

In SafeHandS

Newsletter of the SafeHandS network

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SafeHandS

..Information, support and practical solutions to promote health care worker safety in the Asia Pacific

? 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 Papua New Guinea.

The next issue will be in December 2007.

Deadline for contributions - 20th November, 2007. Guidelines for contributors can be found on the SafeHandS website.

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Editorial



Robyn Hill is currently employed as a Clinical Nurse Consultant in HIV/AIDS at the Albion Street Centre, Sydney, Australia. For the past eight years Robyn has worked closely with people at risk of HIV, hepatitis and sexually transmitted infections (STIs). Robyn has worked both in health care facilities and amongst the communities of remote areas of Australia, Sudan, Rwanda, Indonesia and Papua New Guinea in the fields of clinical care; including assessment, clinical management, harm minimisation, sexual health and education. In the last two years Robyn has also been involved in monitoring and evaluating health service activities, delivering training workshops, particularly community based programs in Papua New Guinea. In all of her positions Robyn has promoted the importance of developing networks and linkages between related organisations to maximise services delivered to target groups, facilitate efficiency and reduce duplication.

I don't assume that I know Papua New Guinea (PNG) well at all, nor do I profess to have a wealth of knowledge about it. I can say, however, that I really enjoy working there and the people are amazing and inspirational. One of the things that stick in my mind the most is the way people, particularly volunteers and health care workers, from different organisations work as a team to get the job done. Many have learnt to be really good net-workers and to do their best with whatever resources they have.

In some places in PNG, the conditions that people have to work in and the standards of infection control are extremely poor. In addition, the incidence of HIV continues to rise alarmingly and remains a serious public health issue which puts greater pressure on an already burdened health system. Yet amongst all of this, are local people who work tirelessly to provide care with very little resources. Perhaps it is another example of the 'wontok system' (or 'one talk'). "Wontok" literally refers to those from the same language group but in reality has more to do with links with people.

Foreigners have been vocal about infection control conditions, and are often very critical. I

am hesitant to make critical comments about the conditions in PNG because this in itself could be an insult to the people who still manage to do their job regardless of the conditions that they have to work in. When talking about this topic with some of the local PNG nurses they were very upset about what foreigners had to say about their practice.

*"Some of them offer all kinds of help. We used to get excited because someone has seen what we do here.... and maybe they can help us.but often they come here, spend a day if that, tell us how we **should** be doing it [looking after people with HIV]. They go and we never see them again. Then we hear along the grapevine how terrible we are'.*

*'We know we need help, but we want some to **help us, not criticise us**. We are just trying to do our best... with nothing.....'*

This was a valuable lesson learned on my first trip to PNG and I try and keep this in mind while at work. The other lesson was to be thankful for what we already have (no matter where we are) and to offer assistance where possible. That is why I think the SafeHandS newsletter is such a great idea. It gives us all an opportunity to share knowledge and to learn from our peers. I have learned a lot from my friends in PNG and I want to continue to share as much as I can with them.

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

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 August 2007, we had 154 members of SafeHandS working in 37 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, Qatar, Samoa, Solomon Islands, Sri Lanka, Taiwan, Thailand, Tibet, Tonga, Turkey, Tuvalu, USA, Vanuatu 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 two profiles of SafeHandS members.



Name: Julie Vit

Title: Nurse Coordinator of the Anua Moriri Clinic in Angau Hospital, Lae. Anua Moriri means "House of Blessing".

This comes from two languages, Anua from Milne Bay and Moriri from Koti.

Describe your current job:

I am the coordinator of the Day Care Centre and I, with my small team, care for people living with AIDS (PHLA) and their families. We do voluntary counselling and testing, comprehensive care of PLHA. i.e nursing assessment and triage, venepuncture and blood collecting, education sessions (eg medication adherence), sorting pharmaceuticals into take home packets for patients and data entry. We also do a lot of community awareness training about HIV. We have really strong relationships with the other health care facilities here in Lae as well, so networking and working as a team is an important part of my job as well. So as you can see we are very busy. We only have a small team here and we have a lot of people that we care for. It is also very difficult to care for so many people with very little resources.



Doing Day Care Centre Training

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

After graduation I was in Bougainville working in the Defence Force clinic. I then came to Angau Hospital in Lae to the medical ward in

1989. In 1989 - 2000 I was working in the TB DOTS programme. In 2003 I did a Psychiatric Nurse's course and in 2005 I came to the Anua Moriri Clinic

What do you like most about your job?

The satisfaction of helping people. Building relationships with people and building their trust. To see someone who has been very sick getting well again.

What do you like least about your job?

Busy days, heavy workload and not having many resources.

What does health care worker safety mean to you?

Keeping myself and others safe from infection and to take all necessary precautions to prevent being exposed to those infections.

What are you reading at the moment?

I haven't read a novel in years. I am reading *HIV management in Australasia: a guide for clinical care* from ASHM to build my knowledge.

What are you currently listening to?

Gospel music. My daughter and I are listening to 'Amazing love' I don't know who sings it but it really gives me strength.

What is your favourite saying?

