1. Introduction

Following discussions and decisions made during the first exploratory meeting on 21 September, 2010 between representatives from private industry and WHO, a second meeting was convened in the World Health Organization Geneva, Switzerland on 2 February 2011.

2. Overall Purpose

The overall goal of WHO Clean Care is Safer Care (CCiSC) is to improve hand hygiene in health care facilities. There are several hurdles to achieving this seemingly simple intervention. Two main problems relate to awareness on the importance of hand hygiene at different levels, such as policy makers, management and health-care workers, and the availability of resources to enable best practices.

There is a potential for the private sector to significantly contribute to these two main areas and amplify the efforts of CCiSC. They can add value in several areas due to their reach, their knowledge in areas such as local situations in many countries and production and distribution systems for hand hygiene products. Several commercial ventures are already actively involved in promoting hand hygiene and health care-associated infection (HAI) education in different parts of the world.

Aligning messages and increasing the reach of messages through such activities could be of great advantage. It could be possible to exploit 'corporate social responsibility' to support health-care system change developments as well as education in resource poor countries. According to recommendations of CCiSC, 'system change' includes primarily making available essential commodities needed for hand hygiene - alcohol-based handrub, water, soap and single use towels - at all times in all health-care facilities. There are also specific recommendations related to numbers, positioning, etc related to these products.
Such a collaboration links with the overall WHO Patient Safety Programme draft strategic objectives of making safety issues everyone's business while making more stakeholders taking responsibility for actions.

Given the purpose of and potential for collaboration, as has been described, this second meeting was deemed a useful next step.

In summary, during the first meeting, two potential areas for action were identified:

1. developing a coherent and lucid collaboration where industry representatives can sign up and thus commit to the regulations and overall work of the collaboration
2. developing a model for micro-production of alcohol-based handrub (ABHR) in resource poor areas, to enable access to products

For full details refer to the report of the first meeting (http://www.who.int/gpsc/information_centre/gpsc_slcyh_meetingreport_oct2010_en.pdf).

3. Summary of second meeting proceedings

The aims of this second meeting were:

1. to keep the momentum generated during the first meeting;
2. to take forward discussions on modalities of working together.

The meeting was chaired by Dr Edward Kelley and Professor Didier Pittet. Welcome, introductions by all (including descriptions from industry representatives on their areas of work and geographical coverage) and preliminary remarks by the Chairs were delivered. Following this, the purpose of the meeting, the current status of the work towards building collaboration modalities and outputs expected from small group discussions during this meeting were explained by Dr Elizabeth Mathai.

Small group discussions followed, featuring the majority of the meeting with feedback subsequently provided. To close the meeting, Ms Claire Kilpatrick provided an update of the CCiSC current activities and the activities proposed for the global call for action on May 5 2011 as part of the WHO SAVE LIVES: Clean Your Hands campaign, before final discussions led by the Chairs.

The agenda, attendee list and slides presented by WHO staff can be found in the appendix.
4. Summary of group discussions on the three potential areas for collaboration

The topics addressed by the groups were the same as that of first meeting namely: education (raising awareness and sharing knowledge), system change (enabling access to essential commodities for hand hygiene) and research (product merits, evidence for impact of hand hygiene and implementation research). The groups focussed on WHO role, collaborator role and benefits as a result of collaboration in these areas.

In summary, the outputs from the group discussions were significant. All groups acknowledged that working on the points outlined with WHO leadership would be acceptable to them. They also expressed willingness to actively participate (success depends on this) in the collaboration and to sign up to some form of 'code of conduct'.

Summary of group discussion on 'Education':
WHO's role is to provide direction and develop educational materials. Industry can further the reach by using the materials in a responsible manner as will be outlined in a 'code of conduct' to be developed. It was further expressed that:
- This work needs to have defined outcomes and a produce a 'legacy';
- Support for the 5 components of WHO's multimodal improvement strategy promoted by CCiSC is essential, for this to be disseminated through education;
- A working group on education with definite terms of reference needs to be established.

