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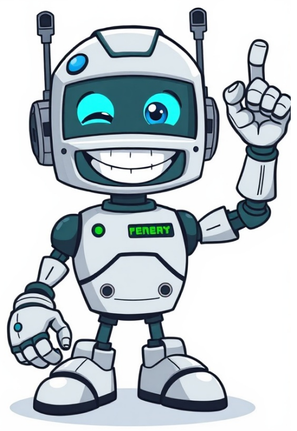

Skip to main content Worldwide, the number of additional people expected to be enjoying better health and wellbeing is projected to be 1.5bn (1.2bn – 1.8bn) by 2025 compared to 2018. Universal health coverage Worldwide, the number of additional people expected to be covered by essential services and not experiencing financial hardship is projected to be 585m (526.1m – 639.5m) by 2025 compared to 2018. Health emergencies protection Worldwide, the number of additional people expected to be protected from health emergencies is projected to be 776.9m (647.4m – 912.5m) by 2025 compared to 2018. The development of global guidelines ensuring the appropriate use of evidence represents one of the core functions of WHO. A WHO guideline is defined broadly as any information product developed by WHO that contains recommendations for clinical practice or public health policy. Recommendations are statements designed to help end-users make informed decisions on whether, when and how to undertake specific actions such as clinical interventions, diagnostic tests or public health measures, with the aim of achieving the best possible individual or collective health outcomes.The Guidelines Review Committee ensures that WHO guidelines are of a high methodological quality and are developed through a transparent, evidence-based decision-making process. Guidelines are subject to a rigorous quality assurance process that helps to ensure that each and every published guideline is trustworthy, impactful and meets the highest international standards. The objective of this guideline is to provide evidence-based recommendations to prevent, diagnose and treat infertility. It provides a source for countries... This document is part of the process for improving the quality of care in family planning. Selected practice recommendations for contraceptive use (SPR)... This document is part of the process for improving the quality of care in family planning. Medical eligibility criteria for contraceptive use (MEC) presents... This WHO guideline recommends integrating services for hypertension, diabetes, and mental health (including depression, anxiety, and substance use) into... The objective of this guideline is to present the complete set of all WHO recommendations and best practice statements relating to abortion. While legal,... The WHO guidelines for malaria bring together the Organization's most up-to-date recommendations for malaria in one user-friendly and easy-to-navigate... The Digital adaptation kit (DAK) for self-monitoring blood pressure during pregnancy enables countries to better help pregnant women manage hypertensive... WHO's global health sector strategies for HIV, viral hepatitis, and sexually transmitted infections (STIs) aim to reduce gonorrhoea and syphilis ... Skip to main content For future leaders in public health A competent and dynamic health workforce at the heart of each health system is essential to advance global health goals. Countries need a pool of health professionals trained and exposed to the systems and processes in the health sector and who understand how stakeholders interact within the international health arena.WHO, as the leader in global public health issues, is committed to building a diverse pool of future leaders in public health. WHO's Internship Programme offers a wide range of opportunities for students and recent graduates to gain insight into the technical and administrative programmes of WHO and enrich their knowledge and experience in various areas, thereby contributing to the advancement of public health. Provide a framework for assigning eligible students from diverse academic backgrounds to WHO programmes where their educational experience can be enhanced through capacity building opportunities.Provide an opportunity for WHO programmes to benefit from engagement from students specializing in various fields related to technical and administrative programmes of WHO.WHO offers internships in technical areas and administrative programmes such as communication, external relations or human resources. Age: You are at least twenty years of age on the date of application.Education: You are enrolled in a course of study at a university or equivalent institution leading to a formal qualification (undergraduate, graduate, or postgraduate), in a public health, medical or social field related to the technical work of WHO, or in a management, administrative, communications, or external relations-related field. Applicants who have already completed a qualification may also qualify for consideration, if they apply to the internship within six months following the completion of the formal qualification. You have completed three years of full-time studies at a university or equivalent institution prior to starting (bachelor's level or equivalent) the internship.Languages: You are fluent at least in one of the working languages of the office of assignment.Family relation: You are not related to a WHO staff member (e.g., son/daughter, brother/sister, or mother/father).Nationality: You hold a valid passport of a WHO Member State.Other: You have not previously participated in WHO's Internship Programme. We invite candidates from across the world to apply to the WHO Global Internship Programme. All applications must be made through the internship position vacancy notices posted on