

Analysis of public policy on healthcare-associated infections: A Kazakhstan and United Kingdom

[Akerke Chayakova](#)¹, [Kenesh Dzhusupov](#)², [Aiman Mussina](#)³

¹ Researcher- lecturer of the Department of Public Health and Epidemiology, Astana Medical University, Astana, Kazakhstan.

E-mail: chayakova19@gmail.com

² Head of the Department of Public Health, International Higher School of Medicine, Kyrgyzstan.

E-mail: d.kenesh@gmail.com

³ Head of the Department of Public Health and Epidemiology, Astana Medical University, Kazakhstan.

E-mail: aiman_m-a@mail.ru

Abstract

The problem of healthcare-associated infections (HAIs) prevention in Kazakhstan is still not sufficiently understood. There are no opportunities for documenting, analyzing and drawing lessons from the accumulated negative and positive experience, there is no methodology for identifying HAIs and evaluating the effectiveness of infection control measures, there are no unified schemes for collecting reliable information about the real scale of HAIs, lack of a unified national comprehensive strategy or program for the prevention and control of HAIs.

The aim of this study was to analyze the main documents underlying the development of public policy in the field of prevention and control of HAIs in two countries. Kazakhstan and the United Kingdom (UK) were selected as both have healthcare systems informed by the social insurance model, involving government funding of healthcare services, financed by general taxation.

The UK experience analysis highlights several potentially useful lessons for health systems that have not yet reached the Monitoring and Evaluation phase. Among them are the need to treat HAIs as a public health issue, the consistent dissemination of evidence-based guidelines, the incorporation of scientific updates into clinical practice, the development of guidance for various types of healthcare settings, and the monitoring of epidemiologically relevant pathogens. Finally, citizen participation in HAIs policy development is highly desirable.

Key words: public policy, healthcare-associated infections, HAIs, infection control.

Corresponding author: Akerke Chayakova, Researcher- lecturer of the Department of Public Health and Epidemiology, Astana Medical University, Astana, Kazakhstan
Postal code: Z01C1E7
Address: Kazakhstan, Astana, Beybitshilik str, 49/A
Phone: +7 777 577 44 66
E-mail: chayakova19@gmail.com

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Introduction

Health care-associated infections (HAIs) are widespread worldwide. So according to World Health Organizations (WHO) 8.9 million HAIs occur every year in acute and long-term care facilities, 6 most common HAI = 2X the total burden of disability-adjusted life years of all other 32 communicable diseases combined. Health care-associated infections and antimicrobial resistance - 75% of HAIs [1-2]. HAIs are contaminations individuals get while they are getting medical services for another condition. HAIs can occur in any medical services office, including emergency clinics, mobile careful focuses, end-stage renal sickness offices, and long haul care offices. HAIs are infections that first appear 48 hours or more after hospitalization or within 30 days after having received health care [3-5]. These HAIs incorporate focal line-related circulation system contaminations, catheter-related urinary parcel diseases, and ventilator-related pneumonia. Diseases may likewise happen at medical procedure destinations, known as careful site contaminations. Centers for Disease Control and Prevention (CDC) attempts to screen and forestall these diseases since they are a significant danger to patient wellbeing [6-7].

Unfortunately, the problem of HAIs prevention in Kazakhstan is still not sufficiently understood. There are no opportunities for documenting, analyzing and drawing

lessons from the accumulated negative and positive experience, there is no methodology for identifying HAIs and evaluating the effectiveness of infection control measures, there are no unified schemes for collecting reliable information about the real scale of HAIs, lack of a unified national comprehensive strategy or program for the prevention and control of HAIs.

According to the WHO, nations should have HAIs Programs (HAIP) at national and local (healthcare settings) levels [8-9]. A national program is intended to regulate, provide guidance, promote, and supervise compliance with regulations.

Studying the processes by which HAIP have been developed in different countries over time will help us to understand the trajectory of change and to identify areas for improvement.

The aim of this study was to analyze the main documents underlying the development of public policy in the field of prevention and control of HAIs in two countries. Kazakhstan and the United Kingdom (UK) were selected as both have healthcare systems informed by the social insurance model, involving government funding of healthcare services, financed by general taxation.