Summary of group discussion on 'System change':
WHO's role is to convene and to facilitate communications between industry (participants in the collaboration) and beneficiaries, i.e. to provide information on needs known to WHO, related to system change, to the participants of the network and then take part in initial actions to facilitate contact between industry and the beneficiary and any other participant such as an Non Governmental Organisation (NGO) interested in this area.
Participants inform WHO of their interest and interact directly with the beneficiary after initial interactions involving WHO. Participants could also inform WHO about needs in health-care facilities or countries they they identify and would like to provide assistance.
The group further expressed the need for:
- Developing a 'code of conduct' clearly addressing conflict of interest, competitive behaviour etc. This should be signed and posted on the 'collaborative working platform';
- Maintaining two way communication respecting requirements of both parties;
- Maintaining confidentiality. This should be stated and details clarified in the 'code of conduct'.
Summary of small group discussion on 'Research':
Areas requiring research were identified by this group. These included improving the evidence base to justify hand hygiene promotion and identifying customer needs. The actionable areas suggested were customized messaging, innovation and education tools to drive change, compliance measurements, impact of work flow on compliance, prevalence of adverse events and cost benefit studies. More details are needed to conceptualise the roles of WHO and industry on this area of collaboration.

5. Mechanism for collaboration proposed

In the first instant, the plan is to develop a web-based platform which will enable WHO to be transparent and provide equal opportunity to all participants. This would also allow for confidentiality of the information shared by participants with WHO.

- The idea was accepted by those present, who also welcomed progressing this as a next step;
- Criteria for participation in the collaboration should be developed;
- Sub-groups or working groups, such as the one suggested for education, should be hosted on the platform;
- That other NGOs, i.e. those involved in improving water supplies, as well participants of WHO CleanHandsNet (the WHO network of coordinators of countries with coordinated hand hygiene promoting campaigns) could be other potential participants;
- At a later stage, it could be used for sharing information between WHO and participants, for announcements and for calling for action on specific proposals.

Specific requests related to May 5 2011 were made and agreed upon. These were:

- Key messages for May 5 to be continually shared through our web pages;
- To include those present in the email list for disseminating information.

It was also proposed and agreed that:

- Representatives who had not yet attended CCISC sessions could request training on WHO strategies and models of promoting hand hygiene in health care;
- Participants would share with WHO their available data on sales of ABHR, to do a global mapping and gap analyses exercise. This could be done as one of the initial activities via the platform. While the information may not be complete and represent the total ABHR sales in the world, this will provide WHO with useful information.
6. Next steps

The participants were informed of the potential for a next meeting to coincide with the International Conference on Prevention and Infection Control (ICPIC) meeting to be held in the University of Geneva from June 29 to July 2 2011.

It was agreed that participants would submit two slides on their main areas of work and geographical coverage to WHO and that WHO would circulate the WHO slides presented and the meetings notes subsequent to necessary approvals.
Appendices
1. Agenda

Second meeting of WHO HQ Patient Safety and industry representatives

With invited representative from University Hospitals Geneva (WHO Collaborating Centre on Patient Safety, Infection Control and Improving Practices)

Wednesday 2 February 2011

Room: M105

Chairs: Dr Ed Kelley and Professor Didier Pittet

09.00 Welcome message (with tea and coffee)  
Professor Didier Pittet & Dr Ed Kelley

09.30 Introductions*  
All (5min/company)

11.00 Update on collaborative working  
Dr. Elizabeth Mathai

11.30 Break (information on group work meeting rooms)  
All

12.00 Lunch

12.45 Group work (in breakout meeting rooms)  
All

14.30 Feedback from group discussions  
All

15.30 Progress on WHO led hand hygiene activities  
Ms. Claire Kilpatrick

16.00 Sum up, plans for next steps, discussion time  
Chairs and all

17.00 Close

*Introductions:
- State in which areas you are current working, would be interested in supporting WHO efforts including in which geographical areas. Also take the opportunity to give any comments on the meeting of September 2010, including the report.

Progressing the ideas for collaborative working - group work:
- Group 1 - discuss what you would like to see on education on the shared ‘platform’ and how you think you would contribute (e.g. just WHO announcements, proposals for collaborative working, guidance on what you can do - do you want to stimulate suggestions or for WHO to lead?)
• Group 2 – discuss what you would like to see on _system change_ on the platform and how you think you would contribute

• Group 3 - discuss what you would like to see on _research_ on the platform and how you think you would contribute.

