandira[6], Wim Van Damme[4] and Wafaa M. El-Sadr[7]

1 International Union Against Tuberculosis and Lung Disease, Paris, France
2 London School of Hygiene and Tropical Medicine, London, UK
3 Operational Research Unit, Medecins sans Frontieres, Operational Centre Brussels, MSF-Luxembourg, Luxembourg
4 Department of HIV and AIDS, Ministry of Health, Lilongwe, Malawi
5 BASICS, Management Sciences for Health, Lilongwe, Malawi
6 Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium
7 International Centre for AIDS Care and Treatment Programs, Columbia University, New York, NY, USA

Summary
The debate on the interaction between disease-specific programmes and health system strengthening in the last few years has intensified as experts seek to issue our common ground and find solutions and synergies to bridge the divide. Unfortunately, the debate continues to be largely academic and devoid of specificity, resulting in the issues being irrelevant to health care workers on the ground. Taking the theme 'What would entice HIV- and tuberculosis (TB)-programme managers to sit around the table on a Monday morning with health system experts', this viewpoint focuses on infection control and health facility safety as an important and highly relevant practical topic for both disease-specific programmes and health system strengthening. Our attentions, and the examples and lessons we draw on, are largely aimed at sub-Saharan Africa where the great burden of TB and HIV/AIDS resides, although the principles we outline would apply to other parts of the world as well. Health care infections, caused for example by poor hand hygiene, inadequate testing of donated blood, unsafe disposal of needles and syringes, poorly sterilized medical and surgical equipment and lack of adequate airborne infection control procedures, are responsible for a considerable burden of illness amongst patients and health care personnel, especially in resource-poor countries. Effective infection control in a district hospital requires that all the components of a health system function well: governance and stewardship, financing, infrastructure, procurement and supply chain management, human resources, health information systems, service delivery and finally supervision. We argue in this article that proper attention to infection control and an emphasis on safe health facilities is a concrete first step towards strengthening the interaction between disease-specific programmes and health systems where it really matters – for patients who are sick and for the health care workforce who provide the care and treatment.

keywords health systems, disease-specific programmes, HIV/AIDS, tuberculosis, infection control

Introduction
At the recent XVIII International AIDS Conference in Vienna in July 2010, there was a well-attended 2-day pre-conference symposium entitled 'Bridging the Divide: Inter-disciplinary partnerships for HIV and Health Systems'. There were excellent presentations and much debate on global policy and the importance of strengthening health systems. Amongst some of us, however, there was a growing, unspoken concern regarding the need for concrete action to move this agenda forward, and we began to think about how we might translate the rhetoric into reality in the context of a district hospital or a health centre in a low-income country. Pertinent questions arose from attendees, two of which struck a cord with our concerns: *'Based on all the discussions, what would we do differently tomorrow?'*

Harries et al (2010) Keeping health facilities safe: one way of strengthening the interaction between disease specific programmes and health systems. Tropical Medicine and International Health vol 15(12) 1407-1412

"For health care workers in different disciplines in a busy district hospital or health centre to gather around the table on a Monday morning requires a topic of mutual interest, importance and relevance. Infection control and health facility safety fulfill these criteria, both for the health care worker fraternity and the constituency of patients who utilize the facility.

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2010.02662.x
VOLUME 15 NO 12 PP 1407–1412 DECEMBER 2010

Viewpoint

Keeping health facilities safe: one way of strengthening the interaction between disease-specific programmes and health systems

Anthony D. Harries[1,2], Rony Zachariah[3], Katie Taylor-Smith[3], Erik J. Schouten[4,5], Frank Chimbwandira[6], Wim Van Damme[4] and Wafaa M. El-Sadr[7]

1 *International Union Against Tuberculosis and Lung Disease, Paris, France*
2 *London School of Hygiene and Tropical Medicine, London, UK*
3 *Operational Research Unit, Medecins sans Frontieres, Operational Centre Brussels, MSF-Luxembourg, Luxembourg*
4 *Department of HIV and AIDS, Ministry of Health, Lilongwe, Malawi*
5 *BASICS, Management Sciences for Health, Lilongwe, Malawi*
6 *Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium*
7 *International Centre for AIDS Care and Treatment Programs, Columbia University, New York, NY, USA*

Summary

The debate on the interaction between disease-specific programmes and health system strengthening in the last few years has intensified as experts seek to tease out common ground and find solutions and synergies to bridge the divide. Unfortunately, the debate continues to be largely academic and devoid of specificity, resulting in the issues being irrelevant to health care workers on the ground. Taking the theme 'What would notice HIV- and tuberculosis (TB)-programme managers to sit around the table on a Monday morning with health system experts', this viewpoint focuses on infection control and health facility safety as an important and highly relevant practical topic for both disease-specific programmes and health system strengthening. Our attentions, and the examples and lessons we draw on, are largely aimed at sub-Saharan Africa where the great burden of TB and HIV/AIDS resides, although the principles we outline would apply to other parts of the world as well. Health care infections, caused for example by poor hand hygiene, inadequate testing of donated blood, unsafe disposal of needles and syringes, poorly sterilized medical and surgical equipment and lack of adequate airborne infection control procedures, are responsible for a considerable burden of illness amongst patients and health care personnel, especially in resource-poor countries. Effective infection control in a district hospital requires that all the components of a health system function well: governance and stewardship, financing, infrastructure, procurement and supply chain management, human resources, health information systems, service delivery and finally supervision. We argue in this article that proper attention to infection control and an emphasis on safe health facilities is a concrete first step towards strengthening the interaction between disease-specific programmes and health systems where it really matters – for patients who are sick and for the health care workforce who provide the care and treatment.