I say this to myself and others for encouragement 'Use the little that you have to do what you are able to do.'



Name: Jacob Bogaperi

Title: Reverend

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Describe your current job:

Coordinator – HIV/AIDS Desk for the United Church of Papua New Guinea.

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

I was working as a Public Servant in the field of Contract Administration and Employment Conditions when the “call” came for me to take up active church ministry work. It was when I was in training as an intern minister that I came to “face to face” with HIV/AIDS. I was told that my little sister had contracted HIV/AIDS and I refused to believe it. In fact I disowned my own sister, did not want to have anything to do with her and never saw her alive again. She died whilst I was away doing my theological studies. I decided there and then to learn as much as I could about HIV/AIDS whilst in the theological college and that I would dedicate my ministry work to HIV/AIDS and its eradication after graduating from the theological college. When the HIV/AIDS Desk was established in the United Church of PNG, in the year 2005 I was then appointed to be the Coordinator.

What do you like most about your job?

To be able to share the word of God with those affected so that they may be able to accept the infected family member. I also enjoy training community health workers and church minister in HIV/AIDS and how we can work together to embrace this problem.

What do you like least about your job?

It is heart breaking for me to conduct funeral services for those that have died from AIDS.

What does health care worker safety mean to you?

It means a lot to me. We need our health care workers to take care of AIDS patients, but then again we have to build their capacity in this area and one of the most important aspect of their work is a “work place safety plan”. We have conducted one workshop in one of our Church regions for all the OICs of health centres on “safety at the workplace” and plans

are in place for more of these workshops, mainly in health centres in the provinces.

What are you reading at the moment?

At this very moment, just before typing up this questionnaire, I was reading a draft HIV/AIDS Policy for the United Church which I am putting together with the help of my Assembly HIV/AIDS Advisory team.

What are you currently listening to?

The results of the current PNG national election and the political bickering that is going on, as to who has the numbers to form the new government. This will have a lot of bearing on the HIV/AIDS work in the country.

What is your favourite saying?

“Put God first in everything”

Recently got email access?

Changed your email address?

If you received this newsletter in the post, it means you have not supplied your email address or the one you gave us is not working.

Please help to keep our costs down by letting 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

New estimates: the face of the HIV epidemic in Papua New Guinea

Media release: Port Moresby, Papua New Guinea, 8 August 2007

http://data.unaids.org/pub/PressRelease/2007/070808_png_new_data_en.pdf?preview=true

The National AIDS Council and National Department of Health have released the latest estimates on national HIV prevalence in Papua New Guinea (PNG).

The 2007 Estimation Report on the HIV Epidemic in Papua New Guinea reveals that the number of people living with HIV is estimated to be 46,275 as at December 2006. In 2006 only, 4,017 people were tested positive representing a 30% increase from 2005, bringing the total cumulative number of diagnosed cases to 18,484. The revised estimates indicate that the national HIV prevalence is 1.28% among adult's ages 15-49 years. While this estimated prevalence is less than previously documented, all HIV related indicators are increasing, with a sharp increasing trend in the projected number of new HIV infections, particularly in rural areas. There are also projected increases in the number of AIDS related deaths, the number of people requiring treatment, and the number of children and youth (0-17 years) being orphaned.

A more comprehensive picture of estimates has been obtained through improvements in methods of estimations applied; assumptions made, as well as increased and improved data from more sites.

Minister for Health and Bougainville Affairs, who is also the Minister Assisting the Prime Minister on HIV/AIDS matters, the Honourable Sir Peter Barter urged Papuan New Guineans to continue their vigilance against HIV. "The lower national HIV prevalence from previous years does not mean a decrease in the epidemic rather all projected HIV indicators show an increase", Sir Peter Barter said. "We must not become complacent and think that we will not become infected or affected by the epidemic. The impact of the epidemic is being felt in every province in the country". "People in rural areas should be aware that the trend is picking up strongly and it is expected that this year we could see a much higher HIV prevalence rate in the rural population

compared to the urban rate". "Papua New Guineans should continue prevention methods like abstaining from sex, being faithful or using a condom every time to prevent HIV infection."

Commenting on this important milestone, Dr Eigil Sorensen WHO Representative, praised NACs and NDOH for producing this report. "This is the one of the documents consistent with international standards in HIV estimations and projections. WHO has been and will continue to support NDOH and NACs in collaboration with other partners in tracking the epidemic. This will contribute to PNG meeting its Millennium Development Goals and universal access to prevention, care and treatment, and support goals".

Welcoming the country's efforts to better monitor its epidemic, Mr. Tim Rwabuhemba, UNAIDS Country Coordinator encouraged the national authorities to continue expanding surveillance, "Consistently improving data collection and methods of analysis is essential to providing an effective response to the HIV epidemic," he said. "The better we understand what is driving a country's epidemic and how it is evolving, the better we can respond to it and prevent new infections."