**Aims of the meeting:**

• To gather input on where industry can further the WHO goal of sustainable improvement of hand hygiene in health-care facilities around the globe (this will be primarily achieved through discussion)

• To discuss how we can work together to further the WHO agenda, for example supporting the availability of resources as well as activities to improve hand hygiene where there is a need, and to contribute to awareness-raising in a manner acceptable to the WHO ethos.

**WHO cannot commit to collaborative activities or accept proposals but will take notes for consideration in order to progress accordingly.**

**Additional information:**

• WHO is not permitted to display any undue advantage to any one company

• WHO is not in a position to validate technology or endorse or test any products;

• WHO does not warrant that all the information presented at the meeting is complete and correct and shall not be liable whatsoever for any damages incurred as a result on its reliance.
2. Industry representatives participating in the meeting

2. Carla von Gosen, Schulke
3. Gerard Lacey, Glanta Ltd,
4. Suchismita Roy, Mölnlycke Healthcare
5. Frédérique Olivier, Anios-Unident
6. Garry Kelley, Bode Chemie
7. Günter Kampf, Bode Chemie
8. Patrick Van De Graaf, Diversey
9. Harvey Yeap, Saraya
10. Isabelle Caniaux, Biomerieux
11. Marc Lessem, Medline Industries, Inc.
12. Paul Alper, Deb Worldwide Healthcare Inc
13. Sean Bay, Glanta Ltd
14. Selin Kozak, Carfarma
15. Semra Ucar, Carfarma
16. Siir Kuran, Carfarma
17. Thomas Hennig, B. Braun Medical AG
18. Wolfgang Merkens, Schulke
19. Jim Arbogast, GOJO
20. Flavio Leal, GOJO
21. Mike Sullivan, GOJO
22. Andy Newsome, Ecolab
23. Tania Desa, Ecolab
24. Nicole Van Hall, Saraya
An update on WHO "Clean Care is Safer Care"

Launched 2005

2 February 2010
2nd year of a global campaign

SAVE LIVES: Clean Your Hands

- Influenza
- MRSA
- MDR Gram negative bacilli
- Diarrhoea

5,000 5,500 6,000 6,500 7,000 7,500 8,000 8,500 9,000 9,500 10,000 10,500 11,000

= number of hospitals registered

4 May 2010
11,543 hospitals
12 298 registered health-care facilities from 145 countries =
Approx 7 mio health-care staff, and 3 mio patient beds
Where do YOU stand on hand hygiene?

The main goal of this year's campaign is for registered healthcare facilities and others to **assess their hand hygiene practices** through:

- Use of the WHO Hand Hygiene Self-Assessment Framework
- We will do this by using the full power of WHO's extent of communications and through cascade communications

Secondary goals are for everyone, especially non-registered healthcare facilities to **commit to hand hygiene** by:

- Registering to the SL:CYHs global annual campaign
- Featuring local activities on local sites (with links on the WHO web pages)
- **WHO will do this through communications, by mobilising key advocates to promote SL:CYHs** and by promoting WHO {translated} HH tools
Hand Hygiene Self-Assessment Framework

WHAT?
- Validated and systematic tool to obtain a **situation analysis of hand hygiene promotion and practices** and identify the level of progress within your health-care facility

WHY?
- To assess the level of progress of your health-care facility with regards to infrastructures, resources, actions, commitment and achievements, in order to ensure optimal hand hygiene practices
- To facilitate development of an action plan for the facility’s hand hygiene improvement programme
- To identify key issues requiring attention and improvement and to document progress over time through the repeated use of the Framework
Hand Hygiene Self-Assessment Framework (2)

**HOW?**

- Downloading the Framework at [http://www.who.int/gpsc/5may/en/](http://www.who.int/gpsc/5may/en/) and filling out the online form
- Completing the Framework and calculating the score to identify the assigned level of hand hygiene promotion and practice in your health-care facility
Score

