



Regional Patient Safety Workshop on "Clean Care is Safer Care"

20-22 June 2007

Executive Summary

1. At the Fifty Ninth Session in August 2006, the Regional Committee for South-East Asia adopted resolution SEA/RC59/R3 on promoting Patient Safety in Health Care.
2. In connection with this, the prevention of health care-associated infection (HAI) was one of four priority areas of work discussed by participants at a WHO Regional Workshop on Patient Safety, held in New Delhi, India in 2006.
3. A progression from the 2006 event sees the Regional Patient Safety Workshop on "Clean Care is Safer Care", bring together technical and policy experts from 10 out of the 11 Member States of SEAR to exchange knowledge and experiences.
4. The workshop was concerned with both the promotion of regional awareness and the regional response to the threat of HAI in the context of patient safety.
5. A South East Asia Regional Committee meeting is scheduled to occur in September 2007, where the outcome and recommendations of the workshop will be presented together with a report on progress in the implementation of Resolution SEA/RC59/R3 on promoting Patient Safety in Health Care.
6. SEARO has committed to monitor implementation of the action points arising during the workshop.

Background and objectives to the SEARO Regional Workshop:

1. The workshop is underpinned within the SEAR by the Regional Committee for South-East Asia resolution SEA/RC59/R3 on promoting Patient Safety in Health Care.
2. Prevention of health care-associated infections was one of four priority areas of work discussed by participants at the WHO Regional Workshop on Patient Safety which was held in New Delhi, India, from 12 to 14 July 2006. Participants recommended that WHO:
 - a. establish a network for sharing information and best practices on prevention of health care-associated infection;
 - b. establish training programmes on prevention of health care-associated infection;
 - c. provide technical assistance to countries when required on specific issues; and,
 - d. disseminate applicable standards and protocols on prevention of health care-associated infection.
3. The June 2007 workshop brings together technical and policy experts from 10 out of the 11 Member States of SEAR to exchange knowledge and experience, and explore how to systematically and holistically address the problem of health care-associated infection in the Region. It also offers an appropriate method to promote regional awareness and catalyse national responses.
4. The overall objective of the workshop is to reduce the burden of health care-associated infection in the context of patient safety. The specific objectives are:
 - a. To review the status of health care-associated infections in the Region;
 - b. To orient participants on the availability of strategies and tools to reduce health care-associated infections;

- c. To outline a set of action points that countries can adopt as part of an integrated strategy to reduce health care-associated infection at the facility level.
5. The next Regional Committee for South-East Asia meeting is in September 2007, during which SEARO will include the outcome and recommendations of this workshop in its report on progress in the implementation of Resolution SEA/RC59/R3 on Patient Safety.

Day 1, 20th June: Regional Workshop (p.m.)

Opening of the Workshop:

Dr Sultana Khanum, Director, HSD/SEARO delivered an Inaugural Speech on behalf of the Regional Director, emphasizing the importance of the workshop in fulfilment of Resolution SEA/RC59/R3.

"It is my hope that all of you will commit to the pledge and return to your respective countries equipped with the expertise necessary to make Clean Care is Safer Care a reality."

Dr Sultana Khanum on behalf of the RD

Session 1: Multi-modal strategies and Tools

1. Julie Storr, Project Manager of the First Global Patient Safety Challenge, presented an overview of the WHO Strategy, describing the barriers to implementation in relation to hand hygiene guidelines and the importance of reliability.
2. The session introduced participants to the concept of the Five Moments for Hand Hygiene.
3. An outline of the session is presented in Annex 1

Questions and comments from day 1:

The common themes and questions emerging are listed below:

1. **Costs:** the audience sought clarification of the costs and benefits of the alcohol-based handrubs.
2. **Hand care, alcohol and cost:** two questions arose - is it acceptable to use hand cream in conjunction with using handrubs e.g. will it affect efficacy. Secondly, are hand creams necessary - this was followed by concerns relating to the costs of hand creams, and perceptions that such products are luxury items in many countries in the region.
3. **Evidence:** a significant portion of time was devoted to explaining in more detail the evidence base behind hand hygiene as a key strategy for the prevention of infection.
4. **Local context:** the launch event focused on the global context and the SEARO regional context was not referred to as strongly as would have been preferable.
5. **Efficacy:** participants asked the team to explain differences in the efficacy of rinses versus gels was asked.
6. **Hand hygiene outside of healthcare:** clarification was sought on whether the programme addresses hand hygiene outside of healthcare - if not, how do we link with other community-based programmes.
7. **Ingestion risks:** assurance was sought on which alcohol handrubs should be recommended if there are concerns about it being ingested?
8. **National production of alcohol-based handrub:** In some SEAR countries the Ministry of Health promotes affordable alcohol-based handrubs. These are produced locally for onward distribution to smaller hospitals.
9. **Prioritization of recommendations:** is it possible to prioritise the guideline recommendations, to help facilities and countries about to embark on such an approach.
10. **Drs don't touch patients:** a discussion thread emphasized the viewpoint that doctors do not have great contact with patients and therefore the strategy should target "technicians and nurses who are the housekeepers of the hospital".
11. **Targets:** Should targets be set for hand hygiene compliance - what level of increase is good?

Role Models: "Our experience is that any programme of this nature will not succeed without the active participation of medical staff".

Participant, SEARO Workshop, Day 1

Brainwash versus handwash: "we need to brainwash staff to accept this concept and then we can start getting them to handwash".

Participant, SEARO Workshop, Day 1

Step by step: "we should encourage people to do the right thing step by step".

Representative of the World Medical Association, SEARO Workshop, Day 1

Getting better: "From today we have a better chance to get better".

Participant, SEARO Workshop, Day 1



Day 2, 21st June: Regional Workshop (a.m.)

Session 2: Country Voices

Regional Context:

Dr Sultana Khanum opened the second day of the regional workshop with a presentation which set out the context within the South East Asia Region. Key comments and themes are summarised below:

1. Think global, act local.
2. In general - sophisticated ICUs in the region are unlike those in the West.
3. It is important to consider how concepts such as the Five Moments relate to the local context.
4. Dr Khanum reminded the participants of the recommendations of the 2006 Working Group on Infection Control:
 - a. For Member States:
 - i. Sensitize all categories of health care professionals from policy makers to technicians and janitors,
 - ii. Establish multidisciplinary infection control committees and teams and empower them to be effective,
 - iii. Adapt existing infection control guidelines and training modules,
 - iv. Educate and train health care professionals with regular updates,
 - v. Ensure a continuous supply of standard and essential supplies,
 - vi. Develop a system to monitor HAI that enables regular feedback and improvement in quality of care.
 - b. For WHO:
 - i. Establish a network for sharing information, experience and best practices in prevention and control of HAI,
 - ii. Disseminate appropriate standards, protocols and guidelines,
 - iii. Organise training programmes with an emphasis on practical application and implementation,

- iv. Establish an information system for surveillance of HAI,
- v. Provide technical assistance as requested in different aspects of HAI prevention and control
- c. These recommendations would be revisited during day 3 and used as the basis for developing a plan of action.
- 5. MRSA currently makes up 70%-80% of all Staph aureus in many Asian countries.
- 6. Indonesia study (2002): 1 in 14 patients has one or more HAI (study in 2 teaching hospitals)
- 7. Bangladesh study, presented in 2006, of 299 patients admitted to a large medical college hospital, 11.37% developed HAI.
 - a. Risk factors were found to be:
 - i. Functional status of the patient
 - ii. Number of visitors per patient
 - iii. Immunosuppressive therapy
 - iv. General cleanliness of the wards.
- 8. An overview of the activity to date across the region was presented, including the 2002 WHO/SEARO Guidelines on the Prevention and Control of HAI and the WHO/WPRO/SEARO Practical Guidelines for Infection Control in Health Care Facilities of 2004.
- 9. There seems to be little demand from hospitals for change, in terms of infection control.
- 10. Why are Guidelines not implemented:
 - a. Heavy workloads and overcrowding
 - b. Absence of continuous safe water and basic sanitation,
 - c. Dirty and cluttered ward environment
 - d. Structural weaknesses in aging and outdated healthcare facilities
 - e. Poor ventilation, dirty air conditioning filters and water leakages
 - f. Shortages of supplies
 - g. Lack of infection control programmes
 - h. Where an infection control committee is in place it is not functional
 - i. Insufficient numbers of well trained infection control personnel
 - j. Training is in place but does not extend to all personnel
 - k. Weaknesses in surveillance and outbreak investigation
 - l. Lack of support from CEOs.
- 11. In summary, more evidence is needed.