Material and methods of research

Research Design

The study utilizes a systematic review approach to analyze the development and implementation of Healthcare-Associated Infection Programs (HAIPs) in Kazakhstan and the United Kingdom (UK). Systematic reviews are a rigorous method used to synthesize and analyze available literature, ensuring comprehensive coverage of existing knowledge while minimizing bias. The review aimed to identify the key phases of HAIP development in both countries, including a historical overview of public policy and regulatory frameworks.

Data Sources

A broad search was conducted across several academic databases, government health portals, and public health organizations' websites to ensure the capture of relevant literature. The databases and sources reviewed included: PubMed, Medline, Cochrane Library, Google Scholar, WHO Publications and Reports, Centers for Disease Control and Prevention (CDC) Archives, Kazakh National Health Databases, UK Government Health Services (NHS) Documentation.

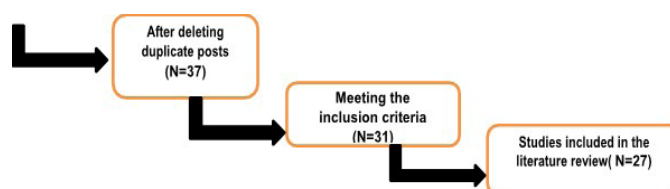


Figure 1 - Strategy search literature

Search Strategy

The search included articles and documents published between 1990 and 2023, in English, Russian, and Kazakh languages. The following key terms were used for the search: "Healthcare-associated infections", "HAI prevention programs", "Infection control policy", "Kazakhstan health system", "UK infection control measures", "Antimicrobial resistance", "HAIP implementation strategies", "National healthcare safety guidelines".

Inclusion Criteria

Articles and reports specifically addressing the development and implementation of HAIP in Kazakhstan and the UK. Documents detailing national policies, infection prevention techniques, and standardization of procedures at healthcare facilities. Studies that describe the effectiveness of HAIP strategies, including monitoring, evaluation, and patient safety outcomes. Historical policy documents that

outline the formation and regulatory evolution of HAIP in both countries.

Exclusion Criteria

Articles focused solely on HAIs in other countries without reference to Kazakhstan or the UK. Studies not addressing national-level HAIP policies or their practical implementation in healthcare systems. Duplicate studies or reports that did not provide original findings or insights.

Data Extraction

Once the literature was reviewed and identified, key data points were extracted, including: The timeline of policy development in Kazakhstan and the UK. The nature of national and local HAIP initiatives, including governmental or regulatory bodies involved. The main infection prevention and control measures adopted at different phases. Evaluation metrics used to measure the success of HAIP strategies (e.g., reduction of HAI incidence, antimicrobial

resistance). Challenges in the adoption and standardization of HAIP in healthcare settings.

Data Analysis

The extracted data was then organized according to four key phases of HAIP development identified through the literature:

Formation: Initial development of infection prevention techniques and practices in healthcare settings.

Standardization: Consolidation of HAIP strategies and establishment of national regulations and guidelines.

Results

United Kingdom

The primary distinction between infection control measures in the UK and those in other countries is that infection control in the United Kingdom is based on the discipline of medical microbiology. Medical microbiologists who have received training in the laboratory identification of infectious agents as well as the diagnosis and treatment of infectious diseases [10-11] primarily pioneer it.

Formation. By the end of WWII, the National Health Service had been established as an integrated, state-funded healthcare service. The establishment of the NHS marked the beginning of the UK government taking responsibility for HAI prevention and control.

Consolidation. The spread of Staphylococcal infections across the UK prompted organizations to take preventative measures. One such measure was the appointment of an Infection Control Nurse as a full-time position to control patient cross infections. It went into effect in April 1959, with the appointment of the first ICN. This indicates that Britain was at the forefront of infection control development. In 1970, the Infection Control Association was founded.

Standardization. The formation of the Infection Prevention Society was the first step toward a more holistic approach to HAI prevention. By including any healthcare professionals involved in infection control and prevention, the society aimed to target infection control at all levels of healthcare.

Monitoring and Evaluation. After the 1970s, the formation of organizations such as the Infection Prevention Society, the Hospital Infection Society, and the Central Sterilizing Club became common. Together with the interested governmental agencies, they contributed to the introduction of recommendations for screening and isolation programs. From then on, much of the emphasis was on identifying and containing an increasing number of antibiotic-resistant bacteria.

