



International Federation of Infection Control

# IFIC e-News

<http://www.theifc.org/>

## FUTURE IFIC CONGRESSES

### CHILE

14-17 October 2008  
9<sup>th</sup> IFIC Congress  
Santiago  
Chile

[www.sociedad-iih.cl](http://www.sociedad-iih.cl)

### LITHUANIA

6-11 October 2009  
10<sup>th</sup> IFIC Congress  
Vilnius  
Lithuania

## Chair Update

Dear IFIC members,

The multi-organizational infrastructure of IFIC is probably unique within infection control yet it is precisely this mix of individual societies that not only gives the Federation its character but is precisely its major strength. The fusion of associations that span the breadth of our globe provides a tremendous opportunity for networking and collaboration that would otherwise be difficult to achieve.

This interaction remains a key goal for the IFIC Board. However getting there would be impossible without the involvement of the member societies. As in anything else in life, the intensity of participation and feedback from the different member societies varies: some are extremely pro-active, others less so.

Nevertheless we invite all IFIC members to send in their suggestions as to how we can continue to grow together and achieve a stronger, more effective Federation. Send us an email, use the "Contact Us" feature in the website, come over to the IFIC Booth at the annual conference, talk to any Board member you may meet at a local or international meeting. Let us know how we can serve you and your association better and improve your possibility to network both within your region and beyond.

Thank you,  
Michael Borg  
Chair, 2008 IFIC Board



Michael Borg  
Chair, 2008

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## Invitation to IFIC Congress 2008

IFIC and the [Chilean Society of Infection Control and Hospital Epidemiology](http://www.theifc.org/) extend an invitation to all professionals involved in the fields of infection control, hospital epidemiology and quality improvement to gather in Santiago in 2008. Together we will build a better future for infection control and patient safety everywhere. International experts will give keynote lectures and participate in symposia. Submission of free papers is strongly encouraged; IFIC will support a number of delegates to attend through scholarships, details about which will be available on [www.theifc.org](http://www.theifc.org) the Federation's website. Pharmaceutical and medical companies are welcome to support this unique event through their participation in the Congress exhibition and industry symposia. <http://www.ific2008.cl/>

Please plan on attending the  
Annual General Meeting on  
Wednesday October 15 at 5 p.m.

9th Congress of the  
International Federation of  
Infection Control



Santiago, Chile  
14 - 17 October 2008

## IFIC - SIG Design, construction and renovation

### Recommendation: Design of a general ward

Donations to support the work of the Federation are welcome. Donations can be designated for either general or scholarship funds. The scholarship fund was established to increase participation at IFIC conferences for under-funded member delegates.

Contributions to IFIC can be sent to:

Pamela Allen  
47 Wentworth Green  
Portadown  
Co Armagh  
BT62 3WG  
N Ireland UK  
Email: [info@theifc.org](mailto:info@theifc.org)

The primary aim of these recommendations is to provide a simple and easy to use help for planning and designing a ward. For special needs and departments, additional planning may be necessary. These recommendations are for hospitals in which clean water supply and electricity are available for 24 hours. All surfaces should withstand cleaners/disinfectants. Carpets seem to pose no additional risk with respect to infections, but get dirty very easily and need a high rate of care for a proper appearance. It is also harder to push equipment with wheels on carpeting. A maximum of about 40 beds on a ward should not be exceeded because of very long distances for the staff to walk. Planning the space of a patient's room: People are getting taller and may need longer beds in the next decades.

(1) Advantages of single rooms according to AIA 2006 and others:

Patient length of stay ↓  
Medication errors and costs ↓  
Nosocomial infection rate ↓  
Patient transfers ↓  
Privacy ↑  
Noise level ↓  
Sleep disturbances ↓  
Patient satisfaction ↑  
Patient control ↑  
Crowding ↓  
Bed reprocessing in room

(2) Toilets must have window ventilation or mechanical air supply.

(3) Cooking should be centralized in addition to having small kitchen wards.

*(Continued on page 5)*

## Community and Hospital Infection Control Association - Canada (CHICA) - an IFIC Member Society—3<sup>rd</sup> Annual Fundraising Run for IFIC – June 2, 2008

For the past 3 years at CHICA's annual Educational Conference the host city in collaboration with CHICA have sponsored a fundraising 'run' for IFIC! The Run or Walk for Fun is always in aid of IFIC's Scholarship fund. This year's CHICA conference was May 20-June 5.