The Estimation Report makes 15 recommendations as the way forward. Some of these include; implementation of the 1st National Surveillance Plan 2007 – 2010, prioritization of behavioural and sentinel sero-surveillance, support and strengthening of laboratories, more focus given to the most high risk population and implementation of a national biobehavioural survey to provide a clear picture of HIV prevalence. The 2007 Estimation Report is essential for the national response and is also useful for advocacy, policy and planning, and surveillance purposes. The report was compiled following the 3rd National Consensus Workshop held in Lae and an international workshop on HIV estimates and projections held in Bangkok during 2007.

Infection control consultancy in Papua New Guinea

By Peter Said



It is said that we think that the grass is always greener somewhere else. Grass is grass and it can grow in even the harshest environment and under extreme conditions.

What I am trying to say is that despite modern technologies and medical advancements, some things persist. Infection Control issues continue to exist regardless of the setting. Access to resources and facilities may be limited in developing countries but the core of many infection control issues is no different. Simple things such as hand hygiene continue to be an issue the world over. In developed countries, such as Australia and the United States, access to running water, soap and paper towels are plentiful but often compliance is no better than in a developing country. Technology is not always a reliable predictor of a successful infection control strategy and there is often much complex behaviour associated with infection control non-compliance.

In June 2006 I was invited by the World Health Organisation (WHO) to be a short term infection control consultant in Papua New Guinea (PNG). In light of the increasing number of cases of avian influenza that threatened PNG's neighbouring borders at the time, there were concerns about the country's ability to effectively combat a potential epidemic. This was an opportunity to examine the current infection control capacity in both central and provincial PNG and make recommendations. PNG has a population of over 5.9 million people, with the majority of those living in rural settings, so access to adequate healthcare is compounded by the sheer size of the country.

The assignment took me to the country's capital, Port Moresby and the Port Moresby General Hospital, (which is currently the only tertiary referral hospital in PNG) and then to Vanimo General Hospital in a western provincial town, to review local infection control programs. The visit highlighted the great disparity that exists between infection control in Australia and countries such as PNG in light of financial resources. What we

access everyday for infection control programs in Australia are often very difficult to access in PNG. These include supplies of soap and running water, a consistent supply of personal protective equipment (PPE), and information about standard precautions and disease transmission. This can result in poor patient placement and stigma against patients and facilitates healthcare associated infections.

Regardless of geographic region, it is this basic understanding of simple yet highly effective infection control principles, which provides the ability to effectively combat the emerging and re-emerging pathogens that face the world today.

Many of the infection control practices that are implemented at a facility level either directly or indirectly provide a level of safety to healthcare workers. Healthcare workers are at the front line in providing quality healthcare, so it is in our best interest to preserve and protect healthcare workers at every possible cost.

But does a lack of financial support and material resources necessarily constitute an inability to provide a safe environment for healthcare workers? It has already been suggested, that even in countries that have adequate healthcare resources non-compliance still exists. Why is it that with unlimited access to running water, the latest in automated tap/faucet and soap dispensing technologies and a plentiful supply of active and non-active hand hygiene products our ability to comply with the simple task of hand washing is so poor? Of course this has been and remains the topic of much speculation and study.

If you don't have running water and soap does this mean that hand hygiene is an impossible feat? Does a lack of PPE equal an inability to provide an effective barrier against blood and body fluids as outlined in standard precautions? And does a lack of single or isolation room accommodation result in the inability to adequately isolate a patient with a highly communicable disease?

My visit to PNG proved both rewarding and challenging. It gave me great insight into the many complexities faced by the healthcare system in PNG as it attempted to implement effective infection control programs whilst combating the many severe restraints inflicted

upon it. The rewards were a direct result of the challenge. The challenge was comparing the “gold standard” of international best practice in infection control and HCW safety against that which is currently available and devising a range of alternatives to provide the safest possible environment for patients and healthcare workers regardless of the level of financial support or available material resources.

Below is a summary of the recommendations for hand hygiene and sharps handling with suggested alternative levels (level 1 being the “gold standard”, level 2 the next best alternative). [Recommendations for choosing appropriate levels of personal protective equipment (PPE) in resource constrained settings can be found in the *Guidance Note on Health Care Worker Safety from HIV and other Blood Borne Infections*¹ available on the SafeHandS website. Training on the use of appropriate PPE is essential and will prevent misuse and decrease unnecessary costs.]

Hand Hygiene



Level 1:

- Repair current sinks and replenish water supply
- Ensure good supply of hand hygiene product (liquid soap) and paper towel (for hand drying) is available and regularly replenished
- Access to Alcohol based rubs and gels.

Level 2:

- Ensure access to a supply of water for essential hand washing
- If liquid soap is not available provide access to bar soap on a suitable drainage rack
- If paper towel is not available, a supply of reusable towels made from old theatre drapes or sheets that are washed regularly and replenished.

All levels:

- Hospital-wide education on the importance

of hand hygiene

- Regular observational hand washing audits with results fed back to staff and use of locally developed hand washing posters demonstrating and reminding staff of the importance of hand hygiene.

Sharps Handling and Disposal



Level 1:

- Use of rigid plastic (approved) sharps containers
- Point of use containers
- Avoid recapping of needles or manipulation of sharps
- Seal sharps containers when $\frac{3}{4}$ full, store securely, do not reopen, and incinerate.
- Wear appropriate footwear
- Ensure adequate transport of sharps containers to waste facility.