Components attributed 100 points

- Each indicator assigned a score
  - Weighted for importance

“Hand hygiene level”

- Inadequate (0-125)
- Basic (126-250)
- Intermediate (251-375)
- Advanced (376-500)
- Leadership
Hand Hygiene Self-Assessment Framework 2010

1. System Change

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 How easily available is alcohol-based handrub in your health-care facility?</td>
<td>Not available</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>available, but efficacy (^2) and tolerability (^4) have not been proven</td>
<td>0</td>
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<tr>
<td></td>
<td>available only in some wards or in discontinuous supply (with efficacy (^2) and tolerability (^4) proven)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>available facility-wide with continuous supply (with efficacy (^2) and tolerability (^4) proven)</td>
<td>10</td>
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<tr>
<td></td>
<td>available facility-wide with continuous supply, and at the point of care (^2) in the majority of wards (with efficacy (^2) and tolerability (^4) proven)</td>
<td>90</td>
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<tr>
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<td>available facility-wide with continuous supply at each point of care (^2) (with efficacy (^2) and tolerability (^4) proven)</td>
<td>50</td>
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<tr>
<td>1.2 What is the sink:bed ratio?</td>
<td>Less than 1:10</td>
<td>0</td>
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<td>at least 1:10 in most wards</td>
<td>5</td>
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<td></td>
<td>at least 1:10 facility-wide and 1:1 in isolation rooms and in intensive care units</td>
<td>10</td>
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<td>1.3 Is there a continuous supply of clean, running water?</td>
<td>No</td>
<td>0</td>
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<td>Yes</td>
<td>10</td>
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<td>1.4 Is soap(^2) available at each sink?</td>
<td>No</td>
<td>0</td>
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<td></td>
<td>Yes</td>
<td>10</td>
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<td>1.5 Are single-use towels available at each sink?</td>
<td>No</td>
<td>0</td>
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<td></td>
<td>Yes</td>
<td>10</td>
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<tr>
<td>1.6 Is there dedicated/available budget for the continuous procurement of hand hygiene products (e.g. alcohol-based handrubs)?</td>
<td>No</td>
<td>0</td>
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<td></td>
<td>Yes</td>
<td>10</td>
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</table>

Extra Question: Action plan

Answer this question ONLY if you scored less than 100 for questions 1.1 to 1.5:

Is there realistic plan in place to improve the infrastructure\(^2\) in your health-care facility?

System Change subtotal /100

System Change subtotal: 50 /100
1. **Add up your points.**

<table>
<thead>
<tr>
<th>Component</th>
<th>Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. System Change</td>
<td>85</td>
</tr>
<tr>
<td>2. Education and Training</td>
<td>60</td>
</tr>
<tr>
<td>3. Evaluation and Feedback</td>
<td>55</td>
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<td>4. Reminders in the Workplace</td>
<td>70</td>
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<tr>
<td>5. Institutional Safety Climate</td>
<td>65</td>
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<td><strong>Total</strong></td>
<td><strong>335</strong></td>
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</table>

2. **Determine the assigned ‘Hand Hygiene Level’ for your facility.**

<table>
<thead>
<tr>
<th>Total Score (range)</th>
<th>Hand Hygiene Level</th>
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<tbody>
<tr>
<td>0 - 125</td>
<td>Inadequate</td>
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<tr>
<td>126 - 250</td>
<td>Basic</td>
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<tr>
<td>251 - 375</td>
<td>Intermediate (or Consolidation)</td>
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<tr>
<td>376 - 500</td>
<td>Advanced (or Embedding)</td>
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Success of SL:CYHs – the roles of all involved

- **Health-care facilities** -
  - **Commit** = register (if not already)
  - **Track progress** = use the WHO Self-Assessment Framework
  - **Plan actions** = address the components of the multimodal improvement strategy and plan reuse of the Framework, and plan and share other 'promotional 5 May 2011' activities

- **Advocates** -
  - at organisational, national and regional level
  - **Promote** key messages, registrations, use of the Framework & all WHO HH tools for improved and sustained hand hygiene practices and ways to promote 5 May 2011 activities

**WHO’s role**: to offer tools and messages of support and maintain the profile of this important patient safety global movement
### Some tools

<table>
<thead>
<tr>
<th>Number</th>
<th>Name Of Hospital</th>
<th>Country</th>
<th>Total number of staff in your Hospital</th>
<th>Total number of inpatient beds in hospital</th>
<th>Year when your hospital was first built or established</th>
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**2011 Free WHO Teledid Series on Infection Control**

In order to participate, visit [http://webbertraining.com/scheduled.php](http://webbertraining.com/scheduled.php).

