

# In SafeHandS

Newsletter of the SafeHandS network

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ALBION STREET CENTRE

*In SafeHandS* is the official newsletter of the SafeHandS network to promote health care worker safety in the Asia Pacific. It is compiled and distributed by the Albion Street Centre.

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#### *Editorial panel:*

Maggy Tomkins; Philip Melling; Peter Said, Alexandra Wilson & Peta-Anne Zimmerman

#### *Compilation & Publication:*

Ann Brennan

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#### Disclaimer

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## ? Contributions

We encourage members to contribute to *In SafeHandS* by:

- Participating in the ‘Member Profile’ by providing a brief profile about yourself and a brief example about your experience in improving health care worker safety in your workplace
- Providing information about recent articles, resources or upcoming events related to health care worker safety
- Submitting a question or concern or comment you have about health care worker safety



Photos courtesy of Mahosot, Lao PDR & Chiang Mai University Hospital, Thailand

The focus of this issue is: Stigma and Discrimination

The topic of the next newsletter to be published in June 2007, will be “Clinical Practice Improvement”.  
*Deadline for contributions for the next issue is 18th May, 2007*

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## Editorial



*Chris Puplick holds a Professorial appointment in the Department of Health and Behavioural Sciences at the University of Wollongong, Australia. He has previously served as Chairman of the Anti-Discrimination Board and as Privacy Commissioner of New South Wales. He also*

*served as Chair of the Australian National Council in AIDS, Hepatitis C and Related Diseases and the Central Sydney Area Health Board. From 1978 to 1984 and from 1984 to 1990 he was a member of the Australian Senate.*

“It is a truth almost universally ignored that all health is political. We have always recognised this about the health of our economies or our systems of government. Almost a century ago we recognised it about the health of our physical environment. It has however, taken us far longer to start to recognise this in relation to the health of our own bodies.”<sup>1</sup>

Any disease, particularly an epidemic one is as much a socio-political phenomenon as it is a medico-scientific one. Any illness, disease or disability which results from acts of personal behaviour, especially if the dominant paradigm defines that behaviour as ‘deviant’ is as much a moral phenomenon as it is a health one. As Waldby states: ‘The management of epidemic is never a politically neutral affair, but is rather enmeshed in particular power relationships and involved in the defence of a particular social order.’<sup>2</sup>

Health itself is a social construct in which stigma has been identified as a critical variable<sup>3</sup> which functions quite independently to any physical manifestation of a condition. It is critical in determining how people experience illness and particularly how it impacts upon their self-esteem<sup>4</sup> and how others, especially health care providers react towards them.<sup>5</sup> Numerous studies have shown that where individuals are the subject of discrimination and stigma because of their “illness” then both their prognoses and eventual health outcomes are compromised.<sup>6</sup>

The *SafeHandS* network provides advice and support to health care workers (HCWs) who are involved directly in the care and support of people with HIV/AIDS and other communicable diseases such as hepatitis C. As such these HCWs are at the very cutting edge of service provision in areas which are rife with stigma, discrimination, prejudice, and all too often actual physical violence practiced against people for whom they are caring.

It is sometimes difficult for HCWs themselves to ensure that their own personal and socio-community prejudices do not intrude into the way in which they manage their patients/clients and the way in which they provide health care. Various enquiries into HIV and HCV related discrimination in Australia have identified the providers of health care services as one of the most frequent sources of discrimination against people with a variety of communicable diseases.<sup>7</sup>

At the same time it must be recognised that there is often prejudice and discrimination practised against HCWs who have chosen to work in difficult and challenging fields such as HIV/HCV and sexually transmissible infections in particular. In the early days of AIDS in Australia the Australian Medical Association produced a video entitled *No-one wants AIDS, Mate* which was not about the AIDS virus or its treatment, but rather an appeal for (especially younger) doctors to volunteer to work in this area of emerging need.

Snide jokes have always been made about “pox doctors” and institutional prejudices delayed, for many years, the recognition of the Australian College of Sexual Health Physicians on the same level as other medical colleges. Negative assumptions are often made about people who choose to work with HIV patients, injecting drug users, or even in the discipline of mental health.

Just as there is an increasing recognition of the underlying political dimension of all aspects of health and health care, there is also some increasing movement to reformulate “the boundaries of medicine and public health, to include social problems such as poverty, violence, refugee-ship, chronic starvation, and family and community breakdown”.<sup>8</sup> This reformulation, and especially its increasing understanding of the problems of violence associated with illness and social

stigmatisation should be welcomed by HCWs.

In the first instance, a reformulation of the paradigm of illness within which they are working can give them a wider sense of their own place and responsibilities within that world. It can help them understand that some of the prejudices and fears which they may experience when providing health services are unjustified and at the same time demonstrate that their particular field of communicable disease care and management is not really that different from any of the other parts of the health environment.

Safety is enhanced through better understanding. That understanding is not just a matter of implementing improved techniques in areas such as sharps disposal or the following of standard (universal) precautions but equally in learning to feel more physically, socially and emotionally secure and comfortable in the wider practice of health care delivery. Better understanding can also be critical in breaking down the prejudices which are manifest against HCWs in the communicable diseases field, because it places them and their work more centrally within the framework of health care delivery generally. There is nothing special about being a HCW in any one particular field – what matters is the provision of service at the highest levels possible in all the (often limiting) circumstances, the dedication to patient care, the pride in professionalism and constant improvement and the determination to be guided by evidence-based best practices.

Stigma and discrimination are evils which cut in all directions. Like the “gentle rain from heaven” it may impact equally upon “him that gives and him that takes”<sup>9</sup> and the elimination of both can only enhance outcomes for everyone concerned.

<sup>1</sup> Puplick C (2001) “Hepatitis C and Discrimination” in Crofts N, Dore G and Locarnini S (eds) : *Hepatitis C – An Australian Perspective* IP Communications, Melbourne: 194

<sup>2</sup> Waldby C (1996) *Aids and the Body Politic* Routledge, London: 9

<sup>3</sup> Green G and Platt S (1997) *Social Health Issues* 19: 70-92

<sup>4</sup> Demas P et al (1995) *AIDS Educ Prev* 7:

86-97; Goffman E (1963) *Stigma – Notes on the Management of Spoiled Identity* Touchstone, New York

<sup>5</sup> Crocker J and Major B (1990) *Psychol Bull* 96: 608-630

<sup>6</sup> Anti-Discrimination Board of New South Wales (1992) *Discrimination – the Other Epidemic* Anti-Discrimination Board, Sydney; Anti-Discrimination Board of New South Wales (2001) *C-Change – Report of the enquiry into hepatitis C related discrimination* Anti-Discrimination Board, Sydney

<sup>7</sup> *ibid*

<sup>8</sup> Bowker JW (1997) “Religions, Society and Suffering” in Kleinmen, A, Das, V and Lock, M *Social Suffering* Uni California Press, Berkley: 376

### Recently got email access?

### Changed your email address?

Please let us know if you get access to email or if your address changes.

Email access means your copy of the newsletter is available the day it is published.

The print version of the newsletter may also be smaller than the email version.

More importantly, you can join in email discussions with other members and receive up to date information by email.

To change your details just email us at: [safehands@sesiahs.health.nsw.gov.au](mailto:safehands@sesiahs.health.nsw.gov.au)

## What is SafeHandS?

SafeHandS is a 'virtual' network designed to link and support health care workers across the Asia-Pacific region who are caring for people with HIV/AIDS and other communicable diseases.

We know that health care workers are essential in responding to HIV/AIDS and other communicable diseases. Without health care workers, there is no health system. We want this network to provide information, support and practical solutions to help health care workers in resource limited settings to feel safe and encouraged to provide optimal care.

SafeHandS is a forum where health care workers can share issues and ideas. We can encourage and learn from each other to find practical solutions to improve health care worker safety in resource limited settings.



SafeHandS is being funded by the Australian Agency for International Development (AusAID) and coordinated by the Albion Street Centre (ASC). ASC is a public health care facility based in Australia for the treatment, care and support of people living with or

affected by HIV/AIDS. The team includes infection control specialists with international experience in health care worker safety.

### Become a member

Benefits of membership include:

- Receiving a newsletter (In SafeHandS) every 3 months
- Participating in a moderated group email discussion e-list for posting questions, comments and issues
- Access to a clearinghouse of new resources & publications produced by different organisations about health care worker safety (links are posted on the website)
- Access to resources developed by SafeHandS
- Joining a database of expertise

Membership is free. To join, you can either:

- Go to our website: <http://www.uow.edu.au/health/safehandS/index.html> and click on the 'membership' page, or,
- Send an email to: [safehandS@sesiahs.health.nsw.gov.au](mailto:safehandS@sesiahs.health.nsw.gov.au)

You can elect to receive a hard copy of the newsletter by post. However, this will be a shorter version than the electronic version.