Country Voices

Lead participants presented an account of current context and activity within countries, based on a pre-provided brief (Annex 2). The summary of each countries presentation is illustrated in the table below. Full versions of the presentations are available on request.

Country	Activity
Bangladesh (Pledged 2006):	<ol style="list-style-type: none"> 1. Blood safety: positive developments have occurred in recent years. More than a 100 hospitals have implemented blood safety policies. 2. Waste management: positive developments in recent years. 3. Injection safety: the work of GAVI has yielded positive results. 4. HAI: <ol style="list-style-type: none"> a. No reliable data b. A qualitative study on HAI was undertaken in 2006 as part of the work related to the GPSC1. The findings reflect the multidimensional nature of the problems: <ol style="list-style-type: none"> i. Practices are best at medical college hospitals and requiring improvement at the smaller Upazila complexes. ii. Access to water at facility and ward level is generally good. iii. Infection Control Committees: 1.5% of hospitals have ICCs - none have dedicated, trained staff. iv. There is low awareness of the importance of hand hygiene in the prevention of HAI.

	<ul style="list-style-type: none"> v. A successful, WHO supported nurse leadership programme has been implemented in some hospitals and improvements in infection control instituted. vi. Use of water and soap for hand hygiene is erratic. vii. Role models are lacking. viii. The ICDDRB have piloted alcohol-based handrub. ix. Chittagong Medical College Hospital is a pilot site for Clean Care is Safer Care. x. During the biennium 2008-2009 a further district hospital and 21 Upazila complexes will pilot the alcohol-based handrub.
Bhutan (Pledged 2006):	<ol style="list-style-type: none"> 1. A new hospital construction programme is in place. 2. Limited data exists on the burden of disease. 3. Infection control manuals exist and are applicable to all hospitals. 4. All hospital supplies are centralised 5. Alcohol-based handrub is available to every hospital. 6. There is strict compliance with hand hygiene in critical care areas and the labour room. 7. Current constraints and challenges: <ul style="list-style-type: none"> a. Poor compliance with hand hygiene outside of these critical areas. 8. Pilot work is occurring to establish a baseline.
India (Pledged 2006):	<ol style="list-style-type: none"> 1. The National-rural launch mission of 2005 aims to decentralise and standardise infection control across the country. 2. In February 2007 the Hospital Infection Society, India, held a meeting focused on hand hygiene, during this meeting the WHO formula and all advocacy materials were disseminated. 3. The Lady Harding Hospital undertook a project manufacturing the WHO formulation for alcohol-based handrub. However, due to cost constraints it has proved more cost-effective to purchase the product commercially. <ul style="list-style-type: none"> a. Within the hospital compliance has increased and hand contamination levels have decreased. b. Preliminary results suggest less infection and less outbreaks, but more data is needed.
Indonesia (Pledge scheduled to occur July 2007):	<ol style="list-style-type: none"> 1. Patient safety has been strengthened across Indonesia in recent years. 2. The recently launched 9 Solutions are being adapted for the local context. 3. Infection control is seen as central to patient safety. 4. There is a national infection control strategy, with capacity building extending to 2012. 5. Surveillance is valued as central to improvement. 6. During 2007-08 monitoring and evaluation will be occurring. 7. Major challenges are summarised as: <ul style="list-style-type: none"> a. Resources b. NGO funding 8. A national campaign is planned - with an emphasis on a "bottom-up" approach. <ul style="list-style-type: none"> a. Essentially hospitals are starting their own campaigning without waiting for government or WHO advices and support.
Maldives:	<ol style="list-style-type: none"> 1. Infection control is being strengthened. 2. Infection control audits: <ul style="list-style-type: none"> a. Quick reference manuals are in place. b. Handwashing posters, with promotional messages are present at all sinks. c. Alcohol-based handrub is freely available in all units. d. Disposable hand towels are in place. e. Single-use, autoclavable towels have been implemented. 3. Constraints: <ul style="list-style-type: none"> a. Inadequate knowledge of patient safety. b. Lack of awareness. c. Lack of experience. d. Inadequate time. e. Lack of access to information. f. Lack of available baseline data on HAI. 4. Plans for the future: <ul style="list-style-type: none"> a. Strengthen and sustain infection control programmes b. Ensure regular audits of infection control c. Implement the national patient safety programme.

