Supplementary Table S5. Other results: Articles demonstrating bacterial contamination of antiseptics, disinfectants and hand hygiene products but with another fomite identified as the actual reservoir and source of infection; articles describing outbreaks related to contaminated eosin (considered and used as an antiseptic). Country income level is based on the data from the World Bank (World Bank2022) at the year of publication. Product names are listed as mentioned in the referred articles; in case of brand names or jargon, the generic name is written in brackets and italics. Bacterial names are listed as mentioned in the referred articles, names according to actual nomenclature (*List of Prokaryotic names with Standing in Nomenclature* and updated species names were used (LPSN, 2022b)) are written between brackets and used in the "Summary/Comment". Abbreviations: AST = antibiotic susceptibility testing, CHG = chlorhexidine gluconate, CFU/ml = colony forming units/ml, ID = Identification, LIC = low-income country, MIC = middle income country.

Author – Year **Country (income level)** **Setting**	**Outbreak: description, potential reservoir and transmission, interventions**	**Microbiology methods**
		Summary/Comment
Pinna 2009 India (MIC) Secondary hospital	Description: *Pseudomonas aeruginosa* endophthalmitis after cataract surgery, 20 patients in 40 days Investigation: Environmental cultures: phacoemulsifier (machine inserted in the lens that emulsifies the cataract), povidone-iodine solution (used as preoperative antisepsis), irrigating solution, operating room air-conditioning system. Reservoir: Growth of *P. aeruginosa* from air-conditioning system, povidone-iodine solution and phacoemulsifier Transmission: Hypothesized: air conditioner's condensate (droplets) or airborne Relatedness environmental – clinical isolates: enterobacterial repetitive intergenic consensus-polymerase chain reaction: similarity of clinical isolates with isolates from the air conditioning but not with isolates from phacoemulsifier and povidone-iodine solution. Intervention: Closure of all operation rooms, intensive cleaning and fumigation with high concentration of formalin performed twice a week, cleaning and reconditioning of the air-conditioning system, and changing of the phacoemulsifier tubes	Methods of sample processing not described AST: disk diffusion, guidelines not mentioned Resistant to cefazolin, fluoroquinolones chloramphenicol, tetracycline, aminoglycosides *Pseudomonas aeruginosa* endophthalmitis after cataract surgery traced to the air conditioning system. **Povidone-iodine** (and the phacoemulsifier) was also contaminated with *P. aeruginosa* but it was unrelated to the causative bacterium.
Pegues 1994 Guatemala (MIC) Tertiary hospital	Description: 26 cases of bloodstream infections in a neonatal intensive care unit, 23 neonates died, isolates included *Serratia marcescens*, *Klebsiella pneumoniae* and *Klebsiella oxytoca* Investigation: epidemiological study (cohort study, review of patient files), environmental investigation and procedure review. Reservoir: *Achromobacter xylosoxidans*, different from the epidemic species, was isolated in 4% chlorhexidine gluconate in concentration of 8 10^6 CFU/ml. *K. pneumoniae* was isolated from neonate rectal swabs and human breast milk, and *S. marcescens* from post-handwashing samples of healthcare workers. Other risk factors were (i) failure of the chlorination of the tap water system and (ii) administration of intravenous medications Relatedness CHG – clinical isolates: no identical bacterial species	Culture; Plating on blood and MacConkey agar Incubation at 35°C for 5 days ID: triple-sugar iron agar (*note: conventional phenotypic tests*) No AST Finding of heavy ***Achromobacter xylosoxidans*** contamination of **chlorhexidine gluconate solution used for handwashing**, but unrelated to the outbreak of bloodstream infections in a Neonatal Intensive Care Unit
Salem 1998 Boukadida1993 Boukadida1999 Tunisia (MIC) Tertiary hospital	Description: 2 cases (not clustered) of *Alcaligenes xylosoxidans (Achromobacter xylosoxidans)* bloodstream infection and meningitis in neonates (one low-birth weight and one premature), one died. Neonates had dermatitis and omphalitis respectively to which eosin was applied. Investigation: environmental investigation (eosin, antiseptics and IV-fluids) Reservoir: water-based eosin solution [a] 2% contaminated with *Alcaligenes xylosoxidans* (> 10^6 CFU/ml), saline and antiseptics yielded no growth Relatedness eosin - clinical isolates: phenotypic identification and Pulse-Field Gel Electrophoresis	Methods of sample processing not described AST: methods not specified ID: API 20NE bioMérieux AST: susceptible to trimethoprim-sulfamethoxazole, piperacillin, ticarcillin and imipenem, resistant to cefotaxime, gentamicin and amikacin ***Alcaligenes xylosoxidans*** bloodstream infection and meningitis caused by contaminated **water-based eosin 2%** applied on skin lesions in neonates. Culture of antiseptics did not grow. (*Note: References Salem1998, Boukadida1993 and Boukadida1999 probably describe the same case report)*.

[a] Eosin is not considered as antiseptic (McDonnell2017)