Level 2:

- Use rigid containers/receptacles e.g. large card board boxes with lids
- If point of use access is not possible, a suitable rigid container such as a kidney dish or similar article can be used to transport needle or sharp to sharps container for disposal
- Boxes should be placed at a suitable height (not on floor, as they may become wet and collapse) and on a level surface to avoid spillage and potential for injury
- Sharps should be filled only to $\frac{3}{4}$ full and sealed prior to transport
- Staff transporting sharps containers should wear appropriate PPE, especially gloves, and transport sharps on a trolley rather than carry them by hand in case of accidental puncture
- If recapping is performed, this should be a one handed technique
- Open toed shoes or thongs should not be worn by those handling or transporting sharps.

I would like to take this opportunity to thank my infection control colleagues in PNG for

their time and assistance during my visit and also to congratulate them for their dedication to infection control as a profession in light of the many hardships they continue to face.

1. Gold J, Tomkins M, Melling P, Bates N (2004) Guidance Note on Health Care Worker Safety from HIV and other Blood Borne Infections The World Bank
<http://www.uow.edu.au/content/groups/public/@web/@health/documents/doc/uow025378.pdf>

An Audit on a Television Programme Medical Detectives

By WF Chan, RN, MPH

Wai-fong Chan is an Infection Control Nurse of Tung Wah Eastern Hospital of Hong Kong SAR. She is currently a part-time research student of School of Nursing, The Hong Kong Polytechnic University.

Introduction

“Medical Detectives” was a television programme produced by Radio Television Hong Kong under the advice of the Centre for Health Protection (CHP) in order to introduce the work of the newly established CHP to the public of Hong Kong. The programme was broadcast between May to July 2005.

Method

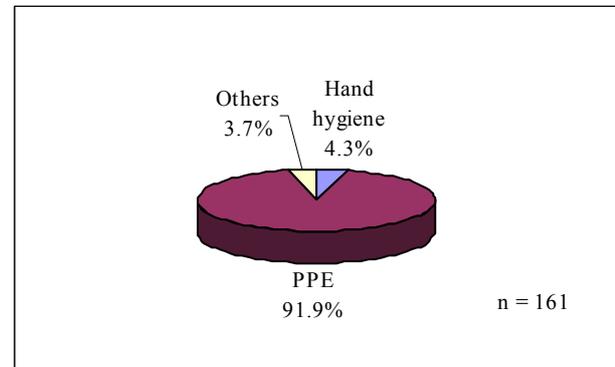
The internet version of “Medical Detectives” was audited in 2006 independently by three Infection Control Nurses to identify the inappropriate infection control actions. Standard precautions were used as the audit standard. Each auditor had at least eight years of field experience. The programme was revisited together by the three auditors in order to reach the consensus of the audit result.

Result

The programme lasted for 222.65 minutes (3.71 hours). A total of 161 shots of inappropriate infection control actions were identified. On average, an inappropriate action appeared on the screen every 1.4 minutes. Some shots even appeared simultaneously. We categorized the inappropriate infection control actions into hand hygiene, personal protective equipment (PPE) and others. The most dominant inappropriate infection control

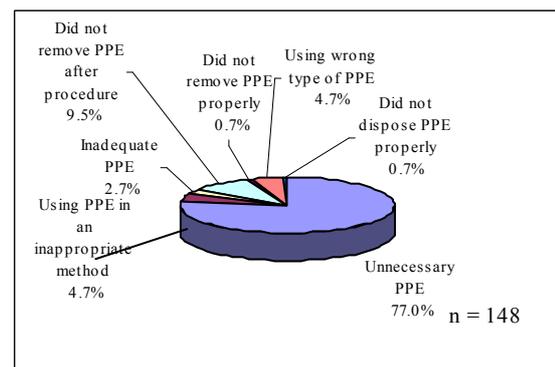
action was related to use of PPE. Fig.1 presented the distribution of the inappropriate infection control actions.

Fig.1: Distribution of inappropriate infection control actions



Among 148 shots of PPE related inappropriate infection control actions, most of them (77.0%) belong to unnecessary PPE, 9.5% of shots demonstrated not removing PPE after the procedure, 4.7% of shots were using wrong type of PPE, another 4.7% of shots were using the PPE in an inappropriate method, 2.7% of shots were related to inadequate PPE, 0.7% of shots showed not removing the PPE properly and the other 0.7% not disposing of the PPE properly. Fig.2 illustrated the details of inappropriate use of PPE during audit.

Fig.2: Distribution of inappropriate use of PPE



All the hand hygiene related inappropriate infection control actions were captured when hand hygiene was not performed after touching contaminated items.

Only 6 shots of inappropriate infection control actions were under the grouping of others. It consists of 33.3% of unnecessary exposure and 66.7% of inappropriate infection control practice.

Conclusion

Audiences should be cautious when interpreting the television programme as it may promote inappropriate infection control practice.