Because multiple-resistant gram-negative bacteria only caused local outbreaks, they were not prioritized as much as bacteria such as *S. aureus* and *Clostridium difficile* when developing specific control policies. Currently, the national HAI surveillance program includes *Escherichia coli*, *Staphylococcus aureus*, *Clostridium difficile*, patients with urinary catheters, and surgical site infections, with annual reports generated. Healthcare professionals in all healthcare settings are given operational guidance for HAI prevention and management. According to surveys, all HAI control measures have resulted in a decrease in the number of nosocomial infections reported [10-19].

Kazakhstan

Formation. Stages of the infection control system implementation in the Republic of Kazakhstan includes

Monitoring and Evaluation: The implementation of national-level HAIP measures with a focus on quality improvement, patient safety, and cost savings.

Sustainability and Improvement: Continuous adaptation and scaling of HAIP, with an emphasis on addressing emerging issues like antimicrobial resistance.

The two countries' trajectories in developing HAIP were then compared based on these phases, and similarities and differences were identified.

Implementation of the Infection Control System in pilot projects in a number of healthcare organizations with AIHA support (1995). Creation of the regulatory and methodological framework (1998-1999). Implementation of the Infection Control System in healthcare organizations nationwide (since 2000) [20].

Standardization. Regulatory documents: On approval of the Rules of Infection Control in Medical organizations, On approval of Sanitary Rules "Sanitary and epidemiological requirements for the implementation of production control" On approval of the Sanitary Rules "Sanitary and epidemiological requirements for the organization and conduct of disinfection, disinfection and deratization" On approval of Sanitary Rules "Sanitary and epidemiological requirements for health facilities" On approval of the Sanitary Rules "Sanitary and epidemiological requirements for the organization and conduct of sanitary and anti-epidemic, sanitary and preventive measures for acute respiratory viral infections, influenza and their complications (pneumonia), meningococcal infection, COVID-19 coronavirus infection, chickenpox and scarlet fever".

Monitoring and Evaluation. Organization of infection prevention and control system in the Republic of Kazakhstan. Kazakhstan has an effective system of HAI surveillance, which at the same time requires at the national level and at the level of healthcare organizations. On 2018, an IPC coordinator has been appointed with WHO support self-assessment of implementation of the main IPC components in 6 emergency medical care facilities were conducted in 2019.

This year the research determination of one stage prevalence of healthcare associated infections and use of antimicrobials in four healthcare organizations providing 24-hour inpatient care in the republic of Kazakhstan for 2021-2022 was conducted in pilot mode jointly with the WHO.

The IPC methodological guidelines were developed taking into account the WHO's and CDC's. Infection Prevention and Control System Improvement Plan for 2022-2027 was developed.

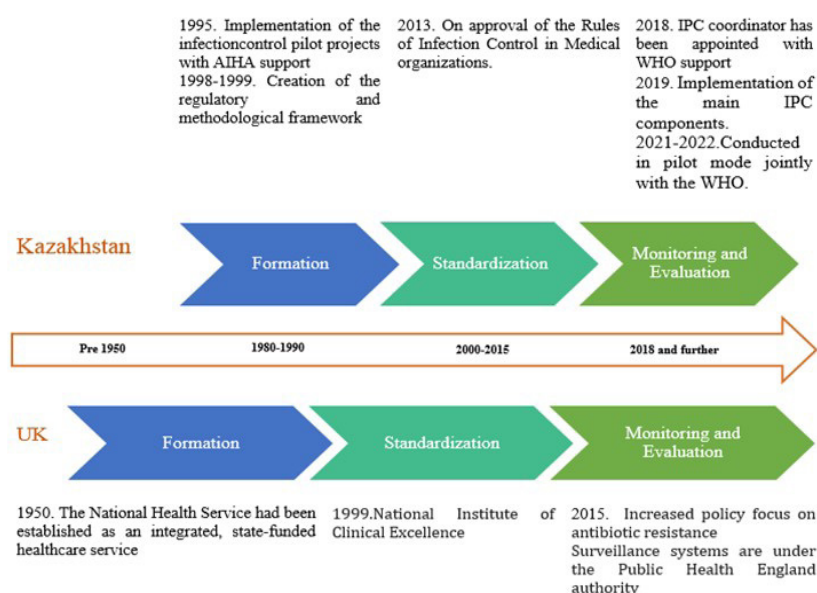


Figure 2 - Evolution of HAIs prevention and control in the United Kingdom and Kazakhstan

