In order to sensitize countries to patient safety, the first regional workshop on patient safety issues took place in the African region, in Kigali, Rwanda, from 10 to 12 December 2007.

The workshop was mainly related to the First Global Patient Safety Challenge “Clean Care is Safer Care”, focusing on the importance of health care-associated infections and their prevention through raising awareness and getting country commitment, as well as improving simple measures such as hand hygiene among health-care providers.

Participants from 19 countries (Botswana, Ethiopia, Gambia, Kenya, Lesotho, Liberia, Malawi, Mauritius, Namibia, Nigeria, Rwanda, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) attended the meeting.

Main objective of the Workshop

The principle objective of the workshop was to raise country awareness on patient safety issues in the African region and to describe the mandate and activities of the First Global Patient Safety Challenge, 'Clean Care is Safer Care.'

Specific objectives:

- To identify the most important patient safety issues in the African region and describe the structure and mandate of the World Alliance for Patient Safety
- To describe methods for detecting adverse events during health-care delivery
- To develop recommendations for national policies and strategies to improve patient safety
- To identify priorities and feasible approaches to improve the quality of care in health-care settings
- To understand the impact of health care-associated infection in terms of the epidemiological magnitude of the problem, but also consequences on patient safety and costs
- To understand the various tools, guidelines and other training materials developed by WHO to support countries fighting health care-associated infections, in particular to improve hand hygiene practices in health care
Workshop Summary

The workshop included plenary sessions, working groups and round table discussions.

Ms Helen Hughes outlined the issues of patient safety and prevalence in a presentation on the work of the WHO World Alliance for Patient Safety. The patient safety programmes of the Alliance were outlined including the Global Patient Safety Challenges (Clean Care is Safe Care and Safe Surgery), Research, Patients for Patient Safety, Safety Solutions, recognising the contribution to this global work within Africa.

Dr J.B Ndihokubwayo highlighted that patient safety is an emerging and crucial issue also in the African region. The opportunities and challenges for patient safety in AFRO were covered and some actions to be initially undertaken were proposed.

Presentations were made also by the WHO World Alliance Patients for Patient Safety Champions, Ms Robinah Kaitiritimba, from Uganda, and Mr Cosmas Kalwambo, from Zambia, on patient perspectives in patient safety and shared learning from their in-country activities on patient engagement.

Dr Fikile Sithole, from the Council for Health Service Accreditation of Southern Africa, from South Africa and Ms Janet Musia, from the Aga Khan University in Kenya, presented on the methodology to investigate incidents in health care in Africa, within the framework of two WHO World Alliance prevalence studies, and to promote patient safety through improving the quality of care in Africa.

Country voices: Representatives from three countries (Seychelles, Nigeria and Zimbabwe) outlined patient safety issues within their countries, prevalence, strategies and their impact.

Professor Andreas Voss, from the Radboud University Nijmegen Medical Centre, in The Netherlands, was the invited expert on infection control. According to his extensive experience and scientific knowledge, he outlined the scientific evidence behind hand hygiene promotion and gave a comprehensive overview of essential prevention methods.

The objectives and strategies of the First Global Patient Safety Challenge were presented by Dr Benedetta Allegranzi and Dr Cyrus Engineer from WHO-Geneva. The main topics covered were: methods to develop advocacy strategies and tools to ensure the implementation of effective branding and marketing foundations and to catalyze political commitment at country level, the global epidemiological and economic impact of health care-associated infection, the WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft), and the WHO multimodal hand hygiene improvement strategy and tools.
Dr Benedetta Allegranzi, Dr Cyrus Engineer and Ms Helen Hughes facilitated working groups and round table discussions on patient engagement in patient safety, advocacy and raising political commitment as well as on hospital associated infection.

Recommendations for improving patient safety and improving infection control in African countries were developed.

Detailed breakdown of the Workshop

DAY 1: MONDAY, 10 DECEMBER 2007

Welcome and opening remarks: This session included presentations from the Minister of Health of Rwanda, the WHO Representative of Rwanda, the representative of the World Alliance for Patient Safety and the WHO AFRO Patient Safety focal point. The presentations emphasized the importance of addressing patient safety, set the African context for work on patient safety and collaboration with the WHO World Alliance for Patient Safety programmes. The mandate of the World Alliance for Patient Safety was outlined along with major patient safety issues worldwide and in the African region and the opportunity to partner with patients and families.