Discussion

Using PPE became more popular after the SARS epidemic in 2003, no matter whether in hospital or public health settings. In Hong Kong, we commonly see healthcare workers wearing their surgical masks all around the clinical area as a routine practice. It is not uncommon for them to wear their surgical masks while attending meetings and educational sessions. The routine use of N95 respirators and other PPE during cardiopulmonary resuscitation without assessing the patient's infectious risk is practiced. The practice of unnecessary usage of PPE appeared to be the commonest inappropriate infection control actions in our audit, which reflects the common practice in most healthcare workers. When PPE is used, the issues of appropriate application, proper wearing, removal and disposal must be addressed, will affect the safety of staff, patients and other supporting members.

Hand hygiene is the single most important measure to prevent the transmission of infection. The inappropriate demonstration in the television programme played as a negative reinforcement to the audience.

To prevent the spread of infection, education on appropriate infection control practices for healthcare workers and the public is essential. The television is an influencing tool for public education. The official organization should make good use of this means for disseminating proper infection control concepts.

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Acknowledgement

The author would like to thank for the contribution of the other two Infection Control Nurses of Hong Kong. Without their support, she cannot work out this paper to share the result with others.

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

Title: Sharps Injuries - Prevention in the NSW Public Health System

Authors: New South Wales Health Department

Date: June 2007

Source: Policy Directive PD2007_052
http://www.health.nsw.gov.au/policies/pd/2007/PD2007_052.html

Country: Australia

Summary: The purpose of this policy directive and associated guidelines is to prevent or minimise sharps injuries in the NSW public health system by directing organisations to develop a sharps injury prevention program utilising a risk management framework. The document also provides guidance for organisations to meet OHS legal obligations with regards to sharps injuries.

While designed for use in New South Wales, there are many resources within this policy directive which could be adapted for local use, including information about setting up a sharps injury prevention program the risk management process and several tools including:

- a survey of health care workers
- a worksheet for estimating implementation costs of safety-engineered medical devices
- a safety-engineered sharps device pre-selection worksheet
- a safety-engineered medical device evaluation form
- a sharps injury program assessment form
- clinical assessment sheets for intravenous cannulation and blood collection.

Title: Attitudes of health care workers to influenza vaccination: why are they not vaccinated?

Authors: Takayanagi IJ. Cardoso MR., et al.

Date: February 2007

Source: American Journal of Infection Control 35(1):56-61

Country: Brazil

Abstract:

Background: Compliance rates with influenza vaccination among health care workers (HCW) are historically low. Although a safe and effective vaccine is available, the reasons for such poor compliance are not well understood.

Methods: After a campaign encouraging HWC to vaccinate against influenza, we conducted an epidemiologic survey to evaluate the reasons for compliance and accompanied the impact of these measures (campaign and questionnaire) during the subsequent 2 years.

Results: Compliance rate was 34.4%. Multivariate analysis showed that "older age" ($P = .008$), "believing that most departmental colleagues had been vaccinated" ($P < .0001$), and "having cared for patients suffering from severe influenza" ($P = .031$) were significantly associated with compliance with influenza vaccination. The main reason given for being vaccinated was "individual protection" and, to a lesser extent, "protection for the patient." In subsequent years, compliance rates among those participating in the survey fell to 20.2% in 2004, when the only measure taken was the questionnaire, and to 12.75% in 2005, when no educational intervention was scheduled.

Conclusion: We conclude that a better understanding of HCW's negative attitude regarding influenza vaccination is needed as are more appealing and convincing continuous education programs, to ensure motivation for influenza vaccination over a longer period.

Title: Determinants of healthcare workers' compliance with infection control procedures

Authors: Yassi A, Lockhart K, et al.

Date: January 2007

Source: Healthcare Quarterly 10(1):44-52

Country: Canada

Abstract: The purpose of this study was to assess determinants of healthcare worker (HCW) self-reported compliance with infection control procedures. A survey was conducted of HCWs in 16 healthcare facilities. A strong correlation was found between both environmental and organizational factors and self-reported compliance. No relationship was found with individual factors. Only 5% of respondents rated their training in infection control as excellent, and 30% felt they were not offered the necessary training. We concluded that compliance with infection control procedures is tied to environmental factors and organizational characteristics, suggesting that efforts to improve availability of equipment and promote a safety culture are key. Training should be offered to high-risk HCWs, demonstrating an organizational commitment to their safety.

Title: Promotion of hand hygiene techniques through use of a surveillance tool

Authors: Pashman J, Bradley E, et al.

Date: 31 May 2007

Source: J Hosp Infect 66(3): 249 - 54

Country: China

Abstract: Effective hand hygiene practice in a clinical healthcare setting is the most effective means to prevent, control and reduce healthcare-associated infections. Despite the introduction of hand hygiene practices and targeted campaigns, surveillance to ensure implementation of these techniques remains limited. Surveillance is widely accepted as an essential component to infection control campaigns. Therefore, we sought to design and test an easy-to-use surveillance instrument for hospital hand hygiene developed and piloted for three months in nine hospitals in China. This paper presents the resulting hand hygiene surveillance instrument as well as

explicit guidelines for its implementation.