- **01/02/11, 13:00 pm (CET):** Quality improvement and infection prevention and control (D. Goldman, Boston, USA)
- **06/04/11, 23:00 pm (CET):** Hand hygiene education and monitoring: returning to the WHO “five moments” concept (H. Sun, Geneva, Switzerland)
- **05/05/11, 23:00 pm (CET):** Special lecture for 5 May 2011 (D. Pittet, Geneva, Switzerland)
- **21/05/11, 13:00 pm (Sydney time):** Establishing an infection control programme for acute respiratory infections and surging pandemic preparedness (E.W. Seth, Hong Kong, China)
- **01/11, 23:00 pm (CET):** Highlights and results from 5 May 2011 initiatives around the world (C. Kilpatrick, B. Albrecht, Geneva, Switzerland)
- **11/11, 23:00 pm (CET):** Latest update on Clostridium difficile control (A. Widmer, Switzerland)
- **11/11, 23:00 pm (CET):** MRSA-A is Search & Destroy the way to go? (A. Vos, Utrecht, Netherlands)
- **11/11, 13:00 pm (NYT):** Current perspectives about disinfection and sterilization (W. P. University of North Carolina, USA)
Estimates of the global burden of health care-associated infection are hampered by limited availability of reliable data.

First Challenge area of work on the burden of health care-associated infection: understanding the magnitude of the problem.

On 5 May 2011

- Release of burden of disease related to HAI
- Teleclass by Professor Didier Pittet
- WHO 'statements'
- CCiSC announcements on:
  - Registration numbers
  - Use of the WHO HHSAF
  - Efforts made by health-care facilities and key advocates
Barriers to implementation and to long-term sustainability

- Resistance to improvement by doctors
- Lack of human resources, including to continue hand hygiene compliance monitoring
- Lack of funding for continuous provision of alcohol-based handrubs
- High staff turnover
- Work overload and understaffing
- Coexistence of different cultures
- Discontinuation of support by leaders

The opportunity to address system change, education and training and research and development
Implementation strategy and toolkit for the WHO Guidelines on Hand Hygiene in Health Care

Knowledge & evidence → Action
What is the WHO Multimodal Hand Hygiene Improvement Strategy?

Based on the evidence and recommendations from the WHO Guidelines on Hand Hygiene in Health Care (2009), made up of 5 core components, to improve hand hygiene in healthcare settings:

ONE System change
Alcohol-based hand rubs at point of care and access to safe continuous water supply, soap and towels

TWO Training and education
Providing regular training to all health-care workers

THREE Evaluation and feedback
Monitoring hand hygiene practices, infrastructure, perceptions, & knowledge, while providing results feedback to health-care workers

FOUR Reminders in the workplace
Prompting and reminding health-care workers

FIVE Institutional safety climate
Individual active participation, institutional support, patient participation

World Health Organization
Patient Safety
A World Alliance for Safer Health Care
SAVE LIVES
Clean Your Hands
Thank you

SAVE LIVES:
Clean Your Hands

5 MAY 2011
Where do YOU stand on hand hygiene?

www.who.int/gpsc
savelives@who.int
Prevalence of HAI worldwide

Developed countries

Canada: 11.6%
Scotland: 9.5%
Finland: 9.1%
Switzerland: 10.1%
Korea**: 3.7%
USA**: 4.5%
UK & Ireland: 7.6%
France: 6.7%
Cyprus: 7.9%

Range: 5.1-11.6%

Developing countries

Latvia: 5.7%
Lithuania: 9.2%
Albania: 19.1%
Algeria: 6.8%
Morocco: 17.6%
Tunisia: 17.8%
Brazil: 14.0%
Mali: 10.7%
Tanzania: 14.8%

