Figure 3. Environmental contamination with *Candida auris* and other multidrug-resistant organisms (MDROs) by time since room cleaning/disinfection.

Figure 1. Weekly incidence of *Acinetobacter* infections at a tertiary hospital in Botswana, by specimen and patient type, corresponding with results from environmental sampling conducted as part of four point-prevalence surveys and three cluster investigations, 1 January – 31 December 2021

gram-positive organisms predominating over gram-negative organisms on environmental surfaces. Limitations include lack of organism sequencing or typing to confirm environmental contamination was from the room resident. Rapid recontamination of environmental surfaces after manual cleaning and disinfection suggests that alternate mitigation strategies should be evaluated.
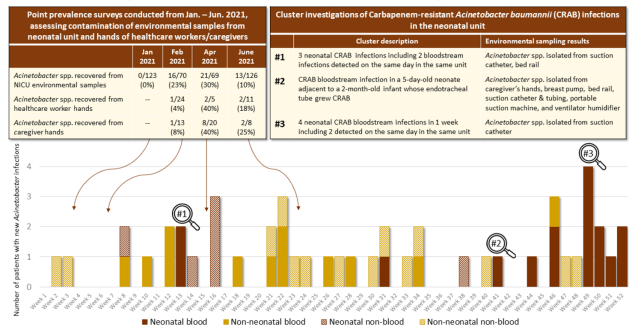
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Carbapenem-resistant *Acinetobacter baumannii* at a tertiary-care hospital in Botswana: Focus on perinatal environmental exposures

Background: Bloodstream infections (BSIs) due to carbapenem-resistant *Acinetobacter baumannii* (CRAB) are difficult to treat and are associated with high mortality, particularly in neonates. Healthcare-associated CRAB infections have been linked to environmental reservoirs and are associated with seasonal clustering. CRAB outbreaks are being reported more frequently in sub-Saharan Africa, but published reports from this region that incorporate comprehensive surveillance data and environmental investigations are rare. **Methods:** We reviewed microbiology surveillance records at a 530-bed, public, tertiary-care hospital in Botswana from January 1 to December 13, 2021, and we collected data regarding age, specimen type, and onset date for all cultures from unique patients growing *Acinetobacter* spp. An automated blood-culture system was used for organism detection, manual biochemical tests were used for identification, and disc and agar diffusion methods were used for antimicrobial sensitivity testing. During this time, we conducted 4 point-prevalence environmental sampling surveys at this hospital's 36-bed neonatal unit from January through June 2021 in addition to 3 neonatal CRAB cluster investigations. Environmental samples from surfaces, hands of caregivers and healthcare workers, and equipment were collected using flocked swabs. Extended-spectrum β-lactamase–producing organisms from environmental samples were identified using selective and differential chromogenic media (CHROMagarTM ESBL). **Results:** Overall, 48 *Acinetobacter* infections were identified, including 28 BSIs (among 3,699 blood cultures processed, approximately one-third of which were from neonates). More than half of cases were perinatal, which included 16 neonatal BSIs (median age, 4 days; case fatality rate, 56%), and 1 fatal case of postpartum sepsis in a 37-year-old mother. Among isolates tested, 35 (92%) of 38 demonstrated carbapenem resistance. Treatment information was not available for all neonatal patients, but delays in appropriate antimicrobial therapy were cited in all fatal cases. Most neonatal CRAB cases clustered in time and space (Fig. 1). For example, 15 (71%) of 21 neonatal cases occurred in the same unit and same week as another case. In the neonatal unit, CRAB clusters were associated with increased *Acinetobacter* recovery during environmental point-prevalence surveys (Fig. 1). *Acinetobacter* contamination was identified on feeding equipment (breast pumps, feeding tubes), respiratory equipment (suction machines or catheters, ventilator humidifiers), and hands of caregivers and healthcare workers. **Conclusions:** We report hyperendemic rates of CRAB infections with evidence of spatotemporal clustering, especially among neonates. Higher CRAB incidence coincided with increased *Acinetobacter* recovery during environmental sampling. We identified plausible transmission vehicles (respiratory or feeding devices, hands) in the neonatal care environment highlighting the value of environmental sampling to support CRAB investigations and reinforcing the importance of comprehensive and consistent disinfection practices, especially in resource-limited settings where equipment is shared or reused.

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Readiness assessment: Implications for COVID-19 infection prevention and control (IPC) preparedness in health facilities

Evelyn Wesangula; Veronica Kamau; Felister Kiberenge; Emmanuel Tanui; Susan Githii; Linus Ndegwa; George Owiso; Irungu Kamau and Jennifer Njuhigu

Background: Monitoring uptake of infection prevention and control (IPC) interventions is critical for the targeted and rational use of limited resources. A national facility readiness assessment conducted in August 2020 provided key information for targeted interventions to strengthen priority IPC areas. We assessed the level of COVID-19 preparedness in the facilities, identified priority COVID-19 IPC gaps, and generated a baseline report to further guide IPC investments at all levels. **Methods:** The Kenya Ministry of Health in collaboration with the CDC and International Training and Education Center for Health adapted a WHO Facility Readiness Assessment tool to include COVID-19–specific areas. In August 2020, data were collected using tablets through an Android-based electronic platform and were analyzed using descriptive statistics. Assessments were conducted in public, private, and faith-based health facilities nationally after 4 months of preparedness and investment in the healthcare system. **Results:** We assessed 684 facilities of the targeted 844 (81%). Overall facility readiness in Kenya was rated above average (61%), and the performance score significantly increased with the Kenya Essential Package for Health level, with level 5 and 6 facilities scoring an average of 83% and 79% respectively. Of the assessed facilities, 82% had an appointed IPC coordinator. Only 14% of the facilities had all the