This year in Montréal, although the weather didn't cooperate, 26 of the delegates certainly did! The 5 km runners and 2.5 km walkers obtained sponsors who donated more than \$3200CAD! Special mention must be made of Nicole Gartner from Edmonton, Alberta who raised in excess of \$1000 herself!! Nicole has been committed to this important event for awhile as she was



*(Continued on page 3)*

*(Continued from page 2)***CHICA Run—continued**

the coordinator at CHICA's 2007 IFIC run. We must also acknowledge and thank CHICA-Canada's Board of Directors who on behalf of CHICA always adds extra monies to the pot and this year donated \$2500CAD. These monies will be used to assist Infection Control Professionals from under-funded or under-resourced countries to attend our IFIC educational meetings. We look forward to CHICA's Run for Fun already scheduled for May 11, 2009 in St. John's Newfoundland!!!

This year for the first time at CHICA a few of our IFIC board members were able to attend the conference. We were delighted to spend educational and social times together and of course are looking forward to meeting again in Santiago, Chile for IFIC's own conference in October this year.

**THANKS TO ALL PARTICIPANTS!**

**National Education Conference on Infection Prevention and Control  
Community and Hospital Infection Control Association - Canada  
(CHICA-Canada)**

DATE OF EVENT: May 9-14, 2009  
Novice ICP Day – May 10, 2009  
Advanced Practitioner Day – May 10, 2009  
PreConference Day – May 11, 2009

TITLE OF EVENT: "Solid Foundations...Shifting Horizons"  
2009 National Education Conference on  
Infection Prevention and Control

ADDRESS OF CONTACT:  
Ms. Gerry Hansen BA  
Conference Planner  
Community and Hospital Infection Control  
Association (CHICA-Canada)  
PO Box 46125 RPO Westdale  
Winnipeg MB  
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Tel: (204) 897-5990/866-999-7111  
Fax: (204) 895-9595  
Email: [chicacanada@mts.net](mailto:chicacanada@mts.net)  
<http://www.chica.org>

LOCATION OF EVENT: St. John's, Newfoundland Labrador (CANADA)

VENUE/SITE: Delta St. John's/St. John's Convention Centre

## INVITATION TO IC SOCIETIES

At the October Congress in Chile, the Chilean Society of Infection Control and Hospital Epidemiology has designed a special room to provide information and promote and encourage relationships among different participant societies.

The room is called "Salón de las Sociedades" (Hall of Societies). Each professional society will have space for one poster. The purpose of poster is to present the society's activities. Posters will remain in the room through the entire Congress (October 14—17).

The poster should have a dimension of 1,5 m high and 1m wide. Please contact Patricia Lopez F. at [lopezfp@gmail.com](mailto:lopezfp@gmail.com) by August 15 if you are interested in displaying a poster for your society.





## APIC hosted IFIC during the annual conference in Denver

This year the Association for Professionals in Infection Control and Epidemiology again welcomed a group of the IFIC board during the annual conference. The APIC and CBIC boards invited us to give a presentation about IFIC to broaden understanding for all who are not yet familiar with the Federation.

The conference was very well organized with many highlights and broad variety in the program. There were approximately 4,000 delegates from 26 countries who could make a choice among 9 educational track sessions. Antimicrobial resistance, antisepsis /disinfection/sterilization and care of the environment, emergency preparedness, IC program and business, international, leadership, skill development and education, special populations/special settings and surveillance.

The posters were presented in a separate hall and poster rounds with the professors were conducted. Leading experts from various countries hosted small groups through the posters. There was also opportunity to discuss the scientific or practical content from peer-reviewed research and educational posters.

APIC provided a booth in the exhibit hall which made it possible to explain to the many visitors what IFIC is doing worldwide. To be at the annual APIC conference offered a great opportunity to promote IFIC. We want to thank all the interested people who stopped at the booth and those who gave donations. Special thanks to Janet Frain, APIC president, Gail Fraine, chair of the 2008 Annual Conference Committee, and Kathy Warye, CEO APIC for this opportunity to learn new things, meet old friends and make new friends.