Session 1: Introduction to patient safety

Patient Safety and prevention of health care-associated infections in Rwanda
Dr Bonaventure Nzeyimana, Representative of the Ministry of Health of Rwanda
The presentation described the situation related to specific patient safety issues in Rwanda. In particular actions to build quality and accreditation system of health-care institutions and to improve waste management and injection safety were described. As regards implementing "clean care", the following challenges were highlighted: need for national leadership and capacity-building at different levels, importance of involvement of local partners (patients), dissemination of guidelines, need for reliable data.

The World Alliance for Patient Safety and the most important themes for Patient Safety and the burden of incidents in health care
Ms H. Hughes, World Alliance for Patient Safety, WHO HQ
The presentation described the nature, prevalence, economic and human cost of patient safety, errors and harm; 1 in 10 admissions to hospitals in developed countries result in unintentional harm to patients. Unsafe systems where failures of equipment, of training, of poor decisions and lack of critical information, lack of resources, supervision and the absence of adherence to clear clinical protocols can result in unsafe care where patients are unintentionally harmed. The 2004 WHA Resolution on Patient Safety was unanimously adopted by all Member States to address this issue. The role of the WHO World Alliance for Patient Safety was outlined; to promote awareness and political commitment and establish expert-led technical programmes to improve patient safety worldwide. These programmes were outlined, recognizing the contribution being made by experts from countries within AFRO. Approaches being used to address patient safety in counties were described, together with opportunities and challenges to implement these within AFRO. The importance of listening to and engaging patients in all patient safety improvement activities was emphasized and participants watched the DVD 'Patient Safety: Patients' Voices' produced by the Alliance Patients for Patient Safety programme.
Session 2: Patient Safety in Africa

Overview of patient safety issues in the African region
Dr J.B Ndihokubwayo, Focal point for Patient Safety, WHO-Regional Office for Africa

The presentation highlighted that patient safety is an emerging but crucial issue in the African region. Weak health systems and shortage of human resources, crumbling infrastructure and management capacity have led to a situation in which the likelihood of adverse events is high and proportionately increases with the systemic and infrastructural challenges. Following the description of the current situation, Dr Ndihokubwayo listed ongoing and planned actions to address the problem at the regional level. In particular, several surveys have been conducted in some African countries to assess the epidemiology of adverse events during health-care delivery and national/hospital steering committees for patient safety have been established and are being linked together through a regional network. More importantly, a paper entitled "Patient Safety in the African health-care services: issues and solutions" will be presented at the Regional Committee in September 2008 to catalyse political commitment from Member States to develop patient safety policies and practices. We have to continue encouraging the countries to create a health-care environment with a culture of vigilance and cooperation that exposes the weaknesses that can combine to cause error.

The methodology to investigate incidents in health care in Africa
Ms Janet Musia, Department of Pediatrics, Aga Khan University, Kenya

The methodology used to conduct a survey on adverse events in two hospitals in Kenya and to validate collected data were described. Challenges and constraints to carrying out such research in two different African settings (a university hospital and a rural hospital) were especially related to the recruitment of medical investigators’, information-finding within the records, technical difficulties with computer equipment and internet connection. Extremely positive sides of this experience were the fact that local solutions to overcome obstacles were found and that local staff encouraged and actively participated in the survey development. Major stakeholders are eagerly awaiting the findings of this very fulfilling experience and its contribution to improving patient safety in Africa.

Promoting patient safety through quality of care improvement in Africa
Dr Fikile Sithole, Council for Health Service Accreditation of Southern Africa, South Africa

The methods used by the Council for Health Service Accreditation of Southern Africa to detect adverse events were described. Written reports are sent by hospitals to the District Unusual Incident Committee which scrutinizes the documents, judges the accuracy and reliability and makes consequent actions to react. Another method is Medical Record Review, being implemented in pilot hospitals to evaluate the applicability of standard definitions in developing countries and to assess adverse event rates. Average rates of 7% were detected in two teaching hospitals; some examples were given. A third method to overcome some drawbacks of the previous ones was developed and is called Incident Monitoring. It consists of a computerised system for monitoring, analysing, reporting and managing problems ranging from near misses to sentinel events across the entire spectrum of health care. Events are scored according to their likelihood to happen and severity of consequences. Results of pilot testing of this system were presented. Many incidents with potential to cause serious harm and which would not normally be reported, were picked up. To this method, a quality and accreditation approach was further added and a new enriched approach was tested in 24 hospitals with very positive results. In addition, the Council experience in managing the reactions of staff who err was presented with many useful insights about cultural issues. Finally, findings about the interrelationship between discipline and safety (human error, negligent conduct, reckless conduct, knowing violations) and learning from reporting systems were put forward as major outcomes of this invaluable work.
Session 3: patients for patient safety in Africa