the WHO Careers site using the WHO online recruitment system (Stellis). There is no possibility to apply for an internship at WHO outside Stellis. More information on the recruitment process can be found in the FAQs section. Internship positions are available in various areas of work and in different organizational locations (regional offices, country offices or headquarters). As internship opportunities are posted on a continuous basis, with each containing different requirements and application deadlines, we encourage you to check the internship page regularly for new opportunities. Until further notice, the WHO Internship Programme is on hold across all WHO offices. WHO provides all interns with medical and accident insurance coverage during the duration of the internship period. Insurance coverage before the start date of the internship and after the end date of the internship, including travel to and from the duty station location, is the sole personal and financial responsibility of the individual intern. As of January 2020, WHO provides living allowance to eligible selected interns who need financial support. All interns must complete a legal Declaration of Interests form. This form requires intern candidates to declare any relevant financial disclosures, including any financial support in the form of grants bursaries, scholarships, etc. Based on the information provided in this form, the intern candidates' eligibility to receive financial support from WHO will be assessed. Lunch vouchers may be provided at some duty stations. Watch this video to learn more about being an intern at WHO headquarters in Geneva. Interns must be available to work full-time for a minimum of six (6) weeks up to a maximum of 24 weeks duration, depending on the needs of the WHO technical unit.Interns must provide proof of enrolment in a course of studies or proof of completion of their last qualification.Interns must disclose any circumstances that could give rise to a potential conflict of interest related to the subject of the activity in which they will be involved during their assignment (Declaration of Interest) including financial support for the internship. Interns must provide the completed WHO medical certificate of fitness for work form prior to the start of their internship.Interns are requested not to send any documents until specifically asked to do so. Interns do not have the status of WHO staff members and shall not represent the Organization in any official capacity.WHO interns are not eligible for appointment to any non-staff position within WHO for a period of three months following the end of their internship. However, no such restriction will apply to temporary or longer-term staff positions if the vacancy has been advertised and a competitive process completed. Any employment with WHO shall be subject to established recruitment and selection procedures. Interns and former interns are free to apply as external candidates to any vacant positions open to external candidates and for which they are qualified.WHO does not sign any agreements, proposed or required by a sponsor, university or equivalent institution.WHO only considers higher educational qualifications obtained from an institution accredited/recognized in the World Higher Education Database (WHED), a list updated by the International Association of Universities (IAU)/United Nations Educational, Scientific and Cultural Organization (UNESCO). The list can be accessed through the link: . Some professional certificates may not appear in the WHED and will require individual review. Please note that internships at WHO are very competitive and only a small number of applicants will be selected every year. Only successful candidates will be contacted. If not selected, you may apply again to other posted internship positions if you are still interested and if you meet the eligibility criteria.For internships in Geneva, SwitzerlandAn important reminder: Although WHO is now providing a living allowance to eligible interns (please see the exact amount in the vacancy notices), be aware that living in Geneva is expensive and finding accommodation can be challenging. Skip to main content The problemAvailable evidence shows that compliance with hand hygiene recommendations during health care delivery remains suboptimal around the world, with an average of 59.6% compliance levels in intensive care units up to 2018, and extreme differences between high income and low income countries (64.5% vs 9.1%).Out of every 100 patients in acute-care hospitals, seven patients in high-income countries (HICs) and 15 patients in low- and middle-income countries (LMICs) will acquire at least one health care-associated infection during their hospital stay.Most health-care facilities have an intermediate level of hand hygiene implementation or higher, for which health care facility funding and country income level are important drivers. Most HAIs are preventable through hand hygiene performed at the right times.The WHO Guidelines on hand hygiene in health care outline hand hygiene recommendations and are complemented by the WHO Multimodal hand hygiene improvement strategy, the Guide to implementation, and an implementation toolkit, which contains many ready-to-use practical tools.The WHO multimodal improvement strategy has been shown as the most effective approach leading to practices improvements. Hand hygiene improvement programmes can prevent