The IFIC also hosted a symposium on infection control in countries with limited resources at the Denver conference. This event was made possible through the generous support of APIC and the APIC'08 organising committee. The session was well attended, with many international delegates present. Dr. Nizam Damani spoke on economics of infection control in developing countries. He highlighted the particular issues that concern the cost of hospital infection in poorer regions of the world and the difficulties that such hospitals face to find the required funds to implement effective infection control initiatives. The second speaker, Dr. Michael Borg, focused on possible strategies that healthcare institutions in developing countries could undertake in order to address the increasing challenge of healthcare infections in these regions. He emphasised the need to concentrate on cost effective initiatives based predominately on education and training in the basic concepts of infection control to all healthcare professions together with unsophisticated surveillance methods to establish the overall impact of these initiatives. The session concluded with an interesting discussion and comments from the floor, in which the need was highlighted to clearly establish what defines limited resources in relation to infection control.

Michael Borg, Chair IFIC  
 Nizam Damani, Treasurer IFIC  
 Ossama Rasslan, Board member IFIC  
 Pola Brenner, Board member IFIC  
 Akeau Unahalekhaka, Board member IFIC  
 Gertie van Knippenberg-Gordebeke, Board member IFIC



### IFIC Patron Members 2008



## Design of a general ward *(Continued from page 2)*

Room	<b>Basic - Even with severely limited resources, this is what you should do as a minimum</b>	<b>Standard – this is what you should aim for in less wealthy countries</b>	<b>Ideal – if you have the resources, this is what you could do</b>
<b>Patients' rooms/bays</b>	If you must have wards with many beds, you should also have some bays or, ideally, single rooms to cohort or isolate infectious patients.	2 beds, maximum 4 beds  There should also be some single rooms for infectious patients.	1 bed per room. (1)  As not every patient might like to stay alone, about 80% 1- bed-rooms might be enough.
<b>Isolation rooms for infectious patients</b>	Recommended, preferably with en-suite wash and separate toilet.	Some single rooms with en-suite wash/shower and toilet.	Some single rooms with en-suite wash/shower and toilet.. At least 2 of these rooms should have anterooms and negative pressure.
<b>Distance between beds</b>	Minimum 1 meter.	2 meters recommended.	More than 2 meters recommended.
<b>Patients' toilets (2)</b>	Toilets on each ward.	Sex-specific toilets on each ward, at least ensuite toilets in single rooms.	En-suite toilets for each room.
<b>Wash/shower/ bathroom</b>	At least one wash/shower or bathroom on each ward (plus patient specific toilets).	En-suite wash/shower for each patient's room, recommended in combination with toilet. One bathroom may be enough for a ward.	En-suite wash/shower/toilet room for each patient's room. One bathroom may be enough for a ward.
<b>Other toilets (2)</b>	Separate toilets for both health care workers and visitors.	Separate sex-specific toilets for both HCWs and visitors.	Separate sex-specific toilets for both HCWs and visitors.
<b>Nurses' workrooms (preparing care).</b>	At least one room for both clean and dirty work. Organize a maximum distance between clean and dirty works to ensure separation.	One room for clean work (preparing infusions...) and one room for dirty work (cleaning/disinfection of medical products, bedpans and perhaps instruments). On large wards more rooms may be necessary to reduce walking distances.	One room for clean work (preparing infusions...) and one room for dirty work (cleaning/disinfection of medical products, bedpans and perhaps instruments). On large wards more rooms recommended to reduce walking distances.
<b>Nurses' rooms</b>	One room for organizing and breaks.	One room for organizing and one room for breaks.	One room for organizing and one room for breaks.
<b>Doctors' treatment/ examination rooms</b>	One room desirable.	At least one room.	At least one room.
<b>Waste room</b>	There should be a specific area, preferably outside the ward, for the storage of waste awaiting collection. Waste sacks should be kept in large containers for collection.	May be combined with room for dirty work.	One special room for waste storage.
<b>Kitchen (3)</b>		Small kitchen with refrigerator.	Small kitchen with refrigerator.
<b>Storage</b>		At least one great storage room.	At least one great storage room.
<b>Bed reprocessing (cleaning; repair and storage also possible)</b>	Bed reprocessing on wards.	Centralized or in a reserved room on the flat.	Centralized or in a reserved room on the flat. No separate room necessary if only single rooms.
<b>Changing room for staff (if uniform is from hospital)</b>		Centralized or one room only for changing on the wards.	Centralized or one room only for changing on the wards.
<b>Cleaning car storage room</b>	Separate cleaning and disinfection agents in some area.	One room with sink, disinfectants, cleaning agents and cleaning car.	One room with sink, disinfectants, cleaning agents and cleaning car.