Title: Occupational Exposure to HIV Among Health Care Providers: A Qualitative Study in Yunnan, China

Authors: Li L, Lin C, et al.

Date: Jul 19 2007

Source: J Int Assoc Physicians AIDS Care

Country: China

Abstract: With the HIV/AIDS epidemic spreading, health care providers (HCPs) in China are facing a growing risk of occupational exposure to and infection with HIV. There is a need to describe occupational exposure cases and compliance with post-exposure prophylaxis (PEP) guidelines among HCPs. Qualitative in-depth interviews were conducted with 33 HCPs in Yunnan Province, China. Information about occupational exposures the HCPs and their co-workers experienced was collected and analyzed using ATLAS.ti. Most occupational exposure accidents happened during emergencies, when HCPs did not have time to consider self-protection. Exposure to HIV caused exposed HCPs severe adverse psychological pressure, such as stress and anxiety. Compliance with PEP guidelines among participants was poor; barriers to better compliance were identified. This study underscored the importance of institutional support in promoting compliance with PEP guidelines among exposed providers. Further training and emphasis on universal precautions and PEP guidelines may reduce the risk of occupational infections.

Title: Immediate and sustained psychological impact of an emerging infectious disease outbreak on health care workers

Authors: McAlonan G, Lee A, et al.

Date: April 2007

Source: Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie

Country: China - Hong Kong

Abstract:

Objective: To assess the immediate and sustained psychological health of health care workers who were at high risk of exposure

during the severe acute respiratory syndrome (SARS) outbreak.

Methods: At the peak of the 2003 SARS outbreak, we assessed health care workers in 2 acute care Hong Kong general hospitals with the Perceived Stress Scale (PSS-10). One year later, we reassessed these health care workers with the PSS-10, the 21-Item Depression and Anxiety Scale (DASS-21), and the Impact of Events Scale-Revised (IES-R). We recruited high-risk health care workers who practised respiratory medicine and compared them with non-respiratory medicine workers, who formed the low-risk health care worker control group.

Results: In 2003, high-risk health care workers had elevated stress levels (PSS-10 score = 17.0) that were not significantly different from levels in low-risk health care worker control subjects (PSS-10 score = 15.9). More high-risk health care workers reported fatigue, poor sleep, worry about health, and fear of social contact, despite their confidence in infection-control measures. By 2004, however, stress levels in the high-risk group were not only higher (PSS-10 score = 18.6) but also significantly higher than scores among low-risk health care worker control subjects (PSS-10 score = 14.8, $P < 0.05$). In 2004, the perceived stress levels in the high-risk group were associated with higher depression, anxiety, and posttraumatic stress scores ($P < 0.001$). Posttraumatic stress scores were a partial mediator of the relation between the high risk of exposure to SARS and higher perceived stress.

Conclusions: Health care workers who were at high risk of contracting SARS appear not only to have chronic stress but also higher levels of depression and anxiety. Front-line staff could benefit from stress management as part of preparation for future outbreaks.

Title: Sustained antibacterial effect of a hand rub gel incorporating chlorhexidine-loaded nanocapsules (Nanochlorex)

Authors: Nhung D, Freydiere A, et al.

Date: 4 April 2007

Source: Int J Pharm 334(1-2):166-72

Country: France

Abstract: In the present study, an original chlorhexidine-loaded nanocapsule-based gel (Nanochlorex) was tested as hand rub gel against the resident skin flora in comparison with 2-propanol 60% (v/v) and 62% (v/v) ethanol-based gel (Purell). After 30-s hand rub, the immediate bactericidal effect of Nanochlorex was found comparable to 2-propanol 60% (v/v) (reduction factor, RF: 0.30 ± 0.35 versus 0.38 ± 0.55 , $P > 0.05$) against aerobic bacteria, whereas the post-values of surviving anaerobes were shown significantly lower from Nanochlorex ($P < 0.001$) and insignificant from 2-propanol 60% (v/v) ($P > 0.05$). Sustained antibacterial effect of Nanochlorex was confirmed against the resident and transient hand flora in two sets of experiment. In the first, the results obtained with the glove-juice technique showed that the bactericidal effect induced by Nanochlorex hand rub persisted throughout 3-h period, while Purell failed to reduce significantly the post-values of surviving bacteria. In the second, repeated artificial contaminations with *Staphylococcus epidermidis* was carried out onto ex vivo human skin pre-treated by either Nanochlorex or Purell for 5min, then maintained in cell diffusion apparatus for 4h. The \log_{10} reduction of surviving bacteria was significantly higher with Nanochlorex than that determined with Purell after three successive contaminations (from approximately 5.5 to 1.5 \log_{10} reduction for Nanochlorex between the first and the third contamination; approximately 1 \log_{10} reduction for Purell throughout the experiment), confirming the sustained antibacterial effect of chlorhexidine-loaded nanocapsule-based gel. The immediate and sustained antibacterial effect of Nanochlorex was explained by chlorhexidine carrier system which improved the drug targeting to bacteria and reduced from osmotic gel further bacterial growth on the skin. Nanochlorex might constitute a promising approach for hygienic hand disinfection in care practice performing multiple procedures.