Patients for patient safety: patient voices in Africa
Ms Robinah Kaitiritimba, WHO World Alliance Patients for Patient Safety Champion, Uganda and CEO of UNHCO

The presentation focused on the experiences of UNHCO with community empowerment and patient safety. Robinah is a WHO World Alliance Patients for Patients Safety Champion. Patient Safety is an important factor in the treatment and prevention of illness, a major component of the right to health, embracing rights & responsibilities to: information, participation/representation, choice, quality care, treatment by named health worker, and the role of patients in safety enhancement is critical but often ignored and undervalued. Research shows untapped patients’ potential could change the whole spectrum of quality and address major current challenges in health. UNHCO creates awareness of patients rights and obligations, community empowerment and sensitization, strengthening feedback and community participation in health care and patient safety, working with the MoH and others, the development of a Patient Safety Campaign, coordinating civil society and patient organizations and building their capacity and providing leadership and patient reporting of error and harm. Constraints to patient participation and responsiveness were outlined, together with the output of a survey on consumer responses on how best their voices can be heard and a summary of what needs to be done: Build leadership capacity for Safety, coordination and strengthening regional efforts, create awareness for all players (governments and advocates), sensitize and protect health-care providers, document and learn from experiences, re-visit systems and procedures, incorporate safety and strengthen implementation.

Patients for patient safety: patient voices in Africa
Mr Cosmas Kalwambo, WHO World Alliance Patients for Patient Safety Champion, Zambia, and founder of the Patients Alliance Leading Safety and Risk Management Foundation

The presentation outlined the work of the Patients Alliance Leading Safety and Risk Management Foundation, whose aim is to promote patient safety and quality health-care for all Zambians. Patients can play an important role in enhancing the safety and quality of their care by becoming active, informed members of their care team. The Foundation is leading patient safety in Zambia, is passionate about quality, is patient-focused and are partners with health-care providers and is registered as a foundation with a growing number of patients organizations (epilepsy, diabetes etc). The Foundation's objectives address four major strategic issues: Service delivery support and rights awareness, Institutional development, policy influence and Advocacy and Capacity development and resource mobilization.

Session 4: Working groups on patient safety

WG 1: Building and sustaining political commitment on patient safety.
Facilitators - Dr J.B. Ndihokubwayo and Dr Cyrus Engineer

This working group comprised members who belonged to Ministries of Health in their respective countries and members who were familiar and interested in political engagement. Members first identified the obstacles they faced in gaining political commitment on patient safety and reasoned among themselves.

Obstacles and key issues identified by the group included the following:

- Magnitude of problem unclear (e.g. number of adverse events, near misses or sentinel events unavailable). In contrast there was no dearth of information for established diseases such as HIV, TB etc.
- Professionals consider practice of medicine to be "safe" and shift blame to system or other people.
• Root causes associated with sentinel events are seldom made known or publicized.
• Absence of funding and/or surveillance systems for capturing unsafe events or practices

The group's recommendations included:

**Building political commitment on patient safety**

1. Collecting baseline data on the level of safety within hospitals
2. Using this data for advocacy to place the issue of patient safety high on the political agenda in all countries
   - Developing key messages to be communicated
   - Identifying and engaging partners to influence policy-makers/politicians
   - Using the data to influence and mobilize funds
3. Identify a dynamic person in each country who will be the patient safety champion and will catalyze the advocacy process
4. Establishing formal patient safety programmes in each country with a budget

**Sustaining political commitment on patient safety**

1. Continue advocacy efforts. Engage lobbyists and the media to periodically reinforce relevance of the issues.
2. Develop a vision and policy document for patient safety in all African countries
3. Establish a strategic plan for patient safety in each country. Implement the plan
4. Use monitoring, evaluation and feedback systems to ensure continuity. Develop and review simple patient safety indicators. Once we start measuring, it is hard to shy away from it. These patient safety indicators could be publicized. Policy-makers and the public would become familiar with this information
5. Use positive feedback from patients and community, which develops popularity among ministerial candidates and those currently in office.
6. Build patient safety into the teaching curricula of medical, nursing and other health-care professions.