*We would like to acknowledge and thank our corporate Strategic Partners for their support and assistance in the fulfillment of our projects and initiatives*

**Baxter**



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## Obituary: Professor A.M. Emmerson OBE

By Nizam Damani

It is with regret that we acknowledge the death of Professor A.M. Emmerson who died on 3<sup>rd</sup> April 2008, aged 70. With his death, infection control has lost one of its most outstanding figures.

I met Mike Emmerson in 1983 at the Whittington Hospital, London when I was applying for the job of registrar in medical microbiology. During my visit he highlighted that hospital acquired infections are grossly neglected and as microbiologists we must develop a special interest to improve the quality of patient care. When I returned, I made a conscious decision to develop my special interest in infection control. It is important to emphasize that the 1980's was the period when microbiologist's involvement in infection control was mainly reactive, i.e., controlling outbreaks.

In 1986, when I completed my part I MRCPATH exam I was appointed and offered a post of specialist register in microbiology at the Royal Victoria Hospital, Belfast. During this period N. Ireland was going through a rough time and I was double minded whether to accept the job in Belfast or not. After the interview, Mike came out and we both walked outside the Royal Victoria Hospital and on to the Falls Road where he assured me that I should accept the job and that the 'local trouble' would not affect me. I decided to accept the job because I felt this was an ideal opportunity for me to work with Mike and gain experience in infection control. I was not disappointed because he took a keen interest and spent a considerable amount of time in teaching trainee microbiologists both in clinical microbiology and infection control. In the following years when I was appointed as a consultant microbiologist in Portadown, he became a good colleague. On two occasions we traveled together at the invitation of the Infection Control Society of Pakistan and did a lecturing tour of Pakistan. I remember his sheer delight when all of us were escorted by the Pakistan army to travel to Khyber Pass where we were guests of the Political Secretary of the tribal area at Landhi Kotal near the Pak-Afghan border where he saw photographs of British soldiers during British colonial rule.

Infection control worlds will miss Professor Emmerson not only for his knowledge and the contribution he has made to infection control but those of us who knew him closely will miss him for his incisive mind and sense of humor.

He graduated in 1965 and obtained MRCPATH in 1972. He was appointed first as consultant microbiologist at the Whittington Hospital in London. In 1984 he was appointed as chair of Microbiology to the Queen's University of Belfast, then in 1989 he moved to the Leicester Medical School and in 1991 he was appointed Chair at the Nottingham University Medical School until his retirement. He was a founder member of the Hospital Infection Society (HIS) and also its journal, *The Journal of Hospital Infection*. He was Chairman of the HIS council from 1990 to 1993 and the President from 2002 to 2006.

*(Continued on page 10)*





Sanatorio Adventista del Plata, Argentina



Clinical Center, Serbia



Banso Baptist Hospital, Cameroon



Cho Ray Hospital, Vietnam

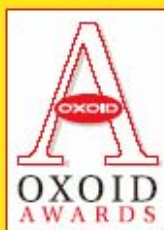
WOULD YOU  
LIKE TO BE  
AMONG THE  
WINNERS?



Worcestershire Acute Hospitals NHS Trust, UK



Craigavon Area Hospital Group Trust, N Ireland



The 2008/2009 Oxoid Infection Control Team of the Year Awards, which are supported by the International Federation of Infection Control, Hospital Infection Society, and the Infection Prevention Society are now open. Make sure you get your team's entry in soon if you want to be in with a chance of winning. As well as being rewarded with one of the monetary prizes - 1st prize: **£5,000**, 2nd prize: **£1,000**, 3rd prize: **£500** - the winning teams will receive a trophy or framed certificate to mark their achievements and be given worldwide publicity.

To find out more visit [www.oxoid.com](http://www.oxoid.com) or contact **Fiona Macrae, Awards Manager** on +44 (0) 1256 841144, email: [fiona.macrae@thermofisher.com](mailto:fiona.macrae@thermofisher.com)

## OXOID INFECTION CONTROL TEAM OF THE YEAR WINNERS APPLAUDED BY COLLEAGUES

Winners of the 2007/2008 Oxoid Infection Control Team of the Year Awards recently received their prizes at a celebratory dinner, held in their honour, at the beautiful Walton Hall Hotel, Wellesbourne, Warwickshire, UK.

Initiated by Oxoid in 2003, the Awards recognize and reward the dedicated teams of infection control microbiologists, infection control nurses and doctors who, each day, strive to prevent or reduce rates of hospital-acquired infections and improve infection control procedures, making our hospitals safer places for patients, staff and visitors alike.