keywords health systems, disease-specific programmes, HIV/AIDS, tuberculosis, infection control

Introduction

At the recent XVIII International AIDS Conference in Vienna in July 2010, there was a well-attended 2-day pre-conference symposium entitled 'Bridging the Divide: Inter-disciplinary partnerships for HIV and Health Systems'. There were excellent presentations and much debate on global policy and the importance of strengthening health systems. Amongst some of us, however, there was a growing, unspoken concern regarding the need for concrete action to move this agenda forward, and we began to think about how we might translate the rhetoric into reality in the context of a district hospital or a health centre in a low-income country. Pertinent questions arose from attendees, two of which struck a cord with our concerns: *'Based on all the discussions, what would we do differently tomorrow?'*

Harries et al (2010) Keeping health facilities safe: one way of strengthening the interaction between disease specific programmes and health systems. Tropical Medicine and International Health vol 15(12) 1407-1412

"Infection control fills the void, and provides relevant issues for discussion that require local leadership, a sound understanding of disease epidemiology, clarity of thought, community inputs and a pragmatic approach to finding solutions."

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2010.02662.x
VOLUME 15 NO 12 PP 1407–1412 DECEMBER 2010

Viewpoint

Keeping health facilities safe: one way of strengthening the interaction between disease-specific programmes and health systems

Anthony D. Harries[1,2], Rony Zachariah[3], Katie Taylor-Smith[3], Erik J. Schouten[4,5], Frank Chimbwandira[6], Wim Van Damme[4] and Wafaa M. El-Sadr[7]

1 *International Union Against Tuberculosis and Lung Disease, Paris, France*
2 *London School of Hygiene and Tropical Medicine, London, UK*
3 *Operational Research Unit, Medecins sans Frontieres, Operational Centre Brussels, MSF-Luxembourg, Luxembourg*
4 *Department of HIV and AIDS, Ministry of Health, Lilongwe, Malawi*
5 *BASICS, Management Sciences for Health, Lilongwe, Malawi*
6 *Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium*
7 *International Centre for AIDS Care and Treatment Programs, Columbia University, New York, NY, USA*

Summary

The debate on the interaction between disease-specific programmes and health system strengthening in the last few years has intensified as experts seek to tease out common ground and find solutions and synergies to bridge the divide. Unfortunately, the debate continues to be largely academic and devoid of specificity, resulting in the issues being irrelevant to health care workers on the ground. Taking the theme 'What would notice HIV- and tuberculosis (TB)-programme managers to sit around the table on a Monday morning with health system experts', this viewpoint focuses on infection control and health facility safety as an important and highly relevant practical topic for both disease-specific programmes and health system strengthening. Our attentions, and the examples and lessons we draw on, are largely aimed at sub-Saharan Africa where the great burden of TB and HIV/AIDS resides, although the principles we outline would apply to other parts of the world as well. Health care infections, caused for example by poor hand hygiene, inadequate testing of donated blood, unsafe disposal of needles and syringes, poorly sterilized medical and surgical equipment and lack of adequate airborne infection control procedures, are responsible for a considerable burden of illness amongst patients and health care personnel, especially in resource-poor countries. Effective infection control in a district hospital requires that all the components of a health system function well: governance and stewardship, financing, infrastructure, procurement and supply chain management, human resources, health information systems, service delivery and finally supervision. We argue in this article that proper attention to infection control and an emphasis on safe health facilities is a concrete first step towards strengthening the interaction between disease-specific programmes and health systems where it really matters – for patients who are sick and for the health care workforce who provide the care and treatment.

keywords health systems, disease-specific programmes, HIV/AIDS, tuberculosis, infection control

Introduction

At the recent XVIII International AIDS Conference in Vienna in July 2010, there was a well-attended 2-day pre-conference symposium entitled 'Bridging the Divide: Inter-disciplinary partnerships for HIV and Health Systems'. There were excellent presentations and much debate on global policy and the importance of strengthening health systems. Amongst some of us, however, there was a growing, unspoken concern regarding the need for concrete action to move this agenda forward, and we began to think about how we might translate the rhetoric into reality in the context of a district hospital or a health centre in a low-income country. Pertinent questions arose from attendees, two of which struck a cord with our concerns: *'Based on all the discussions, what would we do differently tomorrow?'*

© 2010 Blackwell Publishing Ltd

1407

Harries et al (2010) Keeping health facilities safe: one way of strengthening the interaction between disease specific programmes and health systems. Tropical Medicine and International Health vol 15(12) 1407-1412

"Health systems cannot and should not be discussed in the abstract. They have to exist to optimally deliver services for real people, and they have to prevent and treat diseases that have names, such as TB and HIV/AIDS. A focus on infection control provides the necessary specificity, the exemplary practice of which requires that all components of the health system function."