up to 50% avoidable infections acquired during health care delivery and generate economic savings on average 16 times the cost of implementation. Hand hygiene is vital for safe health care delivery, yet practices at the point of care remain suboptimal worldwide. A comprehensive research agenda... Investment in all the drivers and facilitators of hand hygiene action in health care to ensure that it occurs at the point of care and other critical... The WHO and UNICEF-led Hand Hygiene for All Initiative aims at ensuring implementation for WHO's global recommendations on hand hygiene to prevent and... The scope of this document is to address practical aspects related to the performance of routine hand hygiene while providing outpatient care. This document... WHO_IER_PSP_2009.02_chi.pdf (5.297Mb) WHO_IER_PSP_2009.02_per.pdf (1.857Mb) The WHO Guidelines on Hand Hygiene in Health Care provide health-care workers (HCWs), hospital administrators and health authorities with a thorough... Overview"First, do no harm" is the most fundamental principle of any health care service. No one should be harmed in health care; however, there is compelling evidence of a huge burden of avoidable patient harm globally across the developed and developing health care systems. This has major human, moral, ethical and financial implications.Patient safety is defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum." Within the broader health system context, it is "a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur."Common sources of patient harmMedication errors. Medication-related harm affects 1 out of every 30 patients in health care, with more than a quarter of this harm regarded as severe or life threatening. Half of the avoidable harm in health care is related to medications (3).Surgical errors. Over 300 million surgical procedures are performed each year worldwide (6). Despite awareness of adverse effects, surgical errors continue to occur at a high rate; 10% of preventable patient harm in health care was reported in surgical settings (2), with most of the resultant adverse events occurring pre- and post-surgery (7).Health care-associated infections. With a global rate of 0.14% (increasing by 0.06% each year), health care-associated infections result in extended duration of hospital stays, long-standing disability, increased antimicrobial resistance, additional financial burden on patients, families and health systems, and avoidable deaths (8).Sepsis. Sepsis is a serious condition that happens when the body's immune system has an extreme response to an infection. The body's reaction causes damage to its own tissues and organs. Of all sepsis cases managed in hospitals, 23.6% were found to be health care associated, and approximately 24.4% of affected patients lost their lives as a result (9).Diagnostic errors. These occur in 5–20% of physician–patient encounters (10,11). According to doctor reviews, harmful diagnostic errors were found in a minimum of 0.7% of adult admissions (12). Most people will suffer a diagnostic error in their lifetime (13). Patient falls. Patient falls are the most frequent adverse events in hospitals (14). Their rate of occurrence ranges from 3 to 5 per 1000 bed-days, and more than one third of these incidents result in injury (15), thereby reducing clinical outcomes and increasing the financial burden on systems (16).Venous thromboembolism. More simply known as blood clots, venous thromboembolism is a highly burdensome and preventable cause of patient harm, which contributes to one third of the complications attributed to hospitalization (17).Pressure ulcers. Pressure ulcers are injuries to the skin or soft tissue. They develop from pressure to particular parts of the body over an extended period. If not promptly managed, they can have fatal complications. Pressure ulcers affect more than 1 in 10 adult patients admitted to hospitals (18) and, despite being highly preventable, they have a significant impact on the mental and physical health of individuals, and their quality of life. Unsafe transfusion practices. Unnecessary transfusions and unsafe transfusion practices expose patients to the risk of serious adverse transfusion reactions and transfusion-transmissible infections. Data on adverse transfusion reactions from a group of 62 countries show an average incidence of 12.2 serious reactions per 100 000 distributed blood components.Patient misidentification. Failure to correctly identify patients can be a root cause of many problems and has serious effects on health care provision. It can lead to catastrophic adverse effects, such as wrong-site surgery. A report of the Joint Commission published in 2018 identified 409 sentinel events of patient identification out of 3326 incidents (12.3%) between 2014 and 2017 (19).Unsafe injection practices. Each year, 16 billion injections are administered worldwide, and unsafe injection practices place patients and health and care workers at risk of infectious and non-infectious adverse events. Using mathematical modelling, a study estimated that, in a period of 10 years (2000–2010), 1.67 million hepatitis B virus infections, between 157 592 and 315 120 hepatitis C virus infections, and between 16 939 and 33 877 HIV infections were associated with unsafe injections (20). Factors leading to patient harmPatient harm in health care due to safety breaks is pervasive, problematic and can occur in all settings and at all levels