**WG 2: Identifying patient safety issues and priorities in African hospitals.**

Facilitators: Ms H. Hughes and Dr B. Allegranzi

Professionals working in hospitals with responsibilities both at clinical (infectious disease, infection control) and management level participated in this working group. The discussion addressed the most important patient safety issues in Africa and was aimed at identifying the reasons why adverse events occurs in African health-care settings, the most frequent adverse events in these contexts and what would be the most feasible solutions at hospital level to improve the current situation.

**Reasons for adverse events**

1. Lack of funds
   1. at health-care facilities
      - Medications/drugs
      - Lack of personnel
      - Lack of equipment
      - Lack of diagnostic tools
      - Inadequate structures
   2. from the patient's side
2. Absence of protocol/policies/guidelines/clinical pathways – implementation
3. Inadequate training/knowledge/skills
4. Lack of adequate organization
   1. Teamwork/suboptimal use of skills/task definition/leadership/planning
5. Poor communication/attitude/documentation
   • Handover
   • Patient – health-care worker
6. Social/Cultural Issues
7. Lack of consent

**Most frequent adverse events in health care in Africa**
- Hospital Acquired Infection
- Medication errors
- Misdiagnosis
- Misidentification of patients
- Wrong site surgery
- Unnecessary investigations
- Psychological trauma

**Most feasible solutions**
- Develop – disseminate – implement – monitor – evaluate guidelines/protocols
- Improve attitudes/behavioural change
- Training
- Championship/leadership
- Advocacy groups/technical committees

**WG 3: Patient participation**
Facilitator: Ms H. Hughes

This working group considered Patients For Patient Safety advocacy in some countries and developed key recommendations. How are where to begin? The group considered that patient engagement in patient safety should be promoted and supported by Ministry of Health Quality Assurance Units and WHO Representatives in countries, with and through existing NGOs, advocacy groups (including disease-specific groups), existing networks (eg medical associations, patient organizations), individual advocates (including the development and support of Patients for Patient Safety Champions in Africa), as well as the media. The group considered that the following actions were needed (both before and after a PFPS workshop in Africa), with the support of WHO: prepare material on patient safety (seeking input from Champions) and presentations, link people by e-mails, phone calls etc, identify NGOs within each country for collaboration with AFRO workshop participants, arrange a meeting with QA(?) Director/Committee of all hospitals to raise awareness, plan next steps and secure funding for the above-mentioned activities.
Key messages given by participants during Day 1

The participants discussed developing recommendations for their Health Ministries, the WHO AFRO Regional Committee, the WHO World Alliance for Patient Safety, health-care workers, providers, patient organizations and civil society, patients and media in AFRO for disseminating information on patient safety, advocating and publicising action needed to make care safer and for accountability & monitoring. Recommendations were developed as follows:

Recommendations to gain political commitment included:

1. An intense advocacy campaign on patient safety in collaboration with AFRO
   - Generate awareness
   - Use baseline data
2. Brief selected persons on patient safety
   - These persons to facilitate the creation of advocacy groups
3. Advocacy Groups
   - Partners
   - Influence policy-makers/politicians
   - Gather data to influence & mobilise funds
4. Develop patient safety programmes for each Member State
5. For sustainability
   - develop a strategic plan to implement patient safety in countries
   - develop & implement a patient safety policy document
   - monitoring, evaluation & feedback

Recommendations for health-care providers in AFRO included:

1. Set up patient safety working-groups through hospital structures/managers
2. Establish Hospital Advisory Committees for patient safety with remit to include:
   - Ombudsman/client liaison role
   - To investigate patient complaints
   - To include community, religious leaders & patients
3. Engage hospital staff on patient safety
   - Staff and consumers
   - Develop a patient charter together
4. Hospital Advisory Committees to establish guidelines on
   - Infection control
   - Drug issue
   - Communications
   - Patient safety policies
5. Set up review system on patient safety
   - eg patient environment relations committee
   - Data collection
6. Set up health task groups

Recommendations for engaging patients in patient safety
1. Prepare package of awareness, presentation material and plan (English, French and Portuguese)
2. Identify countries and country stakeholders through WR/WHO (English, French and Portuguese)
3. Secure funding - prepare budget and present to WHO AFRO Regional Office
4. Carry out planned meetings in counties (AFRO Regional Office)
5. AFRO Patients for Patient Safety Workshop in 2008