### Update on SafehandS membership

We are pleased to report that at the end of January 2007, we had 134 members of SafeHandS working in 34 countries.

Members work in:

Australia, Cambodia, Canada, China, Cook Islands, East Timor, Fiji, Hong Kong, India, Indonesia, Kenya, Kiribati, Lao PDR, Malaysia, Marshall Islands, Nauru, New Zealand, Nigeria, Niue Island, Northern Mariana Islands, Pakistan, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Taiwan, Thailand, Tonga, Turkey, Tuvalu, USA and Vietnam.

Feedback on membership forms indicates that the services to members would most like are (in order of preference):

- Access to current publications on health care worker safety
- Training resources
- Tools (e.g. surveillance forms, checklists for health care worker safety)
- Sample policies and protocols
- Email discussion forum between members

## Member Profiles

*To help link and support members, we provide one profile of a SafeHandS member.*

### Name:

A/Prof. Dr. Robert Bernstein, MD, PhD, MPH, FACPM

### Title:

Expert Advisor on Public Health & International Development, Singapore Health Services Program of International Medical & Public Health Development Assistance Activities (SingHealth IMPAct), and Associate Professor, Hubert Dept. of Global Health, Rollins School of Public Health, Emory University

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### Describe your current job:

I am the director of SingHealth IMPAct which is a non-profit private sector program which can be used by donor/lender organizations to assist their government and non-government Health Sector organization partners to assess and improve the performance, quality, and results of their essential health functions, services, practices, and technologies as defined by the World Health Organization and World Bank ([http://www.wpro.who.int/publications/PUB\\_9290610824.htm](http://www.wpro.who.int/publications/PUB_9290610824.htm), <http://www.who.int/eht/en>, and [sources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/PHOperations.pdf](http://sources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/PHOperations.pdf)).

### What was your career path that brought you to your current job?

After doctoral and post-doctoral education and training in Molecular Biology & Pharmacology at Penn State University and Yale University, I graduated from the University of Connecticut School of Medicine in 1977 and an Internship & Residency in Preventive Medicine & Public Health in the US Public Health Service and

Johns Hopkins University. From 1979-2002, I was a Medical Epidemiologist and Program Officer for the US Centers for Disease Control & Prevention and the US Department of Health & Human Services Office of Global Health. I was a technical advisor on International Health for Ministries of Health in more than 20 countries in Africa and Asia from 1985 through 2002, while on USDHHS/CDC assignments with WHO, UNICEF, and USAID. From 2002-2004, I was a Technical Advisor on Decentralization in Indonesia where I am fluent in Bahasa Indonesia.

### What do you like most about your job?

Learning while assisting colleagues who have become friends and collaborators over the years.

### What do you like least about your job?

Occasional excesses in travel; frequent constraints due to bureaucracy and other human frailties.

### What does health care worker safety mean to you?

The establishment, implementation, monitoring, evaluation and improvement of occupational safety and health policies and practices which help to reduce the occurrence and severity of illnesses, injuries, and errors among Health Care Workers and thereby helps to protect their patients and colleagues.

### What are you reading at the moment?

Ed McBain police procedural novels and Prevention Education materials from the Association for Prevention Teaching and Research's Prevention Education Resource Center.

### What are you currently listening to?

Bob Marley classics

### What is your favourite saying?

What gets measured is what gets done...

## Stigma and discrimination – how do they relate to health care worker safety?

By Maggy Tomkins

HIV is a highly stigmatised disease and globally, many people infected with HIV experience discrimination. What do these terms mean?

“HIV/AIDS-related **stigma** can be described as a ‘process of devaluation’ of people either living with or associated with HIV/AIDS.”<sup>1</sup> “Stigma lets people or groups see differences or “others” in a negative light while confirming their own sense of normalcy and decency.”<sup>2</sup>

“**Discrimination** follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination breach fundamental human rights and can occur at a number of different levels including: political, economic, social, psychological and institutional.”<sup>1</sup>

There are many reasons for stigma towards people with HIV. The disease is associated in most countries with marginalised groups (such as homosexuals or injection drug users) or with behaviour which is seen as “wrong” (such as sex outside marriage.)

So how does stigma relate to the role of a health care worker?

Stigma or fear of stigma often prevents people from accessing HIV testing, care, support, treatment and prevention.<sup>3</sup>

This may mean people ignore or choose not to know their HIV status. This means they will remain untreated and may lead to the risk of faster disease progression and also to the risk of them transmitting HIV to others.<sup>1</sup>

Stigma in the health system may also lead to reluctance by people with HIV to receive treatment. Discrimination against people with HIV may mean less than optimal treatment is given.

Many people with HIV may be reluctant to disclose that they are infected if they are seeking help for another health problem. This

means there will be undiagnosed persons in the health system – which is one of the reasons why Standard (Universal) Precautions are so necessary.

People who do not know their HIV status or who do not use health services for fear of stigma are more likely to present to the health system at a late stage of HIV infection – with untreated disease – when they will be more infectious and so pose more of a risk if a health care worker is exposed to their blood.

The actions of health care workers who discriminate against people with HIV, or who refuse to care for them, are usually related to fear of infection. This fear is usually based on stigma – not scientific knowledge. Fear of transmission is disproportionate to risk of transmission and at odds with their own scientific knowledge.

Health care workers who do work with people with HIV and other infectious diseases may also experience discrimination from their community and co-workers.<sup>3</sup>

For all these reasons we must address the issue of health care worker safety. Health care workers who understand disease transmission and base their actions on scientific understanding rather than prejudice and stigma are more likely to adopt safe practices appropriate to the situation. If health care workers feel their safety needs are being addressed they are more likely to give good care to their patients. The organisation which addresses the safety needs of its workers is more likely to retain staff and save costs on recruiting and training new staff. If people with HIV feel able to access health services without stigma and discrimination they are more likely to accept treatment and adopt safe practices, which will reduce HIV morbidity and transmission.

*Common at its core*, a report which synthesised research on stigma in Ethiopia, Tanzania, Vietnam, and Zambia found that “there are many more similarities than differences across these contexts in the key causes of stigma, the forms stigma takes, and the consequences of stigma.”<sup>4</sup>

It was found that although in many cases people knew how HIV was transmitted, doubts and false beliefs remained. The report’s

authors suggested this was due to several factors:<sup>4</sup>

- the narrowness and lack of depth and specificity in much HIV and AIDS information
- fear-based prevention messages and sensationalised reporting about HIV
- the constantly evolving scientific knowledge about HIV, sometimes appearing contradictory, causing fear that current information about transmission might be wrong

*Common at its core* makes many good recommendations on how to address stigma – in particular how to modify education messages to be more effective.<sup>4</sup> To quote the last sentence:

“The time to act is now.”<sup>4</sup>

## References

1. UNAIDS (2003) Fact sheet: *Stigma and discrimination* [http://data.unaids.org/Publications/Fact-Sheets03/fs\\_stigma\\_discrimination\\_en.pdf](http://data.unaids.org/Publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf)
2. Smart T (2005) HIV stigma, treatment and prevention *HIV & AIDS Treatment in Practice*, October 13, 2005 <http://hivinsite.ucsf.edu/InSite?page=patip-56>
3. International HIV/AIDS alliance *Antiretroviral (ARV) Treatment Fact Sheet 12: Stigma* <http://synkronweb.aidsalliance.org/graphics/secretariat/publications/FS12.doc>
4. Ogden J & Nyblade L (2005) *Common at its core: HIV related stigma across contexts* International Centre for Research on Women (ICRW) [http://www.icrw.org/docs/2005\\_report\\_stigma\\_synthesis.pdf](http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf)

## Useful resources

### Understanding and challenging HIV stigma: toolkit for action

International Centre for Research on Women

This toolkit provides “sound, evidence-based guidance for launching stigma-reduction activities with key groups, including religious

and political leaders, people living with HIV and AIDS, and community members. Participatory exercises address the knowledge and value issues that underlie stigma and create the necessary awareness of stigma to motivate action. The intent is to motivate people in positions of power and household and community members to use these methods to address the stigma around them.”