of health care provision. There are multiple and interrelated factors that can lead to patient harm, and more than one factor is usually involved in any single patient safety incident:system and organizational factors: the complexity of medical interventions, inadequate processes and procedures, disruptions in workflow and care coordination, resource constraints, inadequate staffing and competency development;technological factors: issues related to health information systems, such as problems with electronic health records or medication administration systems, and misuse of technology;human factors and behaviour: communication breakdown among health care workers, within health care teams, and with patients and their families, ineffective teamwork, fatigue, burnout, and cognitive bias;patient-related factors: limited health literacy, lack of engagement and non-adherence to treatment; andexternal factors: absence of policies, inconsistent regulations, economic and financial pressures, and challenges related to natural environment.System approach to patient safetyMost of the mistakes that lead to harm do not occur as a result of the practices of one or a group of health and care workers but are rather due to system or process failures that lead these health and care workers to make mistakes.Understanding the underlying causes of errors in medical care thus requires shifting from the traditional blaming approach to a more system-based thinking. In this, errors are attributed to poorly designed system structures and processes, and the human nature of all those working in health care facilities under a considerable amount of stress in complex and quickly changing environments is recognized. This is done without overlooking negligence or misbehaviour from those providing care that leads to substandard medical management. A safe health system is one that adopts all necessary measures to avoid and reduce harm through organized activities, including: ensuring leadership commitment to safety and creation of a culture whereby safety is prioritized;ensuring a safe working environment and the safety of procedures and clinical processes;building competencies of health and care workers and improving teamwork and communication;engaging patients and families in policy development, research and shared decision-making; and establishing systems for patient safety incident reporting for learning and continuous improvement. Investing in patient safety positively impacts health outcomes, reduces costs related to patient harm, improves system efficiency, and helps in reassuring communities and restoring their trust in health care systems (4,5).WHO responseGlobal action on patient safetyRecognizing patient safety as a global health priority, and as an essential component of strengthening health systems for moving towards universal health coverage, the Seventy-second World Health Assembly adopted resolution WHA72.6 on "Global action on patient safety" in May 2019. The resolution requested the Director-General to emphasize patient safety as a key strategic priority in WHO's work across the universal health coverage agenda, endorsed the establishment of World Patient Safety Day to be observed annually on 17 September, and requested WHO's Director-General to develop a global patient safety action plan with the involvement of WHO Member States, partners and other relevant stakeholders. Global Patient Safety Action Plan 2021–2030The Global Patient Safety Action Plan 2021–2030 provides a framework for action for key stakeholders to join efforts and implement patient safety initiatives in a comprehensive manner. The goal is "to achieve the maximum possible reduction in avoidable harm due to unsafe health care globally", envisioning "a world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere". World Patient Safety DaySince 2019, World Patient Safety Day has been celebrated across the world annually on 17 September, calling for global solidarity and concerted action by all countries and international partners to improve patient safety. The global campaign, with its dedicated annual theme, is aimed at enhancing public awareness and global understanding of patient safety and mobilizing action by stakeholders to eliminate avoidable harm in health care and thereby improve patient safety. WHO Flagship initiative "A Decade of Patient Safety 2021–2030" WHO has launched the Patient Safety Flagship as a transformative initiative to guide and support strategic action on patient safety at the global, regional and national levels. Its core work involves supporting the implementation of the Global Patient Safety Action Plan 2021–2030. References1. Slawomirski L, Klazinga N. The economics of patient safety: from analysis to action. Paris: Organisation for Economic Co-operation and Development; 2020 (accessed 6 September 2023).2. Panagioti M, Khan K, Keers RN, Abuzour A, Phipps D, Kontopantelis E et al. Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis. BMJ. 2019;366:l4185. doi:10.1136/bmj.l4185.3. Hodkinson A, Tyler N, Ashcroft DM, Keers RN, Khan K, Phipps D et al. Preventable medication harm across health care settings: a systematic review and meta-analysis. BMC Med. 2020;18(1):1–3.4. 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Global prevalence and incidence of pressure injuries in hospitalised adult patients: A systematic review and meta-analysis. International journal of nursing studies. 