Myanmar:	<ol style="list-style-type: none"> 1. The SEARO infection control guidelines have been translated into Myanmar and all staff are trained on these guidelines. 2. A range of risk-related committees are established: <ol style="list-style-type: none"> a. Hospital supervisory committee b. Theater control committee c. Infection control committee d. Waste management committee e. Safe Blood Transfusion committee 3. Infection control and antibiotic policies are being established. 4. Some limited data is available on HAI. 5. Handrubs are available in a limited capacity, but contain methyl alcohol with no emollient property and are very <i>drying</i>. 6. Future plans to start and sustain use of alcohol based handrubs in all clinical areas.
Nepal:	<ol style="list-style-type: none"> 1. Factors of importance to safety and infection control improvements: <ol style="list-style-type: none"> a. Adult literacy is 49% b. Shortages of doctors and nurses. 2. ICN Nurse Leadership Programme in 2004/2005 resulted in: <ol style="list-style-type: none"> a. A study on hand hygiene in hospitals - only targeted nurses (did not involve managers or patients). b. From this study, handwashing compliance increased from 70% (2003) to 90% (2004). c. Infection rates decreased from 39.4% (2001/2002) to 30% (2005) 3. Historical constraints: <ol style="list-style-type: none"> a. No clear HAI policy across all levels. b. No teamwork. c. Low awareness and communication among providers and consumers. d. No reliable data. 4. Future plans: <ol style="list-style-type: none"> 5. Disease specific standards and treatment guidelines to be disseminated to all care providers. 6. Performance indicators. 7. Policies will be reviewed. 8. Specific objectives will be selected.
Sri Lanka:	<ol style="list-style-type: none"> 1. Study undertaken in the national hospital of Sri Lanka: 3000 beds, 2 million out-patients per year, 250,000 in-patients per year, 80,000 surgical operations per year. <ol style="list-style-type: none"> a. 1984: HAI 13% b. 1995: HAI 8% 2. During this period a number of infection control improvements were implemented. 3. Constraints exist due to no proper referral system. 4. Occupancy is normally 100% to 200%, average length of stay: 5 days. 5. Drug expenditure: 400 million rupees (large percentage of which are antibiotics). 6. Infection control programmes exist: <ol style="list-style-type: none"> a. Chief function is monitoring. b. There is an ongoing training programme on HAI for all staff. c. Hospital administrators oversee infection control and lead and guide the programme. d. The administrators responsibility includes providing adequate funds and ensuring a clean and safe environment. e. ICC meets every 3 months. 7. Waste disposal presents major challenges.
Thailand (Pledge 2007):	<ol style="list-style-type: none"> 1. There is an Institute for Quality Improvement and Accreditation. 2. National prevalence surveys have been undertaken to determine the burden of disease, the results are listed below with other milestones: <ol style="list-style-type: none"> a. 1971: First infection control programme established. b. 1982: Short training course in infection control. c. 1983: 8.4% d. 1987: National infection control group established e. 1988: 11.7% f. 1992: 7.3% g. 1996: Hospital standards for quality improvement and accreditation. h. 1998: Infection Control Nurses Group formed. i. 2001: 6.4%