The first edition was developed in Africa. An adaptation of the first edition for the Asian context has been completed and is available in both English and Vietnamese. The entire Toolkit can be found at: <http://www.changeproject.org/technical/hivaids/stigma.html>

### Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers

By Engender Health

“A two-volume curriculum offering a unique training opportunity for health workers in countries hardest hit by the AIDS pandemic. The training course guides health workers through an investigation of the root causes of stigma and discrimination while helping them to understand their own attitudes about HIV, AIDS, and individuals affected by these conditions and how these attitudes might affect the care they offer. The training also provides a review of clients' rights in receiving health care services, information about the use of standard precautions and proper infection prevention techniques to help minimize the risk of occupational exposure to HIV, and guidance in developing action plans to help the participants put what they have learned into practice at their service settings.

The curriculum consists of a participant's handbook and a trainer's manual. The participant's handbook provides essential ideas on each topic, case studies, and a reprint of Engender Health's publication *Infection Prevention: A Reference Booklet for Health Care Providers*. The trainer's manual contains activities aimed at exploring the realities of HIV and AIDS and dispelling common myths and misunderstandings about HIV transmission and providers' risk of occupational exposure. The training employs participatory education techniques - such as

role-plays, small and large-group discussions, and brainstorming - that have been shown to be critical to successful adult learning. ”  
<http://www.engenderhealth.org/res/offc/hiv/stigma/>

### **National AIDS Programmes A Guide to Monitoring and Evaluation**

Measure Evaluation and UNAIDS (1998)  
<http://www.emro.who.int/GFATM/guide/stigma/stigma.html>

**Title:** **Stigma associated with Ghanaian caregivers of AIDS patients... Including commentary by Stevens P, Demi AS, and Ayres L with response by Mill and Mwinituo.**

**Authors:** Whitby M, Pessoa-Silva C, et al.

**Date:** 2006

**Source:** Western Journal of Nursing Research 28(4):369-91

**Abstract:** This study explores the experiences of informal caregivers of AIDS patients in Accra, the capital city of Ghana. Fifteen interviews were completed in 2002 with 11 informal caregivers, including wives, mothers, boyfriends, daughters, sons and brothers of AIDS patients. Three major themes emerge in the analysis of the interviews with caregivers: stigma, caregiver burden, and caregiver commitment. In this article, the authors focus on the theme of stigma by documenting its presence and highlighting its impact on care-giving activities. Caregivers go to great effort to not only "hide" their patients but also their care giving activities, resulting in the social isolation of both patients and their caregivers. Many caregivers live in secrecy, not sharing their family member's diagnosis with extended family members. As a result, they receive limited support from the extended family. Stigma results in negative attitudes of neighbours, relatives, and health care workers toward caregivers and their patients.

**Title:** **[HIV/AIDS-related stigma and discrimination: the case of health care providers in Mexico ] [Spanish]**

**Authors:** Infante C, Zarco A, et al.

**Date:** 2006

**Source:** Salud Publica de Mexico 48 (2):141-50

#### **Abstract:**

**Objective:** To analyze the social construction of stigma and discrimination processes associated with HIV/AIDS and people living with HIV/AIDS (PLHA), based on the perceptions of health care providers in three states of the Mexican Republic.

**Material and Methods:** Qualitative and quantitative description. Observation at nine institutions; in-depth interviews (14) and surveys (373) directed to providers of health services.

**Results:** Seventy-five percent of providers reported having received training related to HIV/AIDS; however, notions persist as to patients being hopeless; discrimination due to the idea of risk groups; the immediate identification of living with the virus, having the syndrome and death; and specific lack of knowledge of forms of transmission. Twenty-three percent would not buy food from a PLHA and 16% think they should be banned from public services. With respect to confidentiality: 89% believe it should be maintained and 38% think that employers and administrators have the right to know about their employees' condition. Isolation, notes in clinical histories pointing to HIV, obligatory testing and delays in surgeries for PLHA were constant practices. The perception that men who have sexual relations with men and sexual workers decide their sexual practices marks the division between innocent victims and guilty ones, which determines the stigmatization and discrimination processes in health services.

**Conclusions:** The design of strategies to decrease stigma and discrimination associated with HIV/AIDS demands the inclusion of an ethical debate about human rights and a structural focus regarding social conditions that go beyond the notion of risk behaviours.

**Title:** Understanding HIV-related stigma and discrimination in a "blameless" population

**Authors:** Cao X, Sullivan S, et al.

**Date:** 2006

**Source:** AIDS Education and Prevention 8 (6):518-28

**Abstract:** HIV-related stigma and discrimination are major barriers to the successful control of HIV. Stigma is associated with the disease as well as the behaviours that lead to infection. A qualitative study was conducted to identify the reasons, sources, and types of HIV-related stigma prevalent in rural China. Eighty in-depth interviews were conducted with people living with HIV/AIDS, their family members, health care providers, and uninfected villagers. Stigmatizing behaviours were primarily associated with fear of HIV rather than with the route of infection. Uninfected villagers were the main source of discrimination, with health workers and family members also holding some stigmatizing attitudes. A primary concern for HIV-positive villagers was protecting their families, especially their children, from discrimination. Secondary stigma also extended to uninfected members of the same village. The results have been used to develop an intervention to reduce fear of casual transmission and stigma in these communities.

**Title:** Prevalence and factors associated with social avoidance of recovered SARS patients in the Hong Kong general population

**Authors:** Lau J, Yang X, et al.

**Date:** 2006

**Source:** Health Education Research 21 (5):662

**Abstract:** The study investigated the general population's perceived infectivity of asymptomatic and recovered severe acute respiratory syndrome (SARS) patients and factors associated with avoidance and discriminatory attitudes, including demographic background, SARS-related perceptions and emotional response to the SARS epidemic. A population-based survey

was conducted in Hong Kong during 3 December 2003 through 4 January 2004; 475 Hong Kong Chinese adults participated in the survey. Perceptions of the infectivity and health conditions of recovered SARS patients and avoidance and discrimination towards them were measured. Of the respondents, 75.7% and 16.2%, respectively, believed that SARS could be transmitted via asymptomatic SARS patients and those patients who have recovered from SARS for 18 months; 72.7% of the respondents believed that the health of SARS patients would severely and permanently be damaged; 16.6% showed some tendency of avoiding recovered SARS patients and 35.7% expressed some sort of job-related discriminatory attitudes. Perceived infectivity of asymptomatic and recovered SARS patients, health sequelae and emotional distress from SARS were independently associated with avoidance and discriminatory attitudes. The study showed that misconceptions about the infectivity of asymptomatic and recovered SARS patients were common. Recovered SARS patients may also be facing avoidance and discrimination.

**Title:** Fear of HIV infection and impact of training on the attitudes of surgical and emergency nurses toward inpatient HIV testing

**Authors:** Ga czak M, Barss P

**Date:** February 2007

**Source:** Infect Control Hosp Epidemiol 28:230-233

**Abstract:** This study evaluates the association between the degree of fear of human immunodeficiency virus (HIV) infection and support for different HIV testing policies. A strong fear of acquiring HIV infection at work was widespread among a sample of 601 Polish surgical and emergency nurses. Most favoured inappropriate HIV testing of all surgical patients and inpatients. Previous training about HIV and acquired immunodeficiency syndrome (AIDS) and experience caring for HIV-positive patients had a significant impact on reducing support for testing of all inpatients but not for testing of surgical patients.

**Title:** **Iranians' attitudes about possible human immunodeficiency virus transmission in dental settings**

**Authors:** Askarian M, Mirzaei K, et al.

**Date:** February 2007

**Source:** Infect Control Hosp Epidemiol 28:234-237

**Abstract:** We conducted a cross-sectional survey from October through December 2004 of 8,312 residents of Shiraz, Iran, to investigate Iranians' perceptions about undergoing dental treatment in dental offices where other patients or the dentist and/or dental assistants are infected with human immunodeficiency virus (HIV). Most survey respondents (83%) had acceptable general knowledge about the mode of transmission of HIV and about acquired immunodeficiency syndrome (AIDS); however, many misconceptions were observed. A negative association was detected between the level of concern about contracting HIV/AIDS and the intention to continue treatment in services where patients with HIV/AIDS were also treated or where the dentist and/or dental assistants had HIV/AIDS.

## A Telephone-Based Global Infection Control Education Program

A Telephone-Based Global Infection Control Education Program

In 2001 a world renowned scientist and researcher and a Canadian businessman met to devise a mechanism by which cutting edge infection control information can be shared with whomever could benefit from it regardless of their geographic location or their ability to pay. Dr. Syed Sattar and Paul Webber had intended to create a modest education program that they called "Teleclass Education". Unintentionally, it has evolved into a worldwide program involving tens of thousands of people on 5 continents, run entirely by volunteers on a not-for-profit philosophy.