**DAY 2: TUESDAY 11 DECEMBER 2007**

SECOND PART OF THE WORKSHOP: FOCUSING ON "CLEAN CARE IS SAFER CARE"

Session 1: burden of health care-associated infection (HAI) and preventive approaches

The global burden and economic impact of HAI
Dr B. Allegranzi, First Global Patient Safety Challenge, WHO, HQ
The presentation was aimed at drawing a picture of HAI epidemiology and its impact worldwide. The speaker highlighted that estimates of the global burden of HAI are hampered by limited availability of reliable data, in particular in developing countries. Most relevant figures on HAI morbidity, mortality and costs in different settings and countries were reported. The following step was to scrutinize the main obstacles to infection control in developing countries and the consequences of poor infection control policies and practices. Finally, the speaker listed possible solutions to be implemented to improve the current situation and cited several examples showing that HAI surveillance and infection control can be feasible, even in settings with limited resources.

The First Global Patient Safety Challenge “Clean Care Is Safer Care”
Prof D. Pittet, Lead, First Global Patient Safety Challenge, University of Geneva Hospitals, Geneva, Switzerland
This was a recorded speech because Prof. Pittet was ultimately unable to attend the meeting due to health problems. He described the objectives and scope of the First Global Patient Safety Challenge, congratulated the Minister of Health of Rwanda who had signed the pledge the day before and stimulated the participants to catalyse political commitment to the Challenge and promote infection control initiatives linked to it in their countries.

National commitments and country launch events
Dr C. Engineer, First Global Patient Safety Challenge, WHO, HQ
Country commitment is one of the key objectives of the First Global Patient Safety Challenge. Ministers of health from WHO Member States are invited to make a formal statement committing to address HAI in their country. The pledging process was described as well as the contents of the pledge. The session also provided the participants with information on actions that countries have started after similar statements were signed e.g. campaigns, allocating resources, shaping policy etc. Country delegates were urged to provide relevant examples of neighbouring countries that had pledged to their ministerial colleagues, e.g. Rwanda, in order to continue the wave.

Advocacy and the First Global Patient Safety Challenge
Dr C. Engineer, First Global Patient Safety Challenge, WHO, HQ
The session was initially designed to engage communications professionals, editors and journalists to participate in and support "Clean Care is Safer Care", strengthening and building links at regional level.
However, it was also intended to inform and train technical people and academics on the simple ways to work with media and generate publicity. Concepts of advocacy, including its definition, use and success in other programmes were introduced to the participants. This was followed by group work where participants were asked to address the following:

- Building and sustaining political commitment
- Expanding partnerships and networks
- Engaging patient involvement
- Attracting media coverage

**Country voices**

**Nigeria, Dr E. J. Suberu**

Dr Suberu listed the main actions in place in his country related to patient safety. In particular the Ministry of Health has started to develop policies on patient safety, including security of healthcare workers. Programmes are in place related to safe blood (national blood transfusion service), vigilance systems for responding to adverse drug reactions, injection safety, clinical waste management, with training in progress (a collaboration with the John Snow Incorporated Foundation). In addition, an institution has been established, the National Food & Drug Administration. Major constraints to improvement were also described; these are lack of funding, personnel, continuous training and scarce access to water in rural health institutions.

**Zimbabwe, Mrs A. Maruta**

The speaker described the Standards that the Infection Prevention and Control Department has developed in her country. The implementation of these Standards is the responsibility of the Infection Prevention and Control Team working in all health-care facilities. Membership and activities of the team were very well defined. A Infection Prevention and Control Committee has also been established in each facility with the task of focusing on most critical infection control issues and to react in case of emergency. The performance indicators used to evaluate the work of the Team were also described.

**Seychelles, Dr D. Louange**

Dr Louange described the main demographic features of his country and the institutions currently involved in infection control activities. In particular, he described the main functions of the Infection Control Committee which are: assessment of facility and programme needs, development and implementation of infection control policies and procedures, evaluation of surveillance information, infection prevention and control measures, accreditation and regulatory activities related to infection monitoring, prevention and control. In addition, he reported on the activities of the Clinical Audit Committee that have conducted a hand hygiene audit. The latter is aimed at evaluating the hand washing equipment and techniques and assessing staff compliance and attitudes towards hand washing in surgical wards. The methods comprised hand hygiene direct observations and a questionnaire. Compliance rates were not reported, but in general equipment was considered largely insufficient, hand washing was not correctly performed and awareness about the importance of hand hygiene was very low. Based on these findings, actions to improve things were organized, including policy and guideline development and educational activities.