	<ul style="list-style-type: none"> j. 2006: Patient safety goals launched - of which HAI reduction is one element. 3. Average length of stays are 10 days. 4. Costs: average \$140 US per infection. 5. 2005. Quality of nosocomial infection control in Thailand Study: <ul style="list-style-type: none"> a. ICCs exist and ICNs are in place - but there is still a need for quality and standards to improve. b. A strategy to improve hand hygiene was launched, consisting of: <ul style="list-style-type: none"> i. Education ii. Posters and promotions iii. Observational compliance and feedback iv. Financial incentives v. Feedback c. Compliance has increased in some areas from: <ul style="list-style-type: none"> i. 4.5% - 44.4% ii. 13.4% - 90.8%
Timor Leste:	<ul style="list-style-type: none"> 1. 1 million population. 2. Limited data. 3. No ICC. 4. Poor practices are thought to be widespread with low awareness of hand hygiene.

Highlights from the Country Voices Session:

"Guidelines exist but are not readily available even at the senior professional level."

Bangladesh

"Can SEARO support the indigenous manufacture of alcohol-based handrubs?"

India

"Empowering medical professionals towards patient safety is important for success."

Indonesia

"The concept of patient safety was not new to administrators, but was entirely new to clinicians".

Maldives

"As a direct result of the New Delhi Patient Safety Workshop (July 2006) a national patient safety committee was established in our country".

Maldives

"Most wards are heavily overcrowded with for example 50 beds, 100 patients, and 2 nurses".

Sri Lanka

"A new national Ministry of Health incentive programme has been instituted to find the cleanest hospital with the best environment. The winning hospital will receive an award."

Sri Lanka



Session 3: Advocacy and Communications

1. Agnès Leotsakos, led an Advocacy & Communications Session which was included in the workshop in response to requests by Members States to strengthen the themes and messages underlying the “Clean Care is Safer Care” Challenge. A detailed background paper on the session can be found in Annex 3.
2. Participants were separated into working groups to discuss and formulate recommendations on the topics:
 1. Building and sustaining political commitment
 2. Expanding partnerships and networks
 3. Communicating in countries and mobilizing society
 4. Attracting media coverage

The outcome of the group work is summarized below:

Expanding partnerships and networks	Building and sustaining political commitment:	Communicating in countries and mobilizing societies:
<ol style="list-style-type: none"> 1. Identify key partners 2. Hold seminars and workshops <p>Constraints:</p> <ol style="list-style-type: none"> 1. Culture of blame 2. Fear and worry associated with exposure 3. Embarrassment 4. Litigation 5. Creating conflict 6. Conflict of interest between stakeholders <p>Prospective partners:</p> <ol style="list-style-type: none"> 1. Care providers and patients 2. Policy makers 3. Hospital accreditation bodies 4. Hospital administrators 5. Professional organizations and medical bodies <p>How to engage:</p> <ol style="list-style-type: none"> 1. Data collection and analysis 2. Publication/ presentation 3. Launching advocacy projects 4. Workshops <p>The priorities:</p> <ol style="list-style-type: none"> 1. Identification of burden of disease due to HAI 2. Sensitization of all healthcare workers to the issues. 	<ol style="list-style-type: none"> 1. Advocacy 2. Transparency 3. Monitoring of progress and follow-up 4. Gain high profile allies, eg Bangladeshi Nobel Prize winner, businessmen, politicians. <p>Attracting Media coverage:</p> <ol style="list-style-type: none"> 1. Pledges by ministers are powerful 2. Collect data on HAI - media are interested in data, numbers (burden of infection) 3. Collect data on adverse events. 4. National campaigning 5. Interviews/features 6. Consider HAI days 	<ol style="list-style-type: none"> 1. Seek technical inputs from professional societies 2. Create an independent body e.g. National HAI Organizations with state and district branches, 3. Implementation through IEC branch of this body. <p>How to mobilize:</p> <ol style="list-style-type: none"> 1. Campaigning for awareness 2. Work with media: street shows - clear public exposure. 3. Sell the message that preventing HAI reduces costs <p>Constraints:</p> <ol style="list-style-type: none"> 1. No specific data to use to publicize the case for. 2. Clear public exposure to HAI can create a backlash 3. Specific messages are needed for specific target groups. <p>Priority best practices:</p> <ol style="list-style-type: none"> 1. High profile launches - regional involvement 2. National - community 3. Produce documentaries in hospitals, street plays, schools, 4. Take every opportunity to campaign on HAI. 5. Countries should decide whether to work with celebrities/mobilize goodwill ambassadors. 6. Use celebrations and festivals as opportunities for campaigning 7. Promote positive messages 8. Work with powerful and important people to promote a single message