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2010.02662.x

VOLUME 15 NO 12 PP 1407–1412 DECEMBER 2010

Viewpoint

Keeping health facilities safe: one way of strengthening the interaction between disease-specific programmes and health systems

Anthony D. Harries[1,2], Rony Zachariah[3], Katie Taylor-Smith[3], Erik J. Schouten[4,5], Frank Chimbwandira[6], Wim Van Damme[7] and Wafaa M. El-Sadr[7]

1 *International Union Against Tuberculosis and Lung Disease, Paris, France*
2 *London School of Hygiene and Tropical Medicine, London, UK*
3 *Operational Research Unit, Medicine sans Frontieres, Operational Centre Brussels, MSF-Luxembourg, Luxembourg*
4 *Department of HIV and AIDS, Ministry of Health, Lilongwe, Malawi*
5 *BASICS, Management Sciences for Health, Lilongwe, Malawi*
6 *Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium*
7 *International Centre for AIDS Care and Treatment Programs, Columbia University, New York, NY, USA*

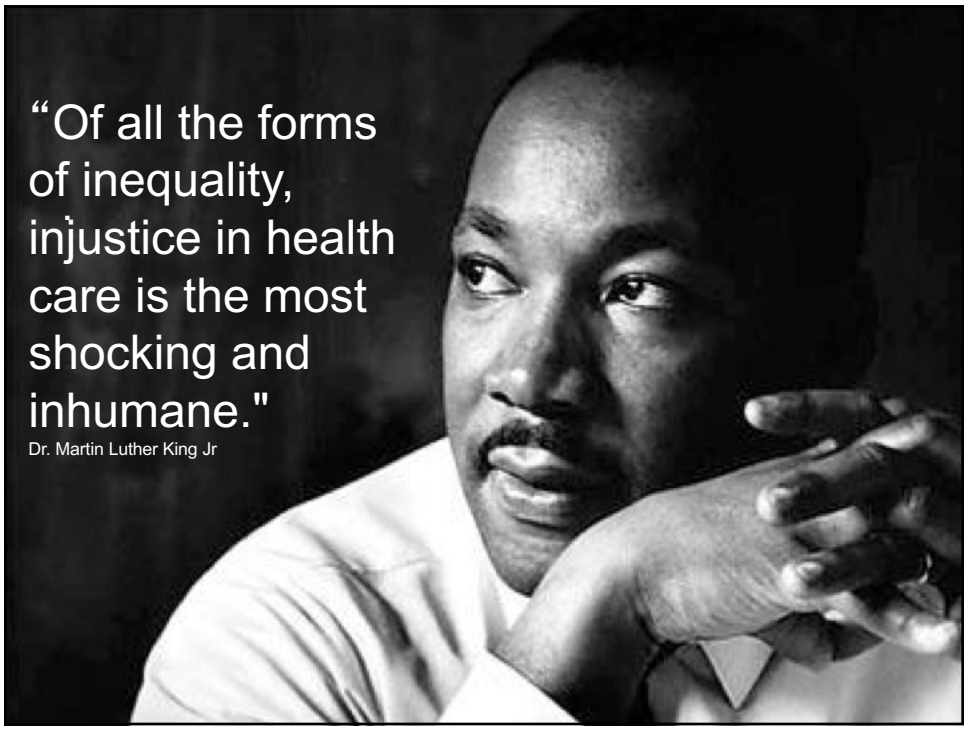
Summary The debate on the interaction between disease-specific programmes and health system strengthening in the last few years has intensified as experts seek to tease out common ground and find solutions and synergies to bridge the divide. Unfortunately, the debate continues to be largely academic and devoid of specificity, resulting in the issues being irrelevant to health care workers on the ground. Taking the theme 'What would entice HIV- and tuberculosis (TB)-programme managers to sit around the table on a Monday morning with health system experts', this viewpoint focuses on infection control and health facility safety as an important and highly relevant practical topic for both disease-specific programmes and health system strengthening. Our attentions, and the examples and lessons we draw on, are largely aimed at sub-Saharan Africa where the great burden of TB and HIV/AIDS resides, although the principles we outline would apply to other parts of the world as well. Health care infections, caused for example by poor hand hygiene, inadequate testing of donated blood, unsafe disposal of needles and syringes, poorly sterilized medical and surgical equipment and lack of adequate airborne infection control procedures, are responsible for a considerable burden of illness amongst patients and health care personnel, especially in resource-poor countries. Effective infection control in a district hospital requires that all the components of a health system function well: governance and stewardship, financing, infrastructure, procurement and supply chain management, human resources, health information systems, service delivery and finally supervision. We argue in this article that proper attention to infection control and an emphasis on safe health facilities is a concrete first step towards strengthening the interaction between disease-specific programmes and health systems where it really matters – for patients who are sick and for the health care workforce who provide the care and treatment.