The Teleclass Education model has three Foundation Principles:

- To provide the best possible information

- To the widest possible audience
- With the fewest barriers to access

A "teleclass" is a live seminar to which people listen and participate over the telephone. Launched initially at the University of Ottawa in Canada, the program is now managed through Webber Training. The world's leading experts on topics of interest to infection control professionals are invited to give a 1-hour lecture on their topic. Their PowerPoint slides and a handout thereof are posted on the web site for registrants to access. Participants can register to join the live teleclass by phone and/or to listen to the recording of the lecture over the internet.

Registrants in developed nations are asked to pay a small registration fee (\$35AUD) per teleclass for their site, regardless of how many people are gathered around the phone. Registrants from nations considered by the United Nations to be "developing" are entitled to full access to all teleclass materials without cost – the "No Barriers Initiative". The No Barriers Initiative applies also to participants in developed nations who are in resource-poor areas although in that case free access is by request rather than automatic.

The website (<http://www.webbertraining.com>) also provides an education resource catalogue containing manuals and recordings of lectures, free posters to download and a library of more than 100 handouts and recordings from previous teleclass lectures.

### How teleclasses work

**Equipment:** The minimum technical requirement to participate in Teleclass Education is access to a telephone and access to the internet. Teleclasses take place over the telephone so participants can join wherever there is phone service. A link to the presenters' slides and handout notes, and the number of the Bridge Line and PIN code are e-mailed to all registrants approximately 48 hours in advance of the teleclass so access to e-mail is necessary. A data projector could be employed to project the speaker's slides, although the slides are also provided in 3/page and 6/page, black and white, pdf files.

A "Bridge Line" is a special telephone line that allows audio conferencing. The Bridge Line

phone number and PIN code number are sent out to all registrants two days before the teleclass date. At the scheduled time all registered sites dial the number, punch in the PIN code number when requested, and are automatically in the conference.

*Participants:* There is no limit to the number of people that can participate at each site – the more the better. The registration fee is per site (per telephone connection).

*Registration fee:* The registration fee of \$35AUD (several teleclasses through the year are free) provides access to the live teleclass, unlimited access to the online recording of the teleclass, permission to tape record the session on their own, and copies of the presenter's slides and handouts. The funds from registration fees also fund the No Barriers Initiative for healthcare professionals in developing nations.

*International participation:* There are 3 English-language teleclass series' – based in New York, London, and (most recently) Sydney – to be convenient for audiences in those areas. Teleclasses are recorded and made available as on-line recordings in the "Recordings Library" of <http://www.webbertraining.com>. Approximately 3 dozen of the lectures are also available as Enhanced Recordings on CD. As requests for teleclasses in other languages (as well as volunteers to manage those lecture series') emerge, non-English teleclasses have been / are being launched. A French-language series is available now, and teleclasses in Spanish, Urdu, Arabic, and Chinese are in the pipeline for 2007 or 2008.

*Founders:* Dr. Syed A. Sattar has, for more than 40 years, been involved in research on microbial pathogens. A major part of this work relates to understanding the influence of environmental factors on the survival and dissemination of pathogens through water, food, air, municipal wastes and animate and inanimate surfaces. He also studies the use of physical and chemical agents in interrupting the spread of infectious agents in indoor settings. Dr. Sattar has published over 200 papers in peer-reviewed journals and conference proceedings as well as several book chapters.

Paul Webber ([paul@webbertraining.com](mailto:paul@webbertraining.com)) has

been the President (or "Top Dog" as he calls himself) of a small Canadian company that supplies industrial and institutional hygiene products. When the scope and size of Teleclass Education became evident he created Webber Training to manage the program with a not-for-profit mandate. Paul Webber speaks on the topic of communicating the infection control message at conferences around the world, and is regularly invited to write and edit articles on similar topics.

Both Syed Sattar and Paul Webber volunteer their time for Teleclass Education, along with many others around the world, including Jane Barnett ([jane@webbertraining.com](mailto:jane@webbertraining.com)) of Christchurch, who heads up the South Pacific Teleclass Series.

### Help Wanted

Infection control professionals fluent in Spanish, French, Arabic, Urdu, and other world languages are needed to help develop infection control education materials for healthcare professionals in developing nations. Applicants will require good knowledge of infection control basics, an ability to assemble a PowerPoint presentation, and internet/email access.

Please contact Paul Webber:  
[paul@webbertraining.com](mailto:paul@webbertraining.com)

For more information visit the website:  
<http://www.webbertraining.com>

## Current Resources

*In this section, we list the abstracts of recent relevant articles about health care worker safety in the Asia Pacific. We will also list any new resources which might be helpful such as policies, protocols and training materials. In some instances we may include references from other regions if they can potentially be adapted to the region.*



SafeHandS invites members to contribute by sending an e-mail to: [safehands@sesiahs.health.nsw.gov.au](mailto:safehands@sesiahs.health.nsw.gov.au)

**Title:** Behavioural considerations for hand hygiene practices: the basic building blocks.

**Authors:** Whitby M, Pessoa-Silva C, et al.

**Date:** January 2007

**Source:** J Hosp Infect 65(1):1-8

**Country:** Australia

**Abstract:** Hand hygiene is considered to be the most effective measure to prevent microbial pathogen cross-transmission and healthcare-associated infections. In October 2005, the World Health Organization (WHO) World Alliance for Patient Safety launched the first Global Patient Safety Challenge 2005-2006, 'Clean Care is Safer Care', to tackle healthcare-associated infection on a large scale. Within the Challenge framework, international infection control experts and consultative taskforces met to develop new WHO Guidelines on Hand Hygiene in Healthcare. The taskforce was asked to explore aspects underlying hand hygiene behaviour that may influence its promotion among healthcare workers. The dynamics of behavioural change are complex and multi-faceted, but are of vital importance when designing a strategy to improve hand hygiene compliance. A reflection on challenges to be met and areas for future research are also proposed.

**Title:** Occupational exposures to blood-borne pathogens among health-care workers in Rio de Janeiro, Brazil

**Authors:** Rapparini C, Saraceni V, et al.

**Date:** February 2007

**Source:** J Hosp Infect 65(2):131-7

**Country:** Brazil

**Abstract:** Abstract: Healthcare workers (HCWs) frequently face the risk of occupational infection from blood-borne pathogens following exposure to blood and body fluids. This study describes the results of a surveillance system of occupational exposure to blood-borne pathogens among HCWs in Rio de Janeiro, Brazil, during an eight-year period. A total of 15035 exposures reported from 537 health units were reviewed. Six circumstances comprised nearly 70% of the reported exposures: recapping needles (14%), performing surgical procedures or handling surgical equipment (14%), handling trash (13%), during disposal into sharps containers (13%), performing percutaneous venepuncture (10%) and during blood drawing (5%). Easily preventable exposures, such as incidents related to recapping needles, handling trash, and sharps left in an inappropriate place, represented 30% of the exposures reported. Post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) was initiated for 46% of exposed HCWs. Although Brazilian guidelines indicate that PEP is usually not recommended for exposures with insignificant or very low risk of HIV infection, PEP was prescribed to a large proportion of exposed HCWs under these circumstances. The prevention of occupational exposure to blood-borne pathogens among HCWs and their safety must be considered as a public health issue. Although infection-preventative measures such as antiretroviral drugs and rapid tests are available, this study shows that there are still a high number of easily preventable exposures. The implementation of more effective prevention strategies is urgently required in this country.

**Title:** **Bacterial contamination of health care workers' pagers and the efficacy of various disinfecting agents**

**Authors:** Beer D, Vandermeer B, et al.

**Date:** November 2006

**Source:** *Pediatr Infect Dis J* 25(11):1074-5

**Country:** Canada

**Abstract:** Health care workers in our facility were surveyed, and their pagers were cultured before and after disinfection with various agents. All pagers were contaminated with bacteria, including the pathogens *Staphylococcus aureus*, *Pseudomonas aeruginosa*, *Acinetobacter baumannii*, *Klebsiella* spp. and methicillin-resistant *S. aureus*. Disinfection reduced bacterial contamination. No risk factors for pager contamination with pathogens were identified.