Day 3, 22nd June: Regional Workshop (p.m)

Session 4: Practical Application:

1. Julie Storr outlined the Five Moments for Hand Hygiene using video footage of clinical scenarios to illustrate the concepts.
2. Examples of countries (eg Costa Rica) which were in the process of reproducing the scenarios to reflect the local health care context were provided and countries encouraged to consider this possibility.
3. The WHO strategy and all associated implementation tools were summarised.
4. An outline of the session can be found in Annex 4.

Session 5: Next Steps - Recommendations arising from the workshop:

Doris Mugrditchian, Regional Focal Point for Quality and Safety facilitated an interactive group session to prioritize action areas arising from the workshop.

1. Country priorities:

- a. Based on the New Delhi Workshop (2006) countries prioritized their top 3 recommendations of what action countries should take as a direct result of the workshop.
- b.

Actions for Member States:						
	Sensitize	Adapt IC GLs	Monitor & Feedback	ICCs & Teams	Education & training	Supplies
Bangladesh	2	1	3			
India	1	3	2			
Bhutan	1		2	3		
Indonesia	1	3		2		
Maldives	1	3	2			
Myanmar			3	1	2	
Nepal	1		2		3	
Sri Lanka	1			2		3
Thailand	1		3	2		
Timor Leste	1	3		2		
Totals	9	5	7	6	2	1

The top 3 recommendations for Member States:

1. Sensitize all categories of health care professionals from policy makers to technicians and janitors
2. Develop a system to monitor HAI that enables regular feedback and improvement in quality of care
3. Establish multi-disciplinary IC committees and teams and empower them to be effective.

Areas for WHO Assistance:					
	Technical Assistance	Network for sharing	Surveillance Systems	Practical Training	Dissemination of GLs & Standards
Bangladesh	1	2	3		
India	3		1	2	
Bhutan		1	3	2	
Indonesia		1		3	2
Maldives	1	2	3		
Myanmar		1	3	2	
Nepal	2	3			1
Sri Lanka		2	3		1
Thailand	3	1			2
Timor Leste	1			2	3
Totals	6	8	6	5	6

The top 3 recommendations for WHO:

1. Establish a network for sharing information, experience and best practices in prevention and control of HAI
2. Provide technical assistance as requested in different aspects of HAI prevention and control
3. Disseminate appropriate standards, protocols and guidelines
4. (Establish an information system for surveillance of HAI)

While three areas scored a total of six votes, the list has been ranked according to the priority placed on the area by member states (ie those scoring 1).

A facilitated open discussion took place to determine any actions or areas of assistance that should be added to the list of recommendations to both member states and WHO. These are listed below:

Indonesia	o Uniform taxonomy
Maldives	o Patient and media involvement o Spread of good practices from tertiary centres to primary care
Myanmar	o Waste management technologies
Nepal	o Pilot projects
Thailand	o Quality improvement and accreditation o National campaigning
Timor Leste	o Legislation



Reflection:

1. Dr Sultana Khanum concluded the session by emphasizing that all of the areas discussed within the group exercise arose from the New Delhi Workshop of 2006 and are already incorporated within the SEARO work plans for 2007/2008 .

2. Member States were urged to share the outcome of the exercise with their ministry of health and WHO country office colleagues. This will go towards ensuring that the recommendations are reflected within the WHO biannual country work plans.
3. The expressed need for assistance from WHO suggests that many member states require help at all levels.
4. WHO SEARO are developing a regional framework and a package of tools for patient safety.
5. A time-frame for action of December 2007 was presented.
6. While media involvement has emerged as an area of possible attention, caution in the exact mechanisms of addressing this should be adopted to ensure such involvement is not counterproductive.
7. The Chair suggested that long-term success requires patient safety to be embedded in medical and nurse undergraduate training.