2020 May 1;105:103546.19. De Rezende HA, Melleiro MM, Shimoda GT. Interventions to reduce patient identification errors in the hospital setting: a systematic review protocol. JBI Evidence Synthesis. 2019;17(1):37–42.20. Pèpin J, Chakra CN, Pèpin E, Nault V, Valiquette L. Evolution of the global burden of viral infections from unsafe medical injections, 2000–2010. PLoS One. 2014;9(6):e99677. Skip to main content Empowered communities as providers of care Communities are not only recipients of health care—they are vital providers, organizers, and stewards of it. Around the world, community members deliver essential services, support continuity of care and bridge gaps between formal health systems and the people they serve. From trained community health workers to traditional caregivers, local volunteers and peer support networks, communities play a central role in promoting health, preventing illness and responding to emergencies. Empowered communities is one of the three pillars of Primary Health Care. Recognizing and strengthening the capacity of communities as users and providers of care is essential for achieving universal health coverage and building resilient, people-centered care. There is a growing consensus that community-based primary care is key to both strengthening health systems and ensuring preparedness for health emergencies and future pandemics. Robust and coordinated primary care is also critical to effectively manage shifting disease burdens and address the social determinants of health and well-being. Well-trained community health workers (CHWs) who are integrated into the health care system can play a central role in understanding and responding to the unique needs of diverse communities. They also play a vital role in delivering integrated services within primary care teams in the journey towards strengthened primary health care. Many countries, however, still lack strong CHW programmes, and where they exist, they are not always seen as an integral component of a national health care system. A reorientation and scaling of CHW training programmes could substantially improve healthcare effectiveness, access to services and readiness for health emergencies. For patients with life threatening conditions, the community has an important role in the early recognition of danger signs, delivery of first aid and initiation of movement to more definitive care. Member States have also highlighted this essential role via World Health Assembly Resolution 76.2 which emphasizes the critical role of community-level responders in strengthening integrated emergency, critical and operative care and also reflects the growing global recognition that timely first response at the community level is essential to reducing preventable deaths from acute conditions. Community First Aid Responders (CFARs) are trained laypersons who operate as part of an organized emergency care system—such as through community clinics, response organizations, or public safety agencies like police and fire services. Unlike bystanders with basic first aid knowledge, CFARs are formally certified and integrated into a structured response mechanism, allowing them to be mobilized to emergency scenes through pre-established systems. CFARs may include community members, first responders (e.g., police, firefighters), community health workers, healthcare assistants and other allied health professionals.CFARs play a vital role in strengthening prehospital emergency services, particularly in settings where formal ambulance systems are limited or hard-to-reach. In areas affected by conflict or landmines, CFAR programs have been shown to significantly reduce preventable deaths by enabling timely and organized first response. WHO's Community First Aid Response learning programme teaches a practical and systematic approach to first aid for community-based first responders who are linked to the health system. Community First Aid Response content is aligned with the WHO-ICRC Basic Emergency Care course, emphasizing a standardized approach to the acutely ill or injured for non-health professionals. Community First Aid Responders are trained to safely approach emergency scenes, recognize life-threatening conditions, provide initial care for medical and traumatic emergencies, and facilitate timely transfer and handover to higher levels of care. Community First Aid Response course is available on OpenWHO. Skip to main content Today, there are an estimated 2 million different kinds of medical devices on the world market, categorized into more than 7000 generic devices groups.A medical device can be any instrument, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination for a medical purpose. Policies, strategies, and action plans for health technologies, specifically for medical devices, are required in any national health plan. Within the context of a robust health system they ensure access to safe, effective, and high-quality medical devices that prevent, diagnose, and treat disease and injury, and assist patients in their rehabilitation.WHO's "Global Model Regulatory Framework for Medical Devices including in vitro diagnostic medical devices" supports Member States to develop and implement regulatory controls and regional guidelines for good manufacturing to ensure the quality, safety and efficacy of medical devices available in their countries. The Organization also works with Member States and collaborating centres