Title: A long-term study of sharps injuries among health care workers in Japan

Authors: Nagao Y, Baba H, et al.

Date: August 2007

Source: American Journal of Infection Control 35(6): 407-411

Country: Japan

Abstract:

Background: The risk of transmission of occupational blood-borne infection is a serious problem for health care workers (HCWs) in Japan. Although the Japanese version of Exposure Prevention Information Network (EPINet) was introduced in 1997, no published data in the clinical setting have been available yet.

Objective: To examine the epidemiology of occupational sharps injuries of HCWs in a university hospital using EPINet and to analyze the trends and changes in epidemiologic characteristics of needlestick injuries in a detailed situation.

Methods: The HCWs were requested to report sharps injury incidents to the Infection Control Nurse when the incidents occurred. Those who were involved in the incidents were required to personally complete an EPINET form.

Results: A total of 259 cases of sharps injuries occurred during the 7-year period. Registered nurses accounted for 72.2% of the cases, constituting the largest group of the HCWs. The incidents occurred most frequently in the hospital wards. Thirty-three cases (55.9%) of the injuries with syringe-needle units occurred "after use before disposal," whereas 34 cases (73.9%) of the injuries with suture needles occurred "during use of device." More than half of the injuries with a winged steel needle occurred despite the protective mechanism.

Discussion: There was no apparent difference in the characteristics of the subjects compared with other reports. The circumstances of the injuries varied with the kinds of instruments. This fact may provide useful information for planning measures to sharps injuries.

Conclusions: With the problem of under-reporting aside, a detailed study, such as ours, comprising by job category and by kind of instrument or the like would provide more useful and effective information in terms of sharps injury prevention.

Title: Challenges in HIV post-exposure prophylaxis for occupational injuries in a large teaching hospital in Malawi

Authors: van Oosterhout J, Nyirenda M, et al.

Date: January 2007

Source: Tropical Doctor 37 (1): 4-6(3)

Country: Malawi

Abstract: We describe the evaluation of the HIV post-exposure prophylaxis (PEP) programme for occupational injuries in Queen Elizabeth Central Hospital, Blantyre, Malawi. An audit was performed 1 year after introduction, by reviewing files of all clients who sought advice regarding PEP. In addition, the incidence of occupational injuries and awareness of the programme were assessed through interviews with nurses. The logistics of the programme were adequate. Of 29 clients who reported occupational injuries, 19 started PEP. Only double antiretroviral drug therapy was available; side-effects were common but generally mild. Attendance of scheduled follow-up visits was poor, and few HIV test results after completion of PEP were obtained. Interviews with nurses revealed a high incidence of occupational injuries, but many did not report for advice about PEP; mostly because of unawareness of the programme and a reluctance to be tested for HIV.

Title: AIDS is a tear in the social fabric of Papua New Guinea: HIV and its impact, 2005-2025

Authors: Worth H, Henderson K.

Date: August 2006

Source: Health Sociology Review 15(3): 293-304

Country: Papua New Guinea

Abstract: Using epidemiological data, this

paper discusses the social impact of HIV in Papua New Guinea over the next two decades. It shows that the country will be facing an adult prevalence rate of nearly 11% by 2025, and that over 300,000 adults will die of AIDS related illness. HIV will impact particularly at the family and community levels, and women may bear a disproportionate burden of that impact. Immense pressure will be placed on families to cope with illness and death -both in terms of caring work and coping financially. This, in turn, will place pressure on village systems. These systems will be undermined by the loss of social capital that comes with widespread illness and the negative impact of the epidemic on the agriculture, education and health sectors. The major governance and security impacts will also be felt at village level - how to sustain viable local governance systems in the face of HIV.

Title: Needlestick injuries in an era of HIV: technical and personal aspects

Authors: Stevens M.

Date: 2007

Source: African Journal of AIDS Research 6(1): 41–48

Country: South Africa

Abstract: Hospitals are workplaces in which HIV has double significance. Needlestick accidents link patients, healthcare workers and cleaning staff through the risk of occupational exposure to HIV. Additionally, concern over needlestick injuries may embody HIV stigma, discrimination and fear. This paper draws on qualitative research from a one-year case study at a large, private South African healthcare company that runs a number of hospitals across the country. Issues surrounding needlestick injuries were discussed with hospital managers, union members, infection-control nurses, health and safety representatives, HIV/AIDS counsellors, and general nursing staff. Needlestick injuries presented a complex set of technical and personal concerns. The research shows that cost-management, human rights, health and safety procedures, stigma and discrimination, and the quality of patient care are all relevant to needlestick injuries in an era of HIV. Participants' concerns focused on: establishing safety procedures, the cost and efficacy of

waste disposal systems, access to post-exposure prophylaxis, legal implications, and baseline HIV tests following needlestick injuries. The last topic revealed numerous other issues, including the possibility of health workers 'legitimising' sexually acquired HIV infection by passing it off as an occupational accident. Healthcare facilities should ensure procedures that minimise occupational exposure to HIV and that minimise infection risk in the event of accidents. We propose that hospitals ought to directly encourage staff to learn their HIV status and seek disease management when needed. Likewise, better approaches to dealing with HIV stigma and discrimination are needed, especially to dispel myths of good and bad ways of contracting HIV.