**WORKING GROUPS**

**WG 1: Infection control constraints and minimum standards for infection control in the African Region at national level.**

Facilitator: Dr J.B Ndihokubwayo
Participants were initially asked to identify the most relevant constraints to implementing infection control activities at the national level in their countries.

**Constraints:**
- Absence of policies
- Absence of guidelines on infection control
- Insufficient funds
- Inappropriate organizational structures & coordination
- Lack of data collection
- Inadequate human resources
- Lack of monitoring & evaluation
- Insufficient commitment of partners
- Inadequate infrastructure
- Insufficient sensitization of health-care workers to policies
- Poor waste management

Following this discussion, **solutions** were identified:

1. **Policy**
   - Perform a situational analysis
   - Declaration of principles
   - Formulation of costed strategic plans / action plans

2. Develop, disseminate & adapt national guidelines on infection control

3. Develop training materials
   - Curriculum development
   - Training of trainers

4. Structures & coordination
   - Infection control focal point at Ministry of Health with an action plan
   - Linkages with implementers & partners (developing terms of reference for partners)

5. Communication with the hospital: high-profile team leader

6. Strengthen data collection
   - Hospital information management systems
   - Develop indicators & strengthen analysis
   - Perform baseline surveys

7. Monitor & evaluate for sustainability

8. Human resource development & motivation: Incentives

9. **Infrastructure**
   - Design (engineering infection control)
   - Install water points & basins
   - 24-hour water & electricity supply
   - Availability of soap, single use towels or hot air drying
   - Gloves
   - Antiseptics
10. Waste management
11. Laboratory support: Bio safety/Laboratory security
12. Involve all health workers in infection control activities
13. Talk to consumer societies

**WG 2: Infection control constraints and minimum standards for infection control in the African Region at facility level.**

Facilitator: Dr B. Allegranzi

Participants were initially asked to identify the most relevant constraints to implementing infection control activities at facility level in their countries.

Most relevant obstacles were: lack of financial resources, lack of knowledge and skilled staff, lack of equipment, negative attitudes, unaccountability, system barriers, cultural barriers.

Following the discussion about their experiences attempting to improve infection control outcomes, participants were invited to shortlist the most feasible actions with available resources to improve infection control in their facility. The recommended minimum requirements were the following:

1. Improve HH practices
2. Raise admin awareness
3. Establish an Infection Control Committee
4. Training and Education
5. Monitoring and Evaluation
6. HCW protection
   - Vaccination
   - PEP

**WG 3: Advocacy and partnership building around the First Global Patient Safety Challenge.**

Facilitator: Dr C. Engineer and Ms H. Hughes

Participants were asked to address the following:

- Building and sustaining political commitment
- Expanding partnerships and networks
- Engaging patient involvement
- Attracting media coverage

In relation to these issues, the group was asked to identify the top recommendations for addressing each issue and the most important next steps.

**Building and sustaining political commitment**

- Use the power of information e.g. data, to drive home the point
- Deploy and lobby hard. Use proven "A" framework for advocacy model
- Apply pressure from media and other partners
- Engage regional networks
- Identify review and feedback measures to maintain high visibility for HAI
Expanding partnerships and networks

- Establish an AFRO network for patient safety with one member from each country. Reducing HAI should be at the top of its agenda.
- Identify other willing partners e.g. NGOs, which can influence decision-making and mobilize resources.
- At the least, we need to set up infection control societies in our respective countries. These would then trigger other possibilities for extended networks and partnerships.

Engaging patient involvement

- Develop a “patient’ charter” of rights and responsibilities. Patients are often not aware of their rights and often make many assumptions which are not always correct.
- Our health-care system is not very mature yet, so a phased approach would be better.
- Sensitization would help bolster courage e.g., through a regional event.

Attracting media coverage

- Data and information needs to be readily available. There is no systematic data collection. Scarce and questionable anecdotal information may not be good enough. Fresh new data e.g., HAI rates, etc. are needed to attract media interest.
- Studies to provide these data need to be tangibly supported.

Session 2: infection control standards

The most effective approaches in infection control
Prof. Andreas Voss, Radboud University Nijmegen Medical Centre, The Netherlands.