to develop guidelines and tools, including norms and standards on medical devices.Additionally, WHO supports Member States in establishing mechanisms to assess national needs for health technologies in particular medical devices and to assure their availability and use, particularly in low-resource settings. A web-based health technologies database serves as a clearing house and provides countries guidance on appropriate medical devices according to levels of care, setting, environment, and intended health intervention, tailored to the specific needs of country or region. Development of medical devices policiesHuman resources for medical devicesRegulation of medical devicesHealth technology assessment of medical devicesHealth technology managementPriority and essential medical devicesPolicy-makers, biomedical engineers working in health care settings and government institutionsHospital and clinical managersDonors of medical devices and NGOs working in health technologyAcademic institutions studying health technologyDistrict, national, regional and global health managers Member States recognized in World Health Assembly (WHA) resolutions WHA60.29 (2007) and WHA 67.20 (2014) that medical devices are indispensable for health-care delivery but that their selection, regulation and use present enormous challenges, especially for low- and middle-income countries (LMIC).In order to increase access to appropriate, safe, affordable, effective medical devices of quality for all; the WHO Medical Devices has enable the WHO Global Fora on Medical Devices. The WHO Global Fora on Medical Devices serve as opportunities to share WHO initiatives to support country needs towards Universal Health Coverage (UHC) and the achievement of the Sustainable Development Goals (SDGs). The Fora also serve as occasions to listen to regional and country activities on medical devices issues. The Fora present the WHO resources available to Member States in a range of topics concerning medical devices:policy of medical devicesregulation of medical devicesnomenclature of medical devicesmedical devices innovation selection and prioritization of medical deviceshuman resources for medical devicesmanagement of medical devicesamong othersThe programmes of the WHO Global Fora have include presentations on the a huge range of topics on medical devices and also help present WHO projects, initiatives, tools, resources and work in progress. Health technologies include medicines, medical devices, assistive technologies, techniques and procedures developed to solve health problems and improve the quality of life. Such technologies are used in all types of health facilities, play a major role in contemporary health-care systems, and contribute directly to the quality of patient care. However, their use needs to be complemented by good staff training and effective organization of health services. Medical devices Medical devices contribute to the attainment of the highest standards of health for individuals. Without medical devices, common medical procedures – from bandaging a sprained ankle, to diagnosing HIV/AIDS, to implanting an artificial hip, or any surgical intervention – would not be possible. Medical devices are used in many diverse settings, for example, by laypersons at home, paramedical staff and clinicians in remote clinics, opticians and dentists, and health-care professionals in advanced medical facilities, for prevention and screening and in palliative care. Such health technologies are used to diagnose illness, monitor treatments, assist disabled people, and intervene and treat illnesses, both acute and chronic. Today there are an estimated 2 million different kinds of medical devices on the world market categorized into more than 22 000 generic devices groups. Decisions on selecting medical equipment for a health-care facility must be supported by evidence and based on clinical needs, financial resources, and the local capacity for effective use. What is precision medicine? Precision medicine is an emerging practice of medicine that uses a person's genetic profile to guide decisions made regarding the prevention, diagnosis, and treatment of disease. Knowledge of a patient's genetic profile can help doctors select the right medication or therapy and administer it using the necessary dose or regimen. It offers great potential to target treatment and increase the efficiency of health systems – from clinical prevention, through early detection and screening, to treatment, rehabilitation, and palliative care. However, implementing precision medicine requires a transformation of health services and significant resources. It also requires the collection and analyses of large amounts of precision health and genomic data, so patients need to trust that it is kept safe and confidential. Citizens need to be informed, empowered, engaged and in control of their data. Additionally, precision medicine requires significant up-skilling of the health workforce, with a strong focus on digital literacy and the interpretation of biomarker information, as well as establishing a new dimension in the patient-provider relationship. To fully unleash the true potential of precision medicine and accelerate its implementation, including in lower income settings, large collaborative efforts are required that can transform this concept from individual success stories to comprehensive real-world applications in routine clinical practice.