Range: 5.7-19.1%

at least x 2


http://www.who.int/gpsc/
Facts about health-care associated infection in developing countries

■ The risk of infection is 2-20 times higher than in developed countries, and the proportion of patients infected can exceed 25% (Allegranzi B & Pittet D. ICHE 2007;28:1323-27)

■ BSI rates in neonates are 3-20 times higher and in some countries approximately half of the patients in neonatal ICUs acquire an infection, and case fatality rates may reach 52% (Zaidi AKM et al. Lancet 2005; 365:1175-1188)

■ VAP incidence varies from 10 to 41.7 per 1000 ventilator-days; VAP is associated with a crude mortality ranging from 16% to 94% and with increased ICU LOS (Arabi Y et al. Int J Infect Dis 2008;12:505-12)

■ **WHO systematic review** device-associated infection incidence is 2-18 times higher than in developed countries
First principle of infection prevention

At least 35-50% of all health care-associated infections are associated with only 5 patient care practices:

- Use and care of urinary catheters
- Use and care of vascular access lines
- Therapy and support of pulmonary functions
- Safety of surgical procedures
- Hand hygiene and standard precautions

- Forward plans for WHO Clean Care is Safer Care.....
WHO Patient Safety

Clean Care is Safer Care

SAVE LIVES: Clean Your Hands

Reduction of HAI

Targeted 5 May HH activities
Self-reported factors for poor adherence with hand hygiene

- Often too busy/insufficient time
- Hand hygiene interferes with HCW-patient relation
- Low risk of acquiring infection from patients
- Lack of role model from colleagues or superiors
- Not thinking about it/forgetfulness
- Scepticism about the value of hand hygiene
- Disagreement with the recommendations
- Lack of scientific information of definitive impact of improved hand hygiene on HCAI

Solving the problems with a new approach

1. Before touching a patient
2. Before clean / aseptic procedure
3. After body fluid exposure risk
4. After touching a patient
5. After touching patient surroundings

WHO Guidelines on Hand Hygiene in Healthcare 2009

World Health Organization
Patient Safety
SAVE LIVES
Clean Your Hands
124 countries committed to address HAI
89.3% world population coverage

October 2005 – June 2010
Countries/areas running hand hygiene campaigns
(August 2010, 41 campaigns)
Score

Components attributed 100 points

- Each indicator assigned a score
  - Weighted for importance

“Hand hygiene level”

- Inadequate (0-125)
- Basic (126-250)
- Intermediate (251-375)
- Advanced (376-500)
- Leadership
Barriers to implementation and to long-term sustainability

- Resistance to improvement by doctors
- Lack of human resources, including to continue hand hygiene compliance monitoring
- Lack of funding for continuous provision of alcohol-based handrubs
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- Work overload and understaffing
- Coexistence of different cultures
- Discontinuation of support by leaders

The opportunity to address system change, education and training and research and development
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Based on the evidence and recommendations from the WHO Guidelines on Hand Hygiene in Health Care (2009), made up of 5 core components, to improve hand hygiene in healthcare settings:

ONE System change
   Alcohol-based handrubs at point of care and access to safe continuous water supply, soap and towels

TWO Training and education
   Providing regular training to all health-care workers

THREE Evaluation and feedback
   Monitoring hand hygiene practices, infrastructure, perceptions, & knowledge, while providing results feedback to health-care workers

FOUR Reminders in the workplace
   Prompting and reminding health-care workers

FIVE Institutional safety climate
   Individual active participation, institutional support, patient participation
Hand Hygiene Self-Assessment Framework

WHAT?
■ Validated and systematic tool to obtain a situation analysis of hand hygiene promotion and practices and identify the level of progress within your health-care facility

WHY?
■ To assess the level of progress of your health-care facility with regards to infrastructures, resources, actions, commitment and achievements, in order to ensure optimal hand hygiene practices
■ To facilitate development of an action plan for the facility's hand hygiene improvement programme
■ To identify key issues requiring attention and improvement and to document progress over time through the repeated use of the Framework
Estimates of the global burden of health care-associated infection are hampered by limited availability of reliable data

First Challenge area of work on the burden of health care-associated infection: understanding the magnitude of the problem

Thank you

SAVE LIVES:
Clean Your Hands

5 MAY 2011
Where do YOU stand on hand hygiene?

www.who.int/gpsc
savelives@who.int
5 May 2011
Where do YOU stand on hand hygiene?