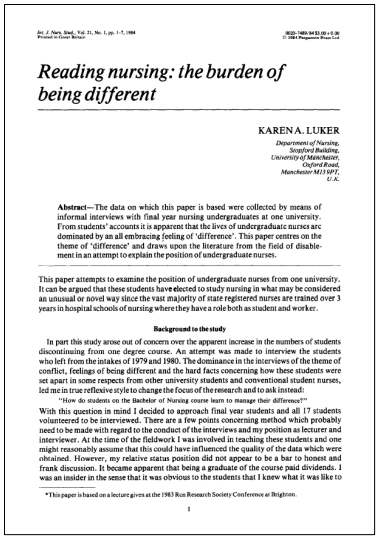
keywords health systems, disease-specific programmes, HIV/AIDS, tuberculosis, infection control

Introduction

At the recent XVIII International AIDS Conference in Vienna in July 2010, there was a well-attended 2-day pre-conference symposium entitled 'Bridging the Divide: Inter-disciplinary partnerships for HIV and Health Systems'. There were excellent presentations and much debate on global policy and the importance of strengthening health systems. Amongst some of us, however, there was a growing, unspoken concern regarding the need for concrete action to move this agenda forward, and we began to think about how we might translate the rhetoric into reality in the context of a district hospital or a health centre in a low-income country. Pertinent questions arose from attendees, two of which struck a cord with our concerns: *'Based on all the discussions, what would we do differently tomorrow?'*

Harries et al (2010) Keeping health facilities safe: one way of strengthening the interaction between disease specific programmes and health systems. Tropical Medicine and International Health vol 15(12) 1407-1412





Reading nursing: the burden of being different

KAREN A. LUKER

Department of Nursing, Stopford Building, University of Manchester, Oxford Road, Manchester M13 9PT, U.K.

Abstract—The data on which this paper is based were collected by means of informal interviews with final year nursing undergraduates at one university. From students' accounts it is apparent that the lives of undergraduate nurses are dominated by an all embracing feeling of 'difference'. This paper centres on the theme of 'difference' and draws upon the literature from the field of disablement in an attempt to explain the position of undergraduate nurses.

This paper attempts to examine the position of undergraduate nurses from one university. It can be argued that these students have elected to study nursing in what may be considered an unusual or novel way since the vast majority of state registered nurses are trained over 3 years in hospital schools of nursing where they have a role both as student and worker.

Background to the study

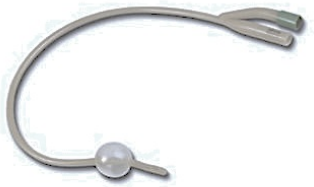
In part this study arose out of concern over the apparent increase in the numbers of students discontinuing from one degree course. An attempt was made to interview the students who left from the intakes of 1979 and 1980. The dominance in the interviews of the theme of conflict, feelings of being different and the hard facts concerning how these students were set apart in some respects from other university students and conventional student nurses, led me in true reflexive style to change the focus of the research and to ask instead:

"How do students on the Bachelor of Nursing course learn to manage their difference?"

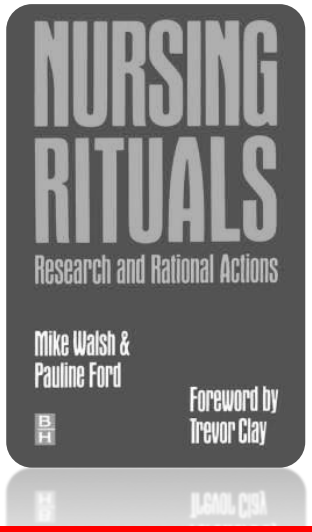
With this question in mind I decided to approach final year students and all 17 students volunteered to be interviewed. There are a few points concerning method which probably need to be made with regard to the conduct of the interviews and my position as lecturer and interviewer. At the time of the fieldwork I was involved in teaching these students and one might reasonably assume that this could have influenced the quality of the data which were obtained. However, my relative status position did not appear to be a bar to honest and frank discussion. It became apparent that being a graduate of the course paid dividends. I was an insider in the sense that it was obvious to the students that I knew what it was like to

*This paper is based on a lecture given at the 1983 Run Research Society Conference at Brighton.