**Title:** **Effective hand hygiene education with the use of flipcharts in a hospital in El Salvador**

**Authors:** Caniza M, Maron G, et al.

**Date:** August 2006

**Source:** *J Hosp Infect* 65(1):58-64.

**Country:** El Salvador

**Abstract:** In developing countries, continuing education for healthcare staff may be limited by staff shortages and lack of sophisticated means of delivery. These limitations have implications for compliance with an important infection control practice, namely good hand hygiene. A comparison was made between the efficacy of two educational tools commonly used in healthcare and practical sanitation settings in developing countries, i.e. videotapes and flipcharts, in delivering hand hygiene education to 67 nurses in a paediatric hospital in El Salvador. Efficacy was measured on the basis of scores obtained in pre- and post-training tests consisting of 10 multiple-choice questions. Half of the nurses received video-based instruction and half received instruction via flipcharts. Both methods of instruction increased participants' knowledge of good hand hygiene, and the extent of knowledge acquisition by the two methods was similar. Feedback obtained from

flipchart users six months after training indicated that most of the respondents used the flipchart to teach hand hygiene to patients' families (62.5%), patients (50%) and health-care workers (43.8%). Flipchart users ranked flipcharts as their favourite educational tool. Flipcharts offer an economical, easy-to-use, non-technological yet effective alternative to videotapes for delivering education in developing countries. Although the use of flipcharts requires a skilled and well-trained instructor, flipcharts could be used more widely to deliver education in resource-poor settings.

**Title:** **Role of Safety-Engineered Devices in Preventing Needle-stick Injuries in 32 French Hospitals**

**Authors:** Lamontagne F, Abiteboul D, et al.

**Date:** September 2006

**Source:** *Infect Control Hosp Epidemiology* 28:18-23

**Country:** France

**Abstract:**

**Objectives:** To evaluate safety-engineered devices (SEDs) with respect to their effectiveness in preventing needle-stick injuries (NSIs) in healthcare settings and their importance among other preventive measures.

**Design:** Multi-centre prospective survey with a 1-year follow-up period during which all incident NSIs and their circumstances were reported. Data were prospectively collected during a 12-month period from April 1999 through March 2000. The procedures for which the risk of NSI was high were also reported 1 week per quarter to estimate procedure-specific NSI rates. Device types were documented. Because SEDs were not in use when a similar survey was conducted in 1990, their impact was also evaluated by comparing findings from the recent and previous surveys.

**Setting:** A total of 102 medical units from 32 hospitals in France.

**Participants:** A total of 1,506 nurses in medical or intensive care units.

**Results:** A total of 110 NSIs occurring during

at-risk procedures performed by nurses were documented. According to data from the 2000 survey, use of SEDs during phlebotomy procedures was associated with a 74% lower risk ( $P < .01$ ). The mean NSI rate for all relevant nursing procedures was estimated to be 4.72 cases per 100,000 procedures, for a 75% decrease since 1990 ( $P < .01$ ); however, the decrease in NSI rates varied considerably according to procedure type. Between 1990 and 2000, decreases in the NSI rates for each procedure were strongly correlated with increases in the frequency of SED use ( $r = 0.88$ ;  $P < .02$ ).

**Conclusion:** In this French hospital network, the use of SEDs was associated with a significantly lower NSI rate and was probably the most important preventive factor.

**Title:** **Needle-stick Injuries to the Feet of Japanese Healthcare Workers: A Culture-Specific Exposure Risk**

**Authors:** Yoshikawa T, Kidouchi K, et al.

**Date:** February 2007

**Source:** Infect Control Hosp Epidemiol 28: 215-8

**Country** Japan

**Abstract:** A comparison of needle-stick injury surveillance data from Japan and the United States revealed a higher proportion of foot injuries to Japanese healthcare workers (HCWs), compared with US HCWs. This study investigates the underlying factors that contribute to this difference and proposes evidence-based prevention strategies to address the risk, including the use of safety-engineered needle devices, point-of-use disposal containers for sharp instruments and devices, and closed-toe footwear.

**Title:** **Epidemiology of needle-stick and sharps injuries among professional Korean nurses**

**Authors:** Smith D, Choe M, et al.

**Date:** November - December 2006

**Source:** J Prof Nurs 22(6):359-66.

**Country** Korea

**Abstract:** Although needle-stick and sharps

injuries (NSI) are known to affect professional nurses at high rates, most studies depend on officially reported data and few have been undertaken in Korea. Thus, we surveyed a large cross-section of nurses from a hospital in Gangneung (response rate, 97.9%). Four hundred and thirty-two incidents of NSI were reported by 263 nurses (79.7%) in the previous 12-month period (average, 1.31 events/nurse/year). Syringe needles were the most common devices, affecting 67.3% and comprising 52% of all NSI events. Sixty percent of all NSI events involved contaminated devices. Opening an ampoule or vial was the most common cause (affecting 35.2% of all nurses and accounting for 15.9% of all NSI events). Logistic regression indicated that nurses working in "other" departments were 5.4 times more likely to suffer any NSI (odds ratio [OR] = 5.4; 95% confidence interval [95% CI] = 2.0-15.2;  $P < .05$ ) and 4.7 times more likely to incur a syringe-needle injury than nurses in intensive care units or inpatient departments (OR = 4.7; 95% CI = 2.0-11.6;  $P < .05$ ). Younger-than-average nurses (< 27 years) were 4.5 times more likely to suffer NSI (OR = 4.5; 95% CI = 1.7-12.6;  $P < .05$ ) and 3.1 times more likely to incur a syringe-needle injury (OR = 3.1; 95% CI = 1.4-7.0;  $P < .05$ ). Working mixed shifts also increased the risk of any NSI (OR = 4.0; 95% CI = 1.7-10.4;  $P < .05$ ) or syringe-needle NSI (OR = 4.4; 95% CI = 2.0-10.1;  $P < .05$ ). Overall, our study suggests that NSI are common among Korean hospital nurses and represent a significant occupational burden for this large Asian demographic. Intervention and preventive strategies to help reduce their NSI exposures are urgently required in this country.

**Title:** **Hospital biohazard control: low-cost device for safe collection and disposal of hypodermic needles**

**Authors:** Onayade A, Omotoso A, et al.

**Date:** October 2006

**Source:** Trop Doct 36(4):214-5

**Country** Nigeria

**Abstract:** This paper describes experience with a low-cost initiative for safe collection and disposal of hypodermic needles in health facilities in developing countries. Produced

locally, a purpose-made container for collecting 500-1000 used hypodermic needles should cost no more than 20-50 US cents. Trial in our immunization clinic and injection room for the last year has shown its potential for injection safety generally and particularly during immunization campaigns.

**Title:** **Introducing Alcohol-Based Hand Rub for Hand Hygiene: The Critical Need for Training**

**Authors:** Widmer A, Conzelmann M, et al.

**Date:** January 2007

**Source:** Infect Control Hosp Epidemiol 28:50-54

**Country:** Switzerland

**Abstract:**

**Background:** Use of an alcohol-based hand rub for hand hygiene has recently been recommended by the Centres for Disease Control and Prevention. However, the proper technique for using hand rub has not been well described and is not routinely taught in hospitals.

**Objective:** To evaluate the impact of training on proper technique as outlined by the European Standard for testing alcohol-based hand rubs (European Norm 1500) in a clinical study.

**Design, setting, and patients:** Prospective study including 180 healthcare workers (HCWs) in a 450-bed, university-affiliated geriatric hospital where alcohol-based hand rub was introduced in the late 1970s.

**Intervention:** Structured training program in hand hygiene with alcohol-based hand rub. Technique for using hand rub was tested by the addition of a fluorescent dye to the disinfectant and the number of areas missed was quantified by a validated visual assessment method. In addition, the number of bacteria eradicated was estimated by calculating the difference between the log<sub>10</sub> number of colony-forming units (cfu) of bacteria on the fingertips before and after the procedure, and reported as reduction factor (RF).

**Main outcome measure:** Log<sub>10</sub> cfu bacterial counts on fingertips before and after training in

the appropriate technique for using hand rub.

**Results:** At baseline, only 31% of HCWs used proper technique, yielding a low RF of 1.4 log<sub>10</sub> cfu bacterial count. Training improved HCW compliance to 74% and increased the RF to 2.2 log<sub>10</sub> cfu bacterial count, an increase of almost 50% ( $P < .001$ ). Several factors, such as applying the proper amount of hand rub, were significantly associated with the increased RF.

**Conclusion:** These results demonstrate that education on the proper technique for using hand rub, as outlined in EN 1500, can significantly increase the degree of bacterial killing.