Discussion

The main difference between the two countries is that in Kazakhstan, along with the guaranteed volume of free medical care at the expense of budgetary funds, compulsory social health insurance is practiced. Whereas, the United Kingdom has a free, publicly funded healthcare system known as the National Health Service (NHS). Apart from the fact that it is funded through taxation rather than health insurance, the NHS is unique among healthcare systems [21]. When comparing the policies of the two countries in the development of HAI public policy, the baseline of each phase in Kazakhstan occurred much later than in the UK. Other factors, however, may have influenced the focus on HAI. Since the beginning, there have been significant differences in the two countries' profitable, undefined, and political geography. Other multinational trends may have influenced HAI public policy developments, according to the findings. In both countries, there has been an increase in public and political awareness of the issue [22].

We discovered similarities in the phases of HAI public policy in both countries; however, when compared to the UK, Kazakhstan began each phase around 40 years later. Notable, our analysis covered the data on HAIs control in sovereign Kazakhstan.

The NHS began in the UK in 1948, while in Kazakhstan; the MH was not fully developed until the 1990s. The influence of international organizations such as the WHO may have aided in the advancement of the HAI topic, particularly in developing countries. Patient safety has been

recognized as a global issue that must be addressed, and HAI rates are recognized as a key indicator of care quality [23-24].

Retrospective analysis of the literature data showed that in Kazakhstan the most critical gaps and problems for the prevention of healthcare associated infections (PHAIs) system at the national level are: the absence of a single national comprehensive strategy or program for the prevention and control of HAIs; lack of an effective epidemiological surveillance system based on effective tools for collecting and analyzing data on cases of HAIs and risk factors; lack of practical guidelines and algorithms for PHAIs activities for most stakeholders; lack of opportunity to gain in-depth knowledge, corresponding to modern ideas and evidence-based workshops on the problems of HAIs and PHAIs, as well as related branches of knowledge, for almost all interested parties; the absence of a monitoring system for activities implemented within the framework of the PHAIs.

Safer care can be viewed as a shared goal in high and middle-income countries, and our research identifies areas of common development in HAIP in the United Kingdom and Kazakhstan [25-27]. Nonetheless, significant differences exist between the two countries. In comparison, Kazakhstan must overcome numerous political and economic obstacles in order to advance universal healthcare provision [25]. The challenge for healthcare systems around the world is to strike a good balance between healthcare access, economic sustainability, and patient safety.

Conclusion

The UK experience analysis highlights several potentially useful lessons for health systems that have not yet reached the Monitoring and Evaluation phase. Among them are the need to treat HAIs as a public health issue, the consistent dissemination of evidence-based guidelines, the incorporation of scientific updates into clinical practice, the development of guidance for various types of healthcare settings, and the monitoring of epidemiologically relevant

pathogens. Finally, citizen participation in HAIs policy development is highly desirable.

Conflict of Interest Statement. The authors declare no conflict of interest.

Author Contributions. A.C. contributed to conceptualizing and editing of the manuscript, writing the original draft. K.D. and A.M. contributed to the methodology. A.C., K.D. and A.M. contributed to data collection.

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Медициналық көмекті көрсетумен байланысты инфекциялар бойынша мемлекеттік саясатты саралау: Қазақстан мен Ұлыбритания

Чаякова А.М.¹, Джусупов К.Е.², Мусина А.А.³

¹ Қоғамдық денсаулық және эпидемиология кафедрасының оқытушы-зерттеушісі, Астана медицина университеті, Қазақстан. E-mail: chayakova19@gmail.com

² Қоғамдық денсаулық сақтау кафедрасының меңгерушісі, Халықаралық жоғары медицина мектебі, Қырғызстан. E-mail: d.kenesh@gmail.com

³ Қоғамдық денсаулық және эпидемиология кафедрасының меңгерушісі, Астана медицина университеті, Қазақстан. Email: aiman_m-a@mail.ru

Түйіндеме

Қазақстанда Медициналық көмекті көрсетумен байланысты инфекциялардың (МКБИ) алдын алу және бақылау мәселелері әлі де өзекті болып отыр. Жинақталған теріс және оң тәжірибеден құжаттау, талдау және сабақ алу үшін мүмкіндіктер жоқ, инфекциялық бақылау шараларының тиімділігін бағалау әдістемесі жоқ, МКБИ нақты ауқымы туралы дәйекті ақпарат жинаудың бірыңғай схемалары жоқ, МКБИ алдын алу және бақылау жөніндегі бірыңғай ұлттық кешенді стратегия немесе бағдарламалар жоқ.