The Awards are judged by a panel drawn from the International Federation of Infection Control, the Hospital Infection Society and the Infection Prevention Society (previously known as the Infection Control Nurses Association), together with renowned infection control professionals and representatives from Oxoid.

"We are delighted to publicly recognise the important work in infection prevention and control undertaken by the winning teams," commented Ali Ball, vice president, marketing and new product development, Oxoid. "The fight against healthcare-associated infections can only be won through the dedication of infection control teams. We are proud to recognise their achievements and to support them in their daily work through our range of products for the detection and diagnosis of infections such as *Clostridium difficile* and MRSA," she concluded.

### ENTRIES WELCOME FROM ALL COUNTRIES OF THE WORLD

The Awards are simple to enter – a summary of activity in 1,800 to 2,500 words is all that is required – and entries are welcome from infection control teams in all countries around the world. Just send an email to [oxoid.awards@thermofisher.com](mailto:oxoid.awards@thermofisher.com) stating "IC Awards" in the subject line, include your name, address and telephone number, and details of how to enter the 2008/2009 Awards will be sent to you when they are available.

Previous winners of the Oxoid Infection Control Team of the Year Awards are:

#### 2007/2008:

- 1<sup>st</sup>: Worcester Acute NHS Trust, UK
- 2<sup>nd</sup>: East Kent Hospitals NHS Trust, UK
- 3<sup>rd</sup>: Sheffield Teaching Hospitals NHS Trust, UK

#### 2006/2007:

- 1<sup>st</sup>: Royal Wolverhampton Hospitals NHS Trust, UK
- 2<sup>nd</sup>: Cho Ray Hospital, Vietnam
- 3<sup>rd</sup>: Joint - Southampton University Hospitals NHS Trust, UK and Aminu Kano Teaching Hospital, Nigeria.

#### 2005/2006:

- 1<sup>st</sup>: Craigavon Area Hospital Group Trust, Co Armagh, N Ireland
  - 2<sup>nd</sup>: Bansa Baptist Hospital, Cameroon
  - 3<sup>rd</sup>: Heart of England NHS Foundation Trust, Birmingham, England
- Highly Commended: Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, England

Further details of the winners' achievements and Oxoid products for use by infection control professionals can be found at [www.oxoid.com](http://www.oxoid.com)

International Infection  
Prevention Week  
October 19 - 25, 2008





## MISSION POSSIBLE

Herma Blaauwgeers  
Tjietska van Linge  
Infection control nurses, Leveste, location Scheperziekenhuis Emmen

In November 2007, two infection control nurses went to Kenya. This wasn't an ordinary journey, but a journey with a mission. They went to St. Mary's Hospital at Mumias to audit the hospital and to provide education about hygiene and infection control. You can read about their experience in this story.

### **The relation between Africa Fund and Africa**

How is it possible that an infection control nurse from Holland is working in a hospital in Kenya? Scheper hospital Emmen has been part of Africa Fund since 1988. This fund focuses on developing healthcare in Africa. There are several projects including support of healthcare workers to work and teach in Africa and sending materials and medical equipment.

St. Mary's Hospital is a private hospital with 200 beds. Nuns from Bergen in Holland established this hospital in 1932. The people from the hospital in Mumias asked for support in hygiene and infection control. We accepted this challenge at once!!

### **Preparation for the journey**

What can you expect from a hospital with less income and materials than the hospitals in Holland and where the infection rate of HIV is 4 to 10? We started to read and talk about the experience with people who already visited the hospital. It gave us a lot of information about the hospital in Mumias. We made a reader and PowerPoint presentation. Most people speak English and all speak Swahili. We practiced English conversation with each other and also tried to speak some Swahili words like "hakuna matata" (don't worry). To protect ourselves against illness we needed some vaccinations and anti-malaria tablets. So we were prepared and our adventure could start.

### **Audits at St. Mary's Hospital**

We left a cold Holland on the 4th of November 2007 and arrived in a sunny Kenya. They picked us up from the airport with an ambulance from the hospital. Our first impressions of Kenya had a huge impact on us. We were driving on a very bad road and saw a lot of people who were walking on the side off the road. We saw many boda-boda's (a bicycle cab) and also a lot of people with merchandise to sell, like vegetables, fruit, shoes and second hand clothes. In the area we stayed, only a few houses were made of stone. Most people live in a self made mud cottages. They told us that in Africa the lifestyle is relaxed and easy going (pole-pole) but when we arrived in Mumias we immediately received a guided tour through the hospital by the matron. We saw all the patient areas. One room had about 40 beds. The patients had no privacy because there were no bed curtains. There was also no possibility for isolation. People with open lung tuberculosis were situated in the same room as other patients. When they wanted to isolate a patient they placed a bed in the corner of the room.