**Title:** **Impact of Severe Acute Respiratory Syndrome Care on the General Health Status of Healthcare Workers in Taiwan**

**Authors:** Chen N-H, Wang P-C, et al.

**Date:** January 2007

**Source:** Infect Control Hosp Epidemiol 28:75-79

**Country:** Taiwan

**Abstract:**

**Background:** The impact of the outbreak of severe acute respiratory syndrome (SARS) was enormous, but few studies have focused on the infectious and general health status of healthcare workers (HCWs) who treated patients with SARS.

**Design:** We prospectively evaluated the general health status of HCWs during the SARS epidemic. The Medical Outcome Study Short-Form 36 Survey was given to all HCWs immediately after caring for patients with SARS and 4 weeks after self-quarantine and off-duty shifts. Tests for detection of SARS coronavirus antibody were performed for HCWs at these 2 time points and for control subjects during the SARS epidemic.

**Setting:** Tertiary care referral center in Taipei, Taiwan. **Subjects:** Ninety SARS-care task force members (SARS HCWs) and 82 control subjects.

**Results:** All serum specimens tested negative for SARS antibody. Survey scores for SARS

HCWs immediately after care were significantly lower than those for the control group ( $P < .05$  by the t test) in 6 categories. Vitality, social functioning, and mental health immediately after care and vitality and mental health after self-quarantine and off-duty shifts were among the worst subscales. The social functioning, role emotional, and role physical subscales significantly improved after self-quarantine and off-duty shifts ( $P < .05$ , by paired t test). The length of contact time (mean number of contact-hours per day) with patients with SARS was associated with some subscales (role emotional, role physical, and mental health) to a mild extent. The total number of contact-hours with symptomatic patients with SARS was a borderline predictor (adjusted  $R^2 = 0.069$ ;  $P = .038$ ) of mental health score.

**Conclusions:** The impact of the SARS outbreak on SARS HCWs was significant in many dimensions of general health. The vitality and mental health status of SARS HCWs 1 month after self-quarantine and off-duty shifts remained inferior to those of the control group.

**Title:** **Epidemiology of exposure to blood borne pathogens on a surgical service**

**Authors:** Bakaeen F, Awad S, et al.

**Date:** November 2006

**Source:** Am J Surg 192(5): 18-21

**Country:** USA

**Abstract:**

**Background:** The goal of this study was to analyze the type and mechanism of blood exposure injuries on the surgical service in order to develop appropriate preventative strategies.

**Methods:** A retrospective review of all exposure injuries affecting members of the operative care line at a single teaching institution between December 2002 and December 2005 was performed.

**Results:** Of 98 exposure injuries on the surgical service, only 17 (17%) were inflicted by hollow-bore needles. Seventy-four (76%) of these reported injuries occurred in the operating room (OR) and 24 (24%) occurred in other clinical areas. Sharps injuries accounted

for 69 (93%) of OR injuries and were inflicted by suture needles ( $n = 37$ , 50%), hollow-bore needles ( $n = 7$ , 9%), and sharp instruments ( $n = 25$ , 34%). Mucocutaneous contamination accounted for 5 (7%) of the OR exposures. Professionals most frequently injured were residents ( $n = 43$ , 44%), followed by nurses ( $n = 28$ , 29%), students ( $n = 17$ , 17%) and other healthcare workers ( $n = 10$ , 10%).

**Conclusions:** Blood exposure prevention strategies should be directed at safety within the surgical field and focused beyond hollow-bore needle stick injuries to include education, mentoring, and competency training.

**Title:** **Duration of Time on Shift Before Accidental Blood or Body Fluid Exposure for House-staff, Nurses, and Technicians**

**Authors:** Green-McKenzie J, Shofer F

**Date:** January 2007

**Source:** Infect Control Hosp Epidemiol 28:5-9

**Country:** USA

**Abstract**

**Background:** Shift work has been found to be associated with an increased rate of errors and accidents among healthcare workers (HCWs), but the effect of shift work on accidental blood and body fluid exposure sustained by HCWs has not been well characterized.

**Objectives:** To determine the duration of time on shift before accidental blood and body fluid exposure in house-staff, nurses, and technicians and the proportion of house-staff who sustain a blood and body fluid exposure after 12 hours on duty.

**Methods:** This retrospective, descriptive study was conducted during a 24-month period at a large urban teaching hospital. Participants were HCWs who sustained an accidental blood and body fluid exposure.

**Results:** House-staff were on duty significantly longer than both nursing staff ( $P = .02$ ) and technicians ( $P < .0001$ ) before accidental blood and body fluid exposure. Half of the blood and body fluid exposures sustained by house-staff occurred after being on duty 8

hours or more, and 24% were sustained after being on duty 12 hours or more. Of all HCWs, 3% reported an accidental blood and body fluid exposure, with specific rates of 7.9% among nurses, 9.4% among house-staff, and 3% among phlebotomists.

**Conclusions:** House-staff were significantly more likely to have longer duration of time on shift before blood and body fluid exposure than were the other groups. Almost one-quarter of accidental blood and body fluid exposures to house-staff were incurred after they had been on duty for 12 hours or more. House-staff sustained a higher rate of accidental blood and body fluid exposures than did nursing staff and technicians.

**Title:** **Fatigue Increases the Risk of Injury From Sharp Devices in Medical Trainees: Results From a Case-Crossover Study**

**Authors:** Fisman D, Harris A, et al.

**Date:** January 2007

**Source:** Infect Control Hosp Epidemiol 28:10-17

**Country:** USA

**Abstract:**

**Background:** Extreme fatigue in medical trainees likely compromises patient safety, but regulations that limit trainee work hours have been controversial. It is not known whether extreme fatigue compromises trainee safety in the healthcare workplace, but evidence of such a relationship would inform the current debate on trainee work practices. Our objective was to evaluate the relationship between fatigue and workplace injury risk among medical trainees and non-trainee healthcare workers.

**Design:** Case-crossover study.

**Setting:** Five academic medical centres in the United States and Canada.

**Participants:** Healthcare workers reporting to employee healthcare clinics for evaluation of needle-stick injuries and other injuries related to sharp instruments and devices (sharps injuries). Consenting workers completed a structured interview about work patterns, time at risk of injury, and frequency of fatigue.

**Results:** Of 350 interviewed subjects, 109 (31%) were medical trainees. Trainees worked more hours per week ( $P < .001$ ) and slept less the night before an injury ( $P < .001$ ) than did other healthcare workers. Fatigue increased injury risk in the study population as a whole (incidence rate ratio [IRR], 1.40 [95% confidence interval {CI}, 1.03-1.90]), but this effect was limited to medical trainees (IRR, 2.94 [95% CI, 1.71-5.07]) and was absent for other healthcare workers (IRR, 0.97 [95% CI, 0.66-1.42]) ( $P = .001$ ).

**Conclusions:** Long work hours and sleep deprivation among medical trainees result in fatigue, which is associated with a 3-fold increase in the risk of sharps injury. Efforts to reduce trainee work hours may result in reduced risk of sharps-related injuries among this group.

**Title:** **Effect of education on hand hygiene beliefs and practices: a 5-year program**

**Authors:** Wisniewski M, Kim S, et al, Chicago Antimicrobial Resistance Project

**Date:** January 2007

**Source:** Infect Control Hosp Epidemiol 28 (1):88-91

**Country:** USA

**Abstract:** To evaluate infection control and hand hygiene understanding at 3 public hospitals, we surveyed 4,345 healthcare workers (HCWs) 3 times during a 5-year infection control intervention. The preference for the use of alcohol hand rub for hand hygiene increased dramatically; in nurses, it increased from 14% to 34%; in physicians, 4.3% to 51%; and in allied HCWs, 12% to 44%. Study year, infection control interactive education-session attendance, infection control knowledge, and being a physician or allied HCW independently predicted a preference for alcohol hand rub.

**Title:** Prevalence and risk factors for blood-borne exposure and infection in correctional health-care workers

**Authors:** Gershon R, Sherman M, et al.

**Date:** January 2007

**Source:** Infect Control Hosp Epidemiol 28 (1):24-30

**Country:** USA

**Abstract:**

**Objective.** To determine the prevalence and risk factors for blood-borne exposure and infection in correctional healthcare workers (CHCWs).

**Design.** Cross-sectional risk assessment study with a confidential questionnaire and serological testing performed during 1999-2000.