The main goal of this year's campaign is for registered health-care facilities and others to **assess their hand hygiene practices** through:

- Use of the WHO Hand Hygiene Self-Assessment Framework
- *We will do this by using the full power of WHO's extent of communications and through cascade communications*

Secondary goals are for everyone, especially non-registered health-care facilities to **commit to hand hygiene** by:

- Registering to the SL:CYHs global annual campaign
- Featuring local activities on local sites (with links on the WHO web pages)
- *WHO will do this through communications, by mobilising key advocates to promote SL:CYHs and by promoting WHO {translated} HH tools*
Self-reported factors for poor adherence with hand hygiene

- Often too busy/insufficient time
- Hand hygiene interferes with HCW-patient relation
- Low risk of acquiring infection from patients
- Lack of role model from colleagues or superiors
- Not thinking about it/forgetfulness
- Scepticism about the value of hand hygiene
- Disagreement with the recommendations
- Lack of scientific information of definitive impact of improved hand hygiene on HCAI

WHO Guidelines on Hand Hygiene in Health Care 2009
Facts about health-care associated infection in developing countries

■ The risk of infection is 2-20 times higher than in developed countries, and the proportion of patients infected can exceed 25% (Allegranzi B & Pittet D. ICHE 2007; 28:1323-27)

■ BSI rates in neonates are 3-20 times higher and in some countries approximately half of the patients in neonatal ICUs acquire an infection, and case fatality rates may reach 52% (Zaidi AKM et al. Lancet 2005; 365:1175-1188)

■ VAP incidence varies from 10 to 41.7 per 1000 ventilator-days; VAP is associated with a crude mortality ranging from 16% to 94% and with increased ICU LOS (Arabi Y et al. Int J Infect Dis 2008; 12:505-12)

■ WHO systematic review device-associated infection incidence is 2-18 times higher than in developed countries
Prevalence of HAI worldwide

**Developed countries**
- Canada: 11.6%
- USA**: 4.5%
- Norway: 5.1%
- Scotland: 9.5%
- Finland: 9.1%
- Switzerland: 10.1%
- Greece: 9.3%
- Italy: 8.3%
- Cyprus: 7.9%

Range: 5.1-11.6%

**Developing countries**
- Latvia: 5.7%
- Lithuania: 9.2%
- Albania: 19.1%
- Turkey: 13.4%
- Lebanon: 6.8%
- Morocco: 17.6%
- Tunisia: 17.8%
- Mali: 18.7%
- Tanzania: 14.8%
- Brazil: 14.0%
- Thailand: 7.3%
- Malaysia: 13.9%

Range: 5.7-19.1%

* Systematic review conducted by WHO, 1996-2008
**Incidence


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at least x 2

World Health Organization

Patient Safety
A World Alliance for Safer Health Care

SAVE LIVES
Clean Your Hands
Implementation strategy and toolkit for the WHO Guidelines on Hand Hygiene in Health Care

Knowledge & evidence → Action

World Health Organization
Patient Safety

WHO Guidelines on Hand Hygiene in Health Care
First Global Patient Safety Challenge
Clean Care is Safer Care

World Alliance for Patient Safety
A World Alliance for Safer Health Care
SAVE LIVES
Clean Your Hands
WHO Patient Safety

Technical work plans with WCC at HUG

Key advocates and stakeholders communications plan

Clean Care is Safer Care

Reduction of HAI

SAVE LIVES: Clean Your Hands

Targeted 5 May HH activities
124 countries committed to address HAI
89.3% world population coverage