After all these impressions we started planning. For two days we audited the whole hospital to get an impression about the knowledge of the healthcare workers, how to prevent themselves from acquiring an infection and how to prevent cross infections.

Other people already in Kenya told us that they didn't have means to protect themselves against micro-organisms. However one year ago the government provided education about HIV. So now they knew how to protect themselves and what to do if they had a blood-blood contact. They also have the potential to give post-exposure prophylaxis against HIV. They don't look for hepatitis B or C. Everywhere there were needle containers and other containers to put in highly infectious materials. This material was burned in an oven on the hospital grounds.

In the audit report we provided advice, for example, on disinfection procedures. They prepared a chlorine solution and healthcare workers used this solution for one week! We asked the firm by e-mail how to use this product. They told us to use it only for two days. Other advice focused on the fact that they mixed four different cleaning and disinfection solutions with each other. We told them that this has a reverse effect.

We asked the healthcare workers if they have a lot of postoperative wound infections. They told us that they didn't often see a postoperative wound infection. However they use a lot of antibiotics and they don't have an intensive care department. They also don't have a surveillance programme.

*(Continued on page 10)*

**MISSION POSSIBLE** *(Continued from page 9)*

The mortality rate is high. Patients come into the hospital when they are already very sick. This is because of the fact that only the people with a job have insurance. And the people who don't have insurance don't have the money to pay the hospital costs.

We heard very sad stories about children who died because of malnutrition. They also bring children to the hospital with skin cuttings, because many people believe in the power of the medicine woman. They think that malaria will disappear when they make little wounds in the skin.

Workers had thought carefully about hand hygiene. They washed their hands with water and soap and after that they dried hands with little cotton towels. Then they threw it in the wash container. The nurses on the ward washed the little towels and dried them in the sun. Not all the water taps worked in patient areas, this wasn't good for compliance with hand hygiene. We advised them to develop a hand wash procedure. We also advised them to appoint someone who focuses on infection control and to install an Infection Commission/Committee to make policies about infection control.

**Lessons about hygiene and infection prevention**

After the audit we started a basic course on infection prevention. Lessons were provided for all workers in the St. Mary's Hospital, including laundry, kitchen and cleaning staff. Also the students of the Clinical Medical school came and asked for lessons. In the course we gave instruction about microbes, the spread of microbes, immunity against microbes, cleaning and disinfection, sterilisation and the standard precautions. We enjoyed giving these lessons, sometimes we were sitting between the sheets in the laundry and the pots and pans in the kitchen. For the people who didn't understand English there was an interpreter to translate into Swahili.

At the end of the two weeks more than 200 hospital workers and students earned their certificate. During the evaluation we heard that the laundry, kitchen and cleaning staff learned much from the lessons, the information was new for them. For the nurses it was a good reminder of their knowledge.

In our opinion the mission was a success. We provided advice and information based on our knowledge of infection control. On the 24 of November we flew back to Holland. Our suitcase was empty but our head and heart were full of impressions which we will never forget. After we left there were elections in Kenya and the situation became turbulent. That's the reason that we don't know what the follow-up is from our advice. The African Fund wants to stay in contact with St. Mary's Hospital and wants to continue this project when the situation is stabilized.

*(Continued from page 6)* **Professor A.M. Emmerson**

One of his main interests was in surveillance of hospital acquired infection and he was a member of the committee who organized the first UK national prevalence survey in 1980. In 1988 he was appointed Chairman of the UK Dept. of Health Microbiology Advisory Committee to the Medical Devices Agency (MDA).

Internationally, his contribution includes Chairman of the European Standards Committee on the Sterilization of Medical Devices and he helped establish the Healthcare-associated Infection Surveillance Centre in South Africa. He was an examiner for a number of universities, including the Chinese University, Hong Kong and was also a postgraduate examiner in Malaysia and Bangladesh. He presented papers at the IFIC congresses. To mark his contribution to infection control, the Michael Emmerson South African Healthcare-associated Infection Centre has been established in Johannesburg.



Mike Emmerson (center) with Michael Borg and the author, Nizam Damani, at the HIS congress gala dinner, Amsterdam 2006



At the entrance of Khyber pass, Peshawar, Pakistan.