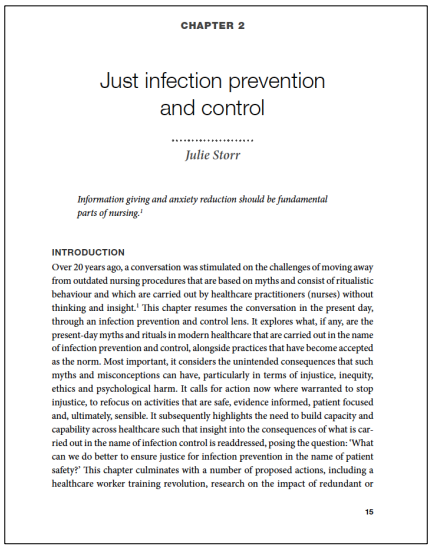
1



Luker KA (1984) Reading nursing: the burden of being different. International Journal of Nursign Studies. Vol 21, no 1. 1-7



Walsh M, Ford P (1989) Nursing Rituals: research and rational actions. Butterworth-Heinemann



CHAPTER 2

Just infection prevention and control

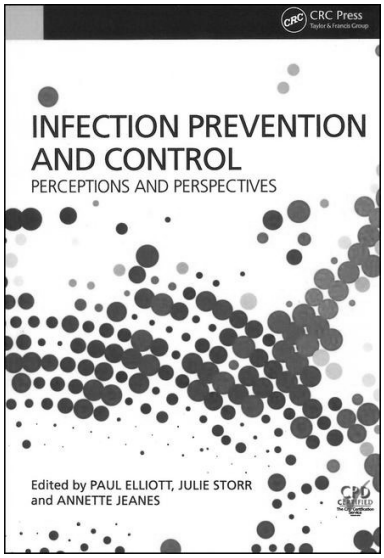
Julie Storr

Information giving and anxiety reduction should be fundamental parts of nursing.[1]

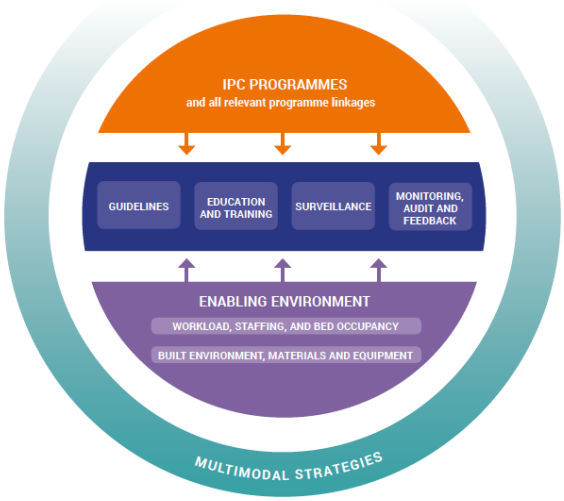
INTRODUCTION

Over 20 years ago, a conversation was stimulated on the challenges of moving away from outdated nursing procedures that are based on myths and consist of ritualistic behaviour and which are carried out by healthcare practitioners (nurses) without thinking and insight.[1] This chapter resumes the conversation in the present day, through an infection prevention and control lens. It explores what, if any, are the present-day myths and rituals in modern healthcare that are carried out in the name of infection prevention and control, alongside practices that have become accepted as the norm. Most important, it considers the unintended consequences that such myths and misconceptions can have, particularly in terms of injustice, inequity, ethics and psychological harm. It calls for action now where warranted to stop injustice, to refocus on activities that are safe, evidence informed, patient focused and, ultimately, sensible. It subsequently highlights the need to build capacity and capability across healthcare such that insight into the consequences of what is carried out in the name of infection control is readdressed, posing the question: 'What can we do better to ensure justice for infection prevention in the name of patient safety?' This chapter culminates with a number of proposed actions, including a healthcare worker training revolution, research on the impact of redundant or

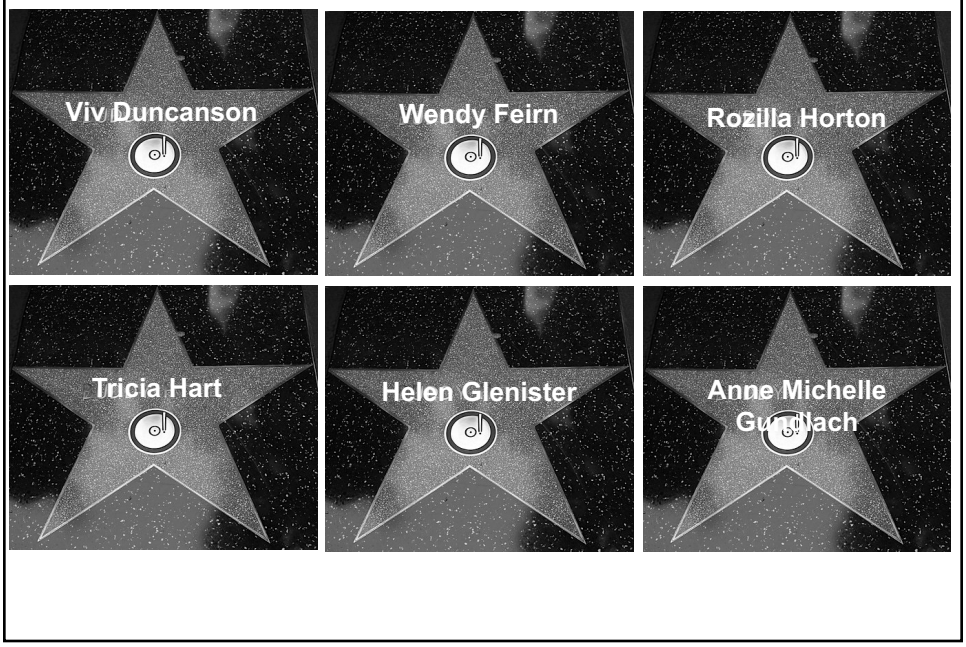
15



Elliott P, Storr J, Jeanes A (2015) Infection prevention and control: perceptions and perspectives. CRC Press