Prof. Voss focused on the importance of health-care associated infections and the risks to acquire them. Subsequently, he described old and new infection control approaches and cited studies to prove the effectiveness of prevention measures. In particular, he focused on the rationale behind standard precautions and on risk factors and prevention of device-related infections. He adapted his presentation to the setting and also emphasized the approach from a developing country perspective.

The scientific evidence behind hand hygiene promotion
Prof A. Voss

Prof. Voss explained the importance of hand hygiene as the most effective prevention measure. He presented the history of the multimodal strategy for hand hygiene improvement, showing that the essential elements of the multimodal approach originated from studies investigating the reasons why health-care workers do not comply with hand hygiene recommendations.

Key messages given by the participants on day 2
Participants were very involved during the discussion and demonstrated an understanding of the importance of infection control as a patient safety issue. They also highlighted the need to position it at a high level on the political agenda in their countries. Emphasis on the value of government commitment and on the positive impact of improved advocacy and communication strategies was very appreciated by participants. The attempt, by both speakers and participants, during the working groups to identify simple feasible actions was very instructive for all. Despite efforts deployed by individuals or groups to improve the situation, the lack of financial and human resources and expertise dedicated to infection control was strongly highlighted as a major need.
obstacle to improvement in developing countries. The limited access to reliable local data to measure healthcare-associated infection is also considered a significant impediment to targeted prevention; difficulties to perform surveillance with limited diagnostic support were considered and a feasible model of surveillance was suggested.

DAY 3: WEDNESDAY, 12 DECEMBER 2007

Session 3: The implementation strategies of the First Global Patient Safety Challenge

The WHO Guidelines on Hand Hygiene in Health Care and their implementation strategy and tools.
Dr. B. Allegranzi

Philosophy and recommendations of the WHO Guidelines were presented together with the implementation strategy and tools. The function of each tool was explained in detail. The session covered the following specific practical aspects of hand hygiene improvement:

1. The 5 components of the WHO Multimodal Improvement Strategy
2. The 5-Steps to implementation
3. The 5 moments for hand hygiene
4. The local production of alcohol-based handrubs

Practical plan for using the WHO hand hygiene improvement strategy and tools in health-care settings
Dr. B. Allegranzi

Practical examples of implementation in pilot sites were given in this session to enable participants to understand how to put into practice the strategy. In particular, given that the overall strategy might be perceived as too complex, participants were guided from the minimum required surveys and actions to achieve hand hygiene improvement in their facilities.

Practical training on how to use alcohol-based hand rub and Training and application of the hand hygiene observation tool
Dr. B. Allegranzi

Dr. Allegranzi showed the technique to use alcohol-based handrubs and invited the participants to perform handrubbing at the same time. Sequences of the WHO Training Film were shown to give examples of the "five moments for hand hygiene" and to explain the method for the observation of hand hygiene practices and calculation of compliance.

Key messages given by the participants on day 3

Participants were very excited by the WHO hand hygiene improvement strategy and, in particular, to have available ready-to-go tools to be implemented in their facilities. During the discussion, they clearly demonstrated a high level of knowledge and experience in the field of infection control. This aspect showed that there are no major barriers to the understanding of the proposed strategy. Participants were very encouraged by the practical examples of other developing countries already implementing the strategy and many of them manifested the intention to adopt it upon return to their facilities. Nevertheless, they clearly pointed out the obstacle of financial constraints and the lack of availability of alcohol-based handrubs. Interestingly, they did not perceive any cultural or religious barriers to the conclusion of a desired system change.
Results of a survey to assess participants' appreciation of the workshop

Before returning to their countries, participants were asked to complete a brief, anonymous questionnaire scoring their answers between "strongly agree" and "strongly disagree" with some proposed statements.

Nobody disagreed (more than 50% strongly agreed in all cases) with the fact that the topics presented covered their expectations, the training material/tools provided were appropriate, the sessions added to their learning on patient safety, the presenters were well prepared and addressed their questions and concerns, and the sessions and working groups were practical and useful.

Whereas most participants agreed that the workshop was well organized, most complained about travel constraints that affected their participation and some requested improved accommodation and document provision before the beginning of the workshop.

Through specific comments, some participants expressed their wish that WHO-AFRO set up a task force to work on the specificities of African facilities and health systems to address patient safety issues. Another participant asked that another version of the training film be prepared in African settings. Some participants suggested the idea of organizing a visit to a local hospital, social events and tour of the city during the workshop. Some participants added further comments of appreciation on the organizers' commitment and technical skills and asked for the organization of further similar events.