**Setting.** Correctional systems in 3 states.

**Results.** Among 310 participating CHCWs, the rate of percutaneous injury (PI) was 32 PIs per 100 person-years overall and 42 PIs per 100 person-years for CHCWs with clinical job duties. Underreporting was common, with only 25 (49%) of 51 PIs formally reported to the administration. Independent risk factors for experiencing PI included being age 45 or older (adjusted odds ratio [aOR], 2.41 [95% confidence interval (CI), 1.31-4.46]) and having job duties that involved needle contact (aOR, 3.70 [95% CI, 1.28-10.63]) or blood contact (aOR, 5.05 [95% CI, 1.45-17.54]). Overall, 222 CHCWs (72%) reported having received a primary hepatitis B vaccination series; of these, 150 (68%) tested positive for anti-hepatitis B surface antigen, with negative results significantly associated with receipt of last dose more than 5 years previously. Serologic markers of hepatitis B virus infection were identified in 31 individuals (10%), and the prevalence of hepatitis C virus infection was 2% (n=7). The high hepatitis B vaccination rate limited the ability to identify risk factors for infection, but hepatitis C virus infection correlated with community risk factors only.

**Conclusion.** Although the wide coverage with hepatitis B vaccination and the decreasing rate of hepatitis C virus infection in the general population are encouraging, the high rate of

exposure in CHCWs and the lack of exposure documentation are concerns. Continued efforts to develop interventions to reduce exposures and encourage reporting should be implemented and evaluated in correctional healthcare settings. These interventions should address infection control barriers unique to the correctional setting.

**Title:** Work Schedule, Needle Use, and Needle-stick Injuries Among Registered Nurses

**Authors:** Trinkoff A, Le R, et al.

**Date:** February 2007

**Source:** Infect Control Hosp Epidemiol 28:156-164

**Country:** USA

**Abstract:**

**Objective:** To examine the association between working conditions and needle-stick injury among registered nurses. We also describe needle use and needle-stick injuries according to nursing position, workplace, and specialty.

**Design:** Three-wave longitudinal survey conducted between November 2002 and April 2004.

**Setting and Participants:** A probability sample of 2,624 actively licensed registered nurses from 2 states in the United States. Follow-up rates for waves 2 and 3 were 85% and 86%, respectively. Respondents who had worked as a nurse during the past year ( $n = 2,273$ ) prior to wave 1 were included in this analysis.

**Results:** Of the nurses, 15.6% reported a history of needle-stick injury in the year before wave 1, and the cumulative incidence by wave 3 was 16.3%. The estimated number of needles used per day was significantly related to the odds of sustaining a needle-stick injury. Hours worked per day, weekends worked per month, working other than day shifts, and working 13 or more hours per day at least once a week were each significantly associated with needle-stick injuries. A factor combining these variables was significantly associated with needle-stick injuries even after adjustment for job demands, although this association was somewhat explained by physical job demands.

**Conclusions:** Despite advances in protecting workers from needle-stick injuries, extended work schedules and their concomitant physical demands are still contributing to the occurrence of injuries and illnesses to nurses. Such working conditions, if modified, could lead to further reductions in needle-stick injuries.

**Title:** **Effect of the Introduction of an Engineered Sharps Injury Prevention Device on the Percutaneous Injury Rate in Healthcare Workers**

**Authors:** Azar-Cavanagh M, Burdt P, et al.

**Date:** February 2007

**Source:** Infect Control Hosp Epidemiol 28:165-170

**Country:** USA

**Abstract:**

**Objective:** To evaluate the effect of introducing an engineered device for preventing injuries from sharp instruments (engineered sharps injury prevention device [ESIPD]) on the percutaneous injury rate in healthcare workers (HCWs).

**Methods:** We undertook a controlled, interventional, before-after study during a period of 3 years (from January 1998 through December 2000) at a major medical center. The study population was HCWs with potential exposure to blood-borne pathogens. HCWs who sustain a needle-stick injury are required by hospital policy to report the exposure. A confidential log of these injuries is maintained that includes information on the date and time of the incident, the type and brand of sharp device involved, and whether an ESIPD was used.

**Intervention:** Introduction of an intravenous (IV) catheter stylet with a safety-engineered feature (a retractable protection shield), which was placed in clinics and hospital wards in lieu of other IV catheter devices that did not have safety features. No protective devices were present on suture needles during any of the periods. The incidence of percutaneous needle-stick injury by IV catheter and suture needles was evaluated for 18 months before and 18 months after the intervention.

**Results:** After the intervention, the incidence of percutaneous injuries resulting from IV catheters decreased significantly ( $P < .01$ ), whereas the incidence of injuries resulting from suture needle injuries increased significantly ( $P < .008$ ). **Conclusion:** ESIPDs lead to a reduction in percutaneous injuries in HCWs, helping to decrease HCWs' risk of exposure to blood-borne pathogens.

**Title:** **A safety information campaign to reduce sharps injuries: preliminary results from the "stop sticks campaign"**

**Authors:** Sinclair R, Harney A, et al.

**Date:** April 2006

**Source:** NORA Symposium 2006; National Institute for Occupational Safety and Health:169-170  
<http://www.cdc.gov/niosh/nora/symp06/pdfs/NORASymposium2006Book.pdf>

**Country:** USA

CDC estimates that more than 350,000 contaminated needle-sticks occur every year among hospital workers in the U.S. As many as half of those injuries are not reported to the employer. The risk of acquiring a blood-borne pathogen infection from needle-stick injuries varies according to a number of factors and the type of pathogen. Nevertheless, every injury may cost both the employee and the employer time and money for employee testing, post-exposure prophylaxis, and stress from the fact that illnesses resulting from such infections are serious and sometimes life-threatening. Needle-stick injuries occur with many occupational groups in hospitals. Although most occur among clinical-care workers, non-clinical workers such as housekeepers, maintenance workers, and laundry workers may also be injured. Sharps devices with safety features are a major component of most needle-stick prevention programs. Frontline workers with patient care responsibilities must be involved in the trial and selection of the most appropriate devices for each procedure in each facility. However, comprehensive exposure control plans, adequately-sized and placed sharps disposal containers, improved work practices, diligent injury reporting, and post-exposure follow-up are important parts of the prevention effort.

Training and information activities are critical for maintaining prevention awareness and skills among all health care workers. Although the health care industry has substantial infrastructure for conducting training and awareness activities, the primary focus is frequently on patient care and safety rather than both that and worker health and safety. Clinical training and information staff are often inexperienced at communicating about worker safety and health. Occupational safety and health staff may be inexperienced at communicating about clinical issues. Our research investigated methods of increasing sharps injury prevention behaviours among health care workers using information and training activities and both occupational safety and health and clinical expertise. We were interested in learning: What are the most effective ways to conduct communications activities around this issue in health care facilities? What are the best predictors of safer clinical behaviours? We conducted a five-year, community-focused information campaign in a U.S. city of under one million population. Training and information activities were conducted at various health care facilities in the community using campaign blitz tactics. Blitzes lasted four to six weeks and included the use of multiple media (posters, demonstrations, safety device fairs, information sessions, games, promotional items) multiple times to cover a small group of repeated messages that were determined by an analysis of sharps injuries at the facility. Pre and post tests were collected from convenient samples of employees. Five blitzes were conducted in high-injury departments (usually OR). One blitz was conducted at the community's largest hospital. One was conducted at a state-run nursing care facility. We found that, while reported exposure to safety messages increased, safety attitudes and knowledge did not change over time. Posters were the most-remembered channel of safety information in all cases but one, but remembering other channels varied due to differences across blitzes. Some safety behaviours increased (self-report), and virtually no safety behaviours decreased. Our most important findings were a) that safety behaviours improved most after blitzes conducted at the department (rather than facility) level, and b) that a perceived positive safety climate was, overall, the best predictor of safety behaviours. We conclude that clinical-care and occupational safety and health staff

should collaborate to conduct sharps injury prevention training and awareness blitzes, and that the scope of the blitz should be matched to available resources. Focus blitzes in high-risk departments if there are insufficient resources to adequately cover the entire facility. Employers can best influence safety behaviours by cultivating a positive safety climate.

**Title:** Cutting down on sharps injuries

**Authors:** Swallow A

**Date:** November 2006

**Source:** Nurs Manage 37(11 Suppl):6-7

**Country:** USA

**Abstract:** A collaborative and participative approach is helpful in reducing the transmission of blood-borne pathogens and other sharps-related injuries.

### A Request from Papua New Guinea for Assistance with Health Care Worker Safety Training

Dear Maggy Tomkins,

Thanks for the listed websites which provide good links.

However, I would greatly appreciate if my request can be kindly placed in this next Newsletter.

Here in PNG, having access to current publications on healthcare worker safety, training resources and policy protocols is one thing but having qualified trainers to deliver the programs to nurses, doctors and other care providers in remote centres of the country is a colossal task.