WHO (2016) Core components of IPC programmes at the national and acute health care facility level


Viv Duncanson
Wendy Feirn
Rozilla Horton
Tricia Hart
Helen Glenister
Anne Michelle

What Makes Infection Prevention and Control Work?
Julie Storr, S3 Global
Broadcast live from the 2017 Infection Prevention Society conference

"As we must recognize. Good ideas with impact - of course - emerge everywhere."

Basu et al. Globalization and Health (2017) 13:64
DOI 10.1186/s12992-017-0288-6

Globalization and Health

COMMENTARY Open Access

The role of South-North partnerships in promoting shared learning and knowledge transfer

Lopa Basu[1,2*], Peter Pronovost[3], Nancy Edwards Molello[2], Shamsuzzoha B. Syed[4] and Albert W. Wu[3]

Abstract

While it is clear that hospitals in developing countries need to improve quality of health services and improve patient safety, hospitals in high resource countries need to do the same. Most often the focus on improvement through institutional health partnerships involves hospital teams from high resource settings attempting to aid and teach hospital staff in low resource settings, particularly in Africa. However these efforts to provide assistance may be more satisfying and sustainable if we understand that partnership learning is bi-directional whereby hospital teams from high resource settings also benefit. One particular partnership-based model that demonstrates this benefit to high resource partners is the World Health Organization African Partnerships for Patient Safety (APPS). Johns Hopkins Medicine Armstrong Institute for Patient Safety & Quality (AI) through the APPS model has co-created twinning partnerships with hospitals in Uganda, South Sudan & Liberia. This commentary aims to deconstruct specific learnings that have benefited the Johns Hopkins AI community through the APPS partnership.

Keywords: Reverse innovation, Partnerships, Patient safety, Learning

Background

Patient safety lessons too often focus on what high-income health systems have often done to inform and guide low-income health systems. However, there is growing evidence that practical and simple approaches to deliver people-centered care to improve the quality of healthcare elicited from low-income countries which have not been fully explored by high-income countries, a process called 'reverse innovation' [1, 2] needs further examination. Interest in this field is increasing in global health dialogues and building a growing global pool of knowledge [3] is a critical next step towards unpacking the specific opportunities for South-North learning.

Global innovation flow

To fully realize the potential for effective flow of innovations, healthcare providers from low and high-income countries need to create trusting, mutually respectful relationships and develop structures and processes to support peer learning. The World Health Organization (WHO) is doing this through its African Partnerships for Patient Safety (APPS) (http://www.who.int/patient-safety/implementation/apps/en/), a program that highlights the importance of human interaction through site visits, joint trainings, bi-directional learning and co-development of new innovations.

One example of an APPS partnership is between the Johns Hopkins Medicine/Armstrong Institute for Patient Safety (AI) and partnering hospitals in Liberia, Uganda & South Sudan. As part of the APPS program, teams have interacted in-person and virtually. During these exchanges, the teams co-created their purpose, core values and selected topics for shared learning.

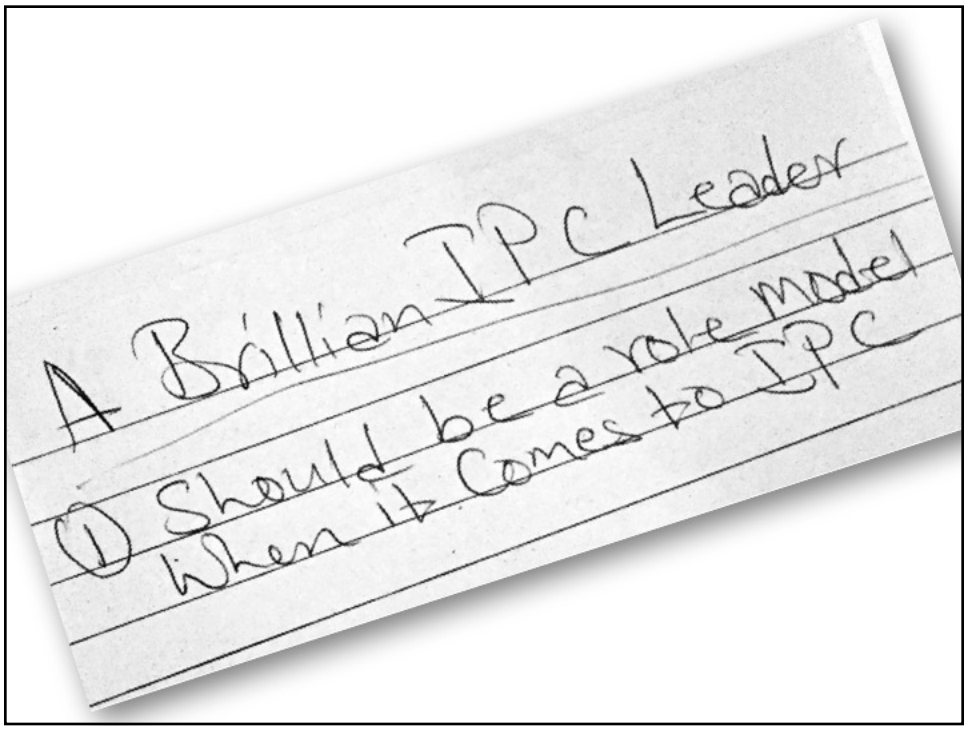
People-centered practices in Africa have provided clear opportunities for learning even in renowned institutions of the globe. South-to-north lessons have also emerged on minimizing waste in healthcare and on building sustainable, environmentally conscious hospitals (Green Living). Below we summarize some of the key lessons we have learned.