Бұл зерттеудің мақсаты екі елде МКБИ алдын алу және оған қарсы күрес саласындағы мемлекеттік саясатты әзірлеу негізінде жатқан негізгі құжаттарды талдау болды. Қазақстан мен Ұлыбритания таңдалды. Себебі екі елде де денсаулық сақтау жүйелері жалпы салық салу есебінен қаржыландырылатын медициналық қызметтерді мемлекеттік қаржыландыруды көздейтін әлеуметтік сақтандыру моделіне негізделген.

Ұлыбритания тәжірибесін талдау, бақылау және бағалау кезеңіне әлі де болса жетпеген денсаулық сақтау жүйелері үшін пайдалы бірнеше тұстарды көрсетеді. Оларға МКБИ-ны қоғамдық денсаулық мәселесі ретінде қарастыру қажеттілігі, дәлелді нұсқауларды дәйекті түрде тарату, клиникалық тәжірибеге ғылыми жаңартуларды енгізу, денсаулық сақтау мекемелерінің әртүрлі түрлеріне арналған нұсқаулықтарды әзірлеу және эпидемиологиялық маңызды патогендердің мониторингі кіреді. Сонымен қатар, МКБИ басқару саясатын әзірлеуге тұрғындардың қатысуы өте қажет.

Түйін сөздер: мемлекеттік саясат, медициналық көмек көрсетуге байланысты инфекциялар, МКБИ, инфекциялық бақылау.

Анализ государственной политики в отношении инфекций, связанных с оказанием медицинской помощи: Казахстан и Великобритания

Чаякова А.М.¹, Джусупов К.Е.², Мусина А.А.³

¹ Преподаватель-исследователь кафедры общественного здоровья и эпидемиологии,
Медицинский университет Астана, Казахстан. E-mail: chayakova19@gmail.com

² Заведующий кафедрой общественного здравоохранения, Международной высшей школы медицины,
Кыргызстан. E-mail: d.kenesh@gmail.com

³ Заведующая кафедрой общественного здоровья и эпидемиологии, Медицинский университет Астана,
Казахстан. E-mail: aiman_m-a@mail.ru

Резюме

Проблемы профилактики и контроля за инфекциями, связанными с оказанием медицинской помощи (ИСМП) в Казахстане все еще остаются актуальной. Отсутствуют возможности для документирования, анализа и извлечения уроков из накопленного негативного и положительного опыта, отсутствует методология оценки эффективности мер инфекционного контроля, отсутствуют унифицированные схемы сбора достоверной информации о реальных масштабах ИСМП, отсутствует единая национальная комплексная стратегия или программы по профилактике и контролю ИСМП.

Целью данного исследования был анализ основных документов, лежащих в основе разработки государственной политики в области профилактики и борьбы с ИСМП в двух странах. Казахстан и Соединенное Королевство (Великобритания) были выбраны, поскольку в обеих странах системы здравоохранения основаны на модели социального страхования, предполагающей государственное финансирование медицинских услуг, финансируемых за счет общего налогообложения.

Анализ опыта Великобритании выделяет несколько потенциально полезных уроков для систем здравоохранения, которые еще не достигли фазы мониторинга и оценки. Среди них — необходимость рассматривать ИСМП как проблему общественного здравоохранения, последовательное распространение руководств, основанных на фактических данных, включение результатов научных исследований в клиническую практику, разработка руководств для различных типов медицинских учреждений и мониторинг эпидемиологически значимых патогенов. Наконец, участие граждан в разработке политики ИСМП крайне желательно.

Ключевые слова: государственная политика; инфекции, связанные с оказанием медицинской помощи, ИСМП, инфекционный контроль.