If any individual or organisation who is able to professionally assist us in implementing healthcare worker safety against blood-borne pathogens, please communicate with me.

Thank you most sincerely,

Dr. Sylvester Lahe

Secretary  
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## Calendar of Events

In SafeHandS *invites members to advise us about any future events related to health care worker safety which other members may be interested to attend. Send an email to: [safehands@sesiahs.health.nsw.gov.au](mailto:safehands@sesiahs.health.nsw.gov.au)*

### **17th European Congress of Clinical Microbiology and Infectious Diseases & 25th International Congress of Chemotherapy 31 March to 3 April, 2007 Munich, Germany**

“The European Society of Clinical Microbiology and Infectious Diseases (ESCMID) and the International Society of Chemotherapy (ISC) are joining forces to address the issues of global challenges in the disciplines of clinical microbiology and infectious diseases. We believe that combining tradition, science and strength of two thriving societies will form the foundation of a leading international meeting in Europe in the field of infectious diseases and clinical microbiology.

The programme committee has designed a programme of the highest scientific quality with keynote lectures, symposia, meet-the-expert sessions, educational workshops, poster discussions and additional sessions of the study and working groups of both societies.

All important aspects of current infectious diseases and clinical microbiology, including developments in opportunistic infections, emerging and re-emerging diseases, microbial resistance, new antimicrobials, vaccines, molecular biology and public health issues will be covered.”

For more information visit the website:  
<http://www.akm.ch/eccmid2007/>

### **The Society for Healthcare Epidemiology of America (SHEA) 17th Annual Scientific Meeting 14-17 April, 2007 Baltimore, USA**

“The SHEA Annual Meeting is the premier scientific meeting for healthcare epidemiologists and other individuals working in the field of healthcare epidemiology.

SHEA 2007's expert international faculty will address healthcare epidemiology issues within plenary, symposia, workshop, and meet the consultant formats. The program will provide attendees with the very latest information, including cutting edge updates on new and emerging issues such as avian influenza, problematic outbreaks, and cost-effective infection control. The program will also feature point-counterpoint discussions on controversial guidelines and reviews of the science and practice related to longstanding issues including antibiotic resistance, *Clostridium difficile*, advances in epidemiologic methods, hand hygiene, and healthcare worker and patient safety.”

For more information visit the website:  
[http://www.shea-online.org/about/annual\\_meeting\\_overview.cfm](http://www.shea-online.org/about/annual_meeting_overview.cfm)

### **Association for Professionals in Infection Control and Epidemiology, Inc (APIC) Annual Conference 24-28 June, 2007 San Jose, California, USA**

“Connect with your health care peers at the APIC 2007 Annual Conference in San Jose, California. APIC's 34th Annual Educational Conference & International Meeting promises to be an unrivalled forum for showcasing cutting-edge ideas in the increasingly complex field of infection prevention and control.

Network with 3,000 attendees representing more than 27 countries to gain innovative cost-saving strategies to improve compliance, manage risk, and reduce adverse outcomes.

Learn progressive techniques for eliminating healthcare-associated infections from leading experts of APIC, CDC, JCAHO, SHEA, and other key organizations.

Visit with nearly 200 vendors at the largest ever expo for infection prevention and control solutions.”

For more information visit the website:  
<http://www.apic.org/scriptcontent/custom/sites/ac2007/index.cfm>

**3rd International Congress of the Asia Pacific Society of Infection Control  
8-11 July, 2007  
Kuala Lumpur, Malaysia**

“The 3rd International Congress of the Asia Pacific Society of Infection Control entitling ‘Infection Control in a Global Village’ will be addressing aspects of new advances and research in infection control and infectious diseases. Our world is becoming smaller each passing day - infection control can thus no longer encompass purely on the human boundaries of a hospital, a city or even a nation. As we have read and seen the dispersion of SARS and Avian Influenza, spreading its influence without a passport, it is only clear that we can only control infection if we view our goals to be incorporated on a global scale. Our developments in order to stay ahead of this race, exploiting all knowledge and experiences we have, will only have to continue as we find more efficient and effective methods of infection control - excitingly, a never ending challenge!”

For more information visit the website:  
<http://www.apsic2007.com/>

**International AIDS Society Conference  
22-25 July, 2007  
Sydney, Australia**

“As the fourth conference in this series, IAS 2007 will feature reports of the latest developments in the areas of basic, clinical and prevention science. The conference will continue its strong emphasis on treatment and pathogenesis, while building upon the biomedical prevention agenda introduced in Rio de Janeiro, Brazil in 2005. As a defining feature of the conference, IAS 2007 will examine how scientific advances can, in very practical ways, inform the global response to HIV/AIDS.

Since the earliest years of the epidemic, Australia has maintained a strong commitment to HIV education, prevention, treatment and research. It was one of the first countries to develop a national strategy on HIV/AIDS, and currently supports dedicated research centres in several disciplines. The Australian response is based on a collaborative partnership between the research, health care, government and community sectors. On be-

half of all of these sectors, Australian Society for HIV Medicine (ASHM), one of the first HIV medicine societies in the world founded in 1987, looks forward to welcoming delegates to Sydney and to serving as local host. The truly international nature of the conference (with more than 125 countries represented in 2005) is an ideal opportunity for networking and collaboration.”

For more information visit the website:  
<http://www.ias2007.org>

**8th International Congress on AIDS in Asia and the Pacific (ICAAP)  
19-23 August 2007,  
Colombo, Sri Lanka**

“The theme of the 8th ICAAP, scheduled to take place in Colombo, Sri Lanka, is Waves of Change, Waves of Hope. The waves are a mighty and integral part of the host country, the island nation of Sri Lanka. Waves of Change signify many things happening; many things in motion, while taking into account milestones in the past and creating new ones for the future, new work-plans, timelines and a future for the HIV and AIDS community and the general public. It also implies that there is a mass of activity that needs to be carried out to change the world; creating a ripple-effect that would encompass the whole globe. Like the ebb and the flow of waves, global activity to prevent, control, battle and treat HIV and AIDS could also be adapted to suit each and every society, community, nation or region. Such action like the endless sea could cross continents but at the same time be culture specific, bringing about change, a new vision and victory against this disease.”

For more information visit the website:  
<http://www.icaap8.lk>

**8th Annual Congress of the International Federation of Infection Control (IFIC)  
18-22 October, 2007  
Budapest, Hungary**

For more information visit the website:  
<http://www.theifc.org>

## GRADUATE CERTIFICATE IN HIV/AIDS

**UNIVERSITY OF WOLLONGONG, Wollongong, Australia  
THE ALBION STREET CENTRE, Sydney, Australia  
CENTRE FOR THE ADVANCEMENT OF INTERNATIONAL HEALTH**

The University of Wollongong's Faculty of Health and Behavioural Sciences and the Albion Street Centre is offering students a new course leading to the formal qualification of a **GRADUATE CERTIFICATE IN HIV/AIDS**.

This course will be of particular interest and value to people who are working or have worked in the field of HIV/AIDS and who would like to gain a formal qualification from an Australian university, or to those who have some prior involvement in health activities and would like to expand their experience into the HIV/AIDS field. Those seeking to work internationally in the field of HIV/AIDS will find this course is designed to meet their needs.

The **Graduate Certificate in HIV/AIDS** provides students with a broad overview of the nature of infectious diseases (with a focus on HIV/AIDS and hepatitis C); an understanding of reproductive health care with an emphasis on developing countries and skills related to working with people affected by and/or living with HIV/AIDS. It will also develop skills in organizational management and reflective practice.

The course is taught both on the campus of the University of Wollongong and at the Albion Street Centre in Sydney. Some modules can be completed as part of the University's distance education programme. The **Graduate Certificate in HIV/AIDS** may be completed over the course of either one or two semesters (six or twelve months) and is available in each semester (commencing February and July).

### ENROLMENT DETAILS

On-line enrolment details may be found at:

<http://www.uow.edu.au/prospective/downloads/app-forms/pg-application.pdf>

### FURTHER CONTACT DETAILS

Enquiries about this Course, including enquiries about possible contractual delivery of the programme to offshore students should be addressed in the first instance to:

Mr Jeffrey Sheather  
Education Manager  
Albion Street Centre  
150 Albion St  
Surry Hills NSW 2010 Australia  
Tel: 61 (0)2 9332 9721  
Fax: 61 (0)2 9360 4387  
Email: [jeffrey.sheather@sesiahs.health.nsw.gov.au](mailto:jeffrey.sheather@sesiahs.health.nsw.gov.au)