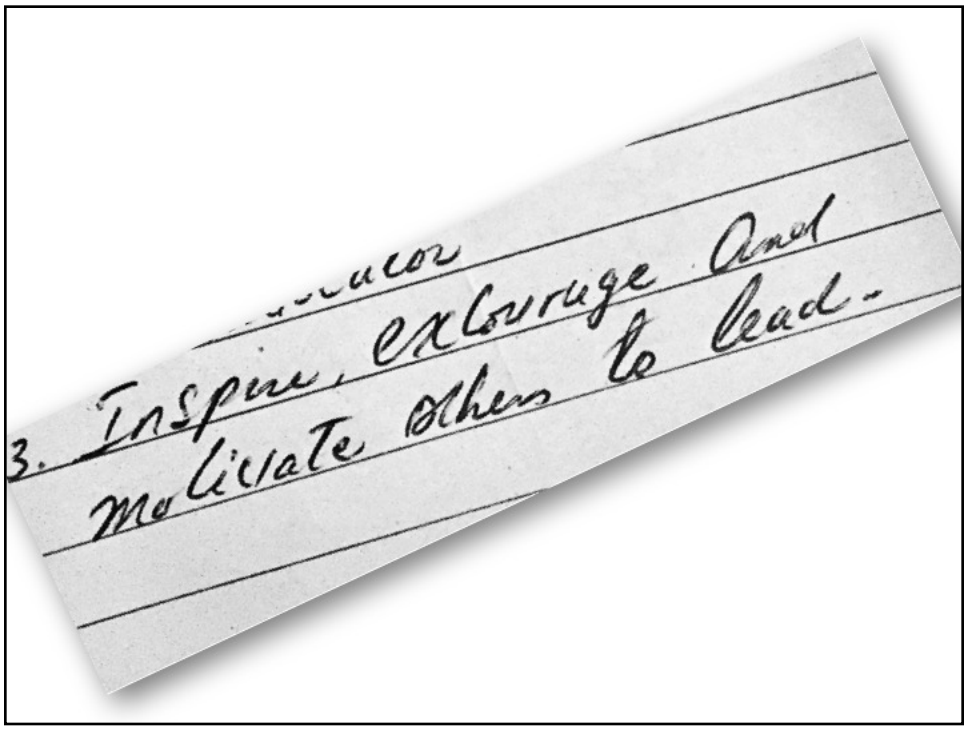
* Correspondence: basul@who.int
[1]World Health Organization Service Delivery & Safety Department, 750 East Pratt Street, 15th floor, Baltimore, MD 21202, USA
[2]Armstrong Institute for Patient Safety & Quality, 750 East Pratt Street, 15th floor, Baltimore, MD 21202, USA
Full list of author information is available at the end of the article