Closing remarks:

1. The messages from the workshop will be taken to SEARO and shared with the Regional Director and presented to Ministries of Health.
2. What emerges is that whilst it is essential to tackle the macro level issues such as facilities, micro level concerns are important and can be addressed in parallel.
3. It is important to make the best use of the available resources (eg the health workforce).



Annex 1: Session 1: Multimodal strategies and tools

Objectives

By the end of this session workshop participants should be able to:

- Describe the barriers to implementation in relation to hand hygiene guidelines
- Describe the importance of reliability and hand hygiene improvement
- Analyse the possible solutions and best strategies for sustained improvement in particular the:
 - Five Step Process of the WHO Multimodal Improvement Strategy
 - Application of social marketing to hand hygiene improvement
- Develop and understand the action planning and review cycle
- Review the application of the principles of "scale-up" to hand hygiene improvement
- Begin to explore the concept of the Five Moments for Hand Hygiene and its application in practice

Materials Required

- PowerPoint technology and DVD player/computer with DVD capability
- Hard copies of the hand-outs
- Alcohol-based handrub samples

Method of Work

The sessions will be delivered primarily with exposition and visual demonstrations. There will be opportunity for group discussion and interaction throughout the session. The session will close with plenary feedback.

Detailed Breakdown of the Session

Description	Method
Introduction to the WHO multimodal hand hygiene improvement strategy	Exposition/PowerPoint Group work – establishing baseline through surveys
Video relating to importance of hand hygiene to patients	Video
Overcoming the barriers - reliability and the Five Step WHO Multimodal Strategy	Exposition/PowerPoint Group discussion
Sustainability and spread	Exposition/PowerPoint
Introduction to the Five Moments for hand hygiene	PowerPoint visuals
Close of the session and questions and answers	Group discussion Plenary

Expected outcome:

Participants will be able to apply the methodology described here for improving hand hygiene in a highly reliable way across a range of health care settings to attain long term improvements.

Annex 2: Session 2: Country Voices

Overall purpose of the Country Voices Session:

To provide an overview or "snapshot" of the current situation within the country in terms of the control and prevention of Health Care-Associated Infection (HAI), with an emphasis on hand hygiene.

The speakers are advised to base the presentations around:

- Setting the context - the burden of disease
- Existing structures
- Current interventions
- Plans for the future

Specific detail on what this means is listed below:

1. Country data on burden of disease of HAI - is this available?
2. What is the nature of work currently occurring to tackle HAI?
3. What is the nature and extent of work (if any) relating to hand hygiene?
 - a. is alcohol based handrub promoted/used in health care facilities in the country?
 - b. Does any form of measurement occur in relation to hand hygiene?
4. What is the current status of infection control staffing across the country - are infection control doctors/nurses in place?
5. Are training programmes available for infection control practitioners?
6. What other activity is in place in relation to the prevention and control of HAI?
7. What activity is planned in relation to the prevention and control of HAI?
8. Is there an advocacy component to the country work to address HAI?

Annex 3: Session 3: Advocacy & Communications

Background

The Advocacy & Communications Session responds to requests by Members States for the themes and messages underlying the "Clean Care is Safer Care" Challenge and to review the basic steps in effective advocacy. The Session also addresses the first two objectives of this Workshop:

- To raise awareness of the impact of health care-associated infection and promote WHO preventive strategies within regions and countries; and,
- To build commitment from countries to give priority to reducing health care-associated infection.

Objectives

By the end of the Session participants should be able to:

- Identify and engage communications professionals and journalists to participate in and support the "Clean Care is Safer Care" initiative
- Identify ways to enhance advocacy messages and tactics
- Identify regional events and planning activities and products to support advocacy and communications work
- Inform and train technical professionals and academics on the simple ways to work with media and get publicity
- Build links between regional technical professionals and communications/media experts.