October 2005 – June 2010
2nd year of a global campaign

SAVE LIVES: Clean Your Hands

- Influenza
- MRSA
- MDR Gram negative bacilli
- Diarrhoea

5,000 5,500 6,000 6,500 7,000 7,500 8,000 8,500 9,000

= number of hospitals registered

4 May 2010
11'543 hospitals
Countries/areas running hand hygiene campaigns (August 2010, 41 campaigns)
First principle of infection prevention

At least 35-50% of all health care-associated infections are associated with only 5 patient care practices:

- Use and care of urinary catheters
- Use and care of vascular access lines
- Therapy and support of pulmonary functions
- Safety of surgical procedures
- Hand hygiene and standard precautions
- Forward plans for WHO Clean Care is Safer Care——
Facilities registered – January 2011 update

12,298 registered health-care facilities from 145 countries =
Approx 7 mio health-care staff, and 3 mio patient beds
An update on WHO "Clean Care is Safer Care"

Launched 2005

2 February 2010
Exploring possibilities of working together – update for the second meeting

Elizabeth Mathai
Sustainable improvement in hand hygiene at the point of care in all settings everywhere
Potential areas of collaboration

- Improving access to essential commodities
  - ABHR
  - Water, soap, towels etc
- Raising awareness and sharing knowledge
- Participating in identified research areas
Alcohol-based hand rub market

North America
Sales are driven by producers’ promotional activity and financial incentives
50 mn litres

Europe
Sales are driven by strong government support
141 mn litres

Asia Pacific
Increasing concerns about infectious diseases drive growth in the region
58 mn litres

Latin America
Major investment in private clinics and hospitals have been driving sales
37 mn litres

Africa and the Middle East
Low awareness and limited availability determine growth
5 mn litres

Australasia
Sales are driven by government support and initiatives of non-profit organisations
4 mn litres

Global sales in 2007: US$3 billion in value and 295 million litres in volume
Raising awareness and sharing knowledge

Health Care Workers at the point of care

WHO has made recommendations and tools to facilitate

*Industry can amplify efforts*
- Resources
- Wider access to point of care
- Channels and methods
### Benefits of working together

<table>
<thead>
<tr>
<th>WHO</th>
<th>Collaboration</th>
<th>Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines Policies, standards</td>
<td>Rapid scale up</td>
<td>Channels for sale and promotion</td>
</tr>
<tr>
<td>Bring partners together</td>
<td>Demand creation</td>
<td>Demand creation</td>
</tr>
<tr>
<td>Ensure quality</td>
<td>Consumer information</td>
<td>Reaching HCF</td>
</tr>
<tr>
<td>Efforts for universal access</td>
<td>Product availability</td>
<td>Production, transport, delivery</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Influencing price</td>
<td>Research, needs assessment for implementation</td>
</tr>
</tbody>
</table>
Several successful examples of collaboration

Through WHO/ WCC reaching Countries

- Medicines availability
- Bednet availability
- Awareness raising
- Research – operational/implementation developmental
Progress so far

First meeting in 21 September 2010

- To gather preliminary information on whether and how industry can further the WHO goal of sustainable improvement of hand hygiene in health-care facilities around the globe

Report is available on the web

Summary points from the first meeting

Clear enthusiasm for collaboration

Modalities needed to work together upholding
WHO policies, guidelines and values and
Interests, policies of those working with WHO

Corporate responsibility could be an avenue

Concerns
Inherent conflict of interest
Competitors working together
Summary points (contd)

Areas explored for potential collaboration
  Education, system change and research

WHO role, collaborator role and benefits to country/HCF were discussed

Three groups produced some useful thoughts for us to proceed further
  - a platform for interactions
  - to explore further the idea of micro-production of ABHR in low resource settings
The platform idea is currently being addressed

WHO
- Transparency
- Equal opportunity
- Others

Industry
- Confidentiality of information shared
- Equal opportunity to respond
Second meeting on February 2 2011

Aims
To keep the momentum going
To take discussions on the modality of working together forward

Three groups as for the first meeting, discuss
Use of a web based platform as you see it - considering WHO role, collaborator role and benefit to the target group for each item proposed through the platform

Further input on ‘micro-production’ model
Other points for consideration

Your company’s active participation in this platform

Signing up to certain stipulations for participation etc

Your expectations from participating