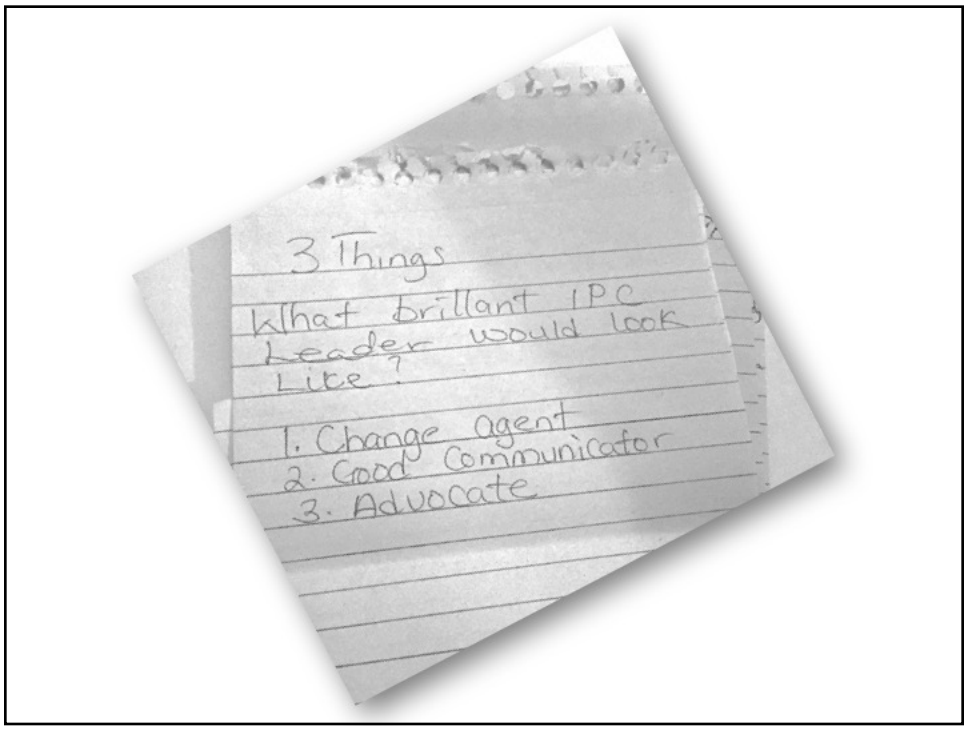
Basu L et al (2017) The role of South-north partnerships in promoting shared learning and knowledge transfer. Globalization and Health 13: 64

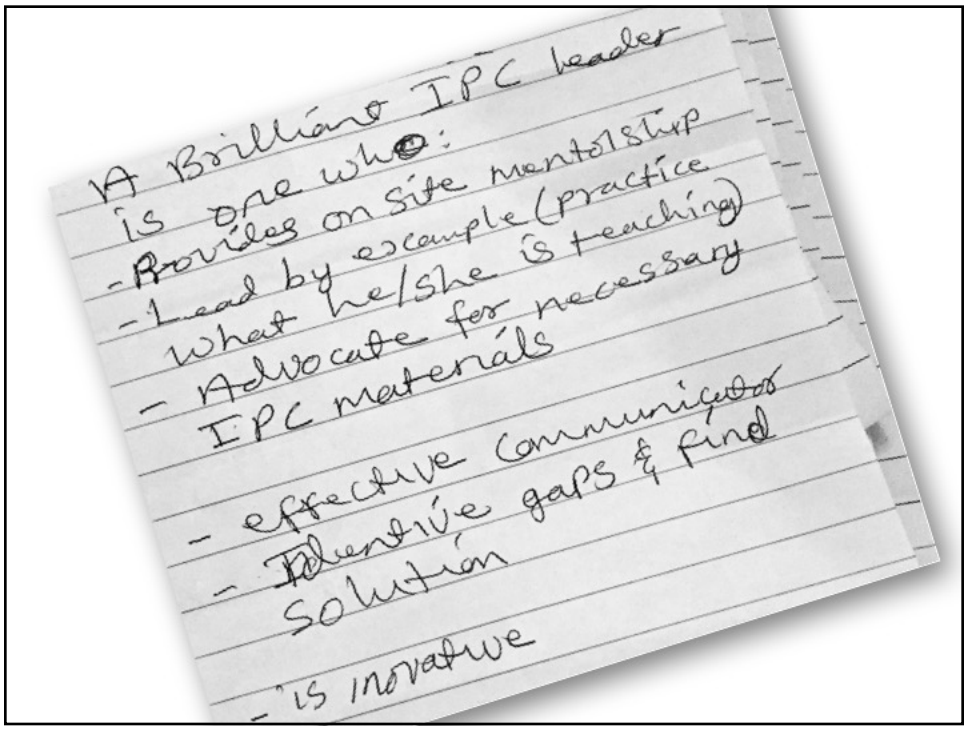
A Webber Training Teleclass
www.webbertraining.com

Helen Bevan (2017) New and revised: 10 things fab leaders do
https://twitter.com/helenbevan/status/850038936361738244?lang=en


A Brilliant IPC Leader
① Should be a role model
When it Comes to IPC


3. Inspire, Encourage And
Motivate Others to Lead.


3 Things
What brillant IPC Leader would look Like?
1. Change Agent
2. Good Communicator
3. Advocate


A Brilliant IPC leader is one who:
- Provides on site mentorship
- Lead by example (practice what he/she is teaching)
- Advocate for necessary IPC materials
- effective Communicator
- Identifies gaps & find Solution
- is innovative

THANK YOU

What Makes Infection Prevention and Control Work?
Julie Storr, S3 Global
Broadcast live from the 2017 Infection Prevention Society conference

A Webber Training Teleclass
www.webbertraining.com


Thanks to Teleclass Education
PATRON SPONSORS
Sealed Air
Diversey Care
www.sealedair.com
VIROX
TECHNOLOGIES INC.
www.virox.com
World Health Organization
Infection Prevention and Control Global Unit
www.who.int/gpsc/en