Method of work

- Introductory plenary—presentation with all participants in attendance
- Working groups —participants will be divided into four working groups to discuss and formulate recommendations on one of the following four topics—each group will be assigned one topic (TOR attached):
 - Building and sustaining political commitment
 - Expanding partnerships and networks
 - Communicating in countries and mobilizing society
 - Attracting media coverage
- Final plenary— recommendations presented by the four Rapporteurs will be discussed and finalized.

Terms of Reference for the Working Groups

Each group will elect a Chair and a Rapporteur who will present the top three recommendations and the most important next steps at the final plenary.

Group 1: Building and sustaining political commitment: Discussion points:

- What encourages or constrains political backing ?
- What can key partners be doing to address this ?
- Who are the perspective allies (for e.g. business community, celebrities, academic community)? Which ones would have the greatest influence on political commitment? Which events? Are there common political mechanisms or should each country be addressed individually?
- What messages and themes are the most effective in mobilizing policy makers (for e.g. threat of MRSA, financial implications, HAI affects equally the rich and the poor)?
- How can governments/institutional actions be measured?
- What are the top three recommendations for building powerful political support?
- What are the most important next steps?

Group 2: Expanding partnerships and networks: Discussion points:

- What are we doing to expand partnerships and networks to address HAI?
- What encourages or constrains NGOs, patients groups and corporations from joining in with such an initiative?
- Which prospective partners could hold the greatest potential for promoting efforts to address HAI (for e.g. academics, public relations companies, medical associations, NGOS, business community)?
- How can new partners be engaged?
- How can public-private partnerships be facilitated?
- What strategies and materials will be needed to promote this initiative through partners (brochures, presentations, web sites reports etc) ?
- What are the top three recommendations for expanding partnerships and networks
- What are the most important next steps?

Group 3: Communicating in countries and mobilizing society:

Suggested discussion points:

- How can we communicate in countries about the challenge of health care-associated infection ?
- How can we best mobilize society in addressing these infections now ?
- What encourages or constrains country communication or society mobilization on health care initiatives?
- What are the top best practice examples that exist in country communication or society mobilization and how can we use them for the "Clean Care is Safer Care " initiative (for e.g. engaging celebrities and goodwill ambassadors, organizing special events) ?
- What strategies and materials will be needed to promote this initiative (for e.g. brochures, presentations, web sites, reports)?
- What are the top three recommendations for communicating in countries and mobilizing society
- What are the most important next steps?

Group 4: Attracting media coverage:

Suggested discussion points:

- What media hooks are required to attract media attention on the burden of health care-associated infection
 - What media strategies have worked for similar initiatives
 - What data on the burden of HAI are available to publicize
 - What special event can be organised to attract attention
 - What statements could regional leaders and outstanding spokespeople be making
 - What are the best options for news coverage considering the epidemic of competing health initiatives?
- Are there reoccurring events that can be built to sustain media visibility in countries (for e.g. national immunization days, infection control week, celebrity tours)
- What are the top three recommendations for attracting media coverage
- What are the most important next steps?

Annex 4: Session 4: Practical Application (from knowledge to action)

Objectives

By the end of this session participants should be able to:

- Observe the complexity of opportunities for hand hygiene in practice
- Analyze various scenarios involving patient contact/clinical practice
- Discuss alternative methods to measure outcome
- Discuss and apply the newly developed Five Moments for hand hygiene
- Observe the WHO observational compliance monitoring tools and their application

Materials Required

- PC capable of playing a DVD
- Sample copies of the Hand Hygiene Observation Survey

Method of Work

The workshop will be delivered by PowerPoint presentation, video scenario and an interactive session related to the video.

Detailed Breakdown

Description	Method
Measuring hand hygiene and hand hygiene opportunities	Exposition/PowerPoint
Introduction to the video scenario	Exposition
Video	Video clip
Applying the tools in practice	Interactive session
Feedback	Facilitated discussion
Discussion and close	Plenary

Expected outcomes

Participants will have a complete appreciation of the complexity of measuring compliance as a marker of success. Participants will be able to assess current strategies for monitoring hand hygiene compliance and agree how to tackle this issue locally including assessing the feasibility of participating as Complementary Test Sites.