Title: Use of the Haddon matrix as a tool for assessing risk factors for sharps injury in emergency departments in the United Arab Emirates

Authors: Ganczak M, Barss P, et al.

Date: June 2007

Source: Infect Control Hosp Epidemiol 28 (6):751-4

Country: United Arab Emirates

Abstract:

We investigated the epidemiology and prevention of sharps injuries in the United Arab Emirates. Among 82 emergency nurses and 38 doctors who responded to our questionnaire, risk factors for sharp device injuries identified using the Haddon matrix included personal factors (for the pre-event phase, a lack of infection control training, a lack of immunization, and recapping needles, and for the post event phase, underreporting of sharps injuries) and equipment-related factors (for the pre-event phase, failure to use safe devices; for the event phase, failure to use gloves in all appropriate situations). Nearly all injuries to doctors were caused by suture needles, and among nurses more than 50% of injuries were caused by hollow-bore needles.

Title: Percutaneous venepuncture practice in a large urban teaching hospital

Authors: Little M, Hussein T, et al.

Date: June 2007

Source: Clin Med 7(3):243-9

Country: United Kingdom

Abstract: Occupational exposure to blood-borne pathogens remains an important and largely preventable issue in hospital practice. This article argues that formal training can increase use of best practice phlebotomy. A survey of at-risk healthcare workers at a central London hospital was conducted to identify factors associated with use of an evacuated blood collection system (BD Vacutainer and gloves while taking blood. Eighty per cent of doctors and 37% of non-doctors performing percutaneous venepuncture did not use the Vacutainer system exclusively. Doctors qualified less than three years were particularly likely to prefer needle and syringe. Venepuncture technique training significantly increased the probability of always using the Vacutainer system from 7% to 46%. The only factor independently associated with glove use was operator experience. There is considerable room for improvement in phlebotomy technique, particularly among junior doctors. The Modernising Medical Careers initiative provides a unique opportunity to implement this.

Title: Needlestick injuries among surgeons in training

Authors: Makary M, Al-Attar A, et al.

Date: 28 June 2007

Source: N Engl J Med 356(26):2693-9

Country: USA

Abstract:

Background: Surgeons in training are at high risk for needlestick injuries. The reporting of such injuries is a critical step in initiating early prophylaxis or treatment.

Methods: We surveyed surgeons in training at 17 medical centres about previous needlestick injuries. Survey items inquired about whether the most recent injury was reported to an

employee health service or involved a "high-risk" patient (i.e., one with a history of infection with human immunodeficiency virus, hepatitis B or hepatitis C, or injection-drug use); we also asked about the perceived cause of the injury and the surrounding circumstances.

Results: The overall response rate was 95%. Of 699 respondents, 582 (83%) had had a needlestick injury during training; the mean number of needlestick injuries during residency increased according to the post-graduate year (PGY): PGY-1, 1.5 injuries; PGY-2, 3.7; PGY-3, 4.1; PGY-4, 5.3; and PGY-5, 7.7. By their final year of training, 99% of residents had had a needlestick injury; for 53%, the injury had involved a high-risk patient. Of the most recent injuries, 297 of 578 (51%) were not reported to an employee health service, and 15 of 91 of those involving high-risk patients (16%) were not reported. Lack of time was the most common reason given for not reporting such injuries among 126 of 297 respondents (42%). If someone other than the respondent knew about an unreported injury, that person was most frequently the attending physician (51%) and least frequently a "significant other" (13%).

Conclusions: Needlestick injuries are common among surgeons in training and are often not reported. Improved prevention and reporting strategies are needed to increase occupational safety for surgical providers.

Title: Costs of Management of Occupational Exposures to Blood and Body Fluids

Authors: O'Malley E, Scott R, et al.

Date: June 2007

Source: Infection Control and Hospital Epidemiology 28 (7): 774 - 782

Country: USA

Abstract:

Objective: To determine the cost of management of occupational exposures to blood and body fluids.

Design: A convenience sample of 4 health-care facilities provided information on the cost of management of occupational exposures that varied in type, severity, and exposure

source infection status. Detailed information was collected on time spent reporting, managing, and following up the exposures; salaries (including benefits) for representative staff who sustained and who managed exposures; and costs (not charges) for laboratory testing of exposure sources and exposed healthcare personnel, as well as any postexposure prophylaxis taken by the exposed personnel. Resources used were stratified by the phase of exposure management: exposure reporting, initial management, and follow-up. Data for 31 exposure scenarios were analyzed. Costs were given in 2003 US dollars.

Setting: The 4 facilities providing data were a 600-bed public hospital, a 244-bed Veterans Affairs medical centre, a 437-bed rural tertiary care hospital, and a 3,500-bed healthcare system.

Results: The overall range of costs to manage reported exposures was \$71-\$4,838. Mean total costs varied greatly by the infection status of the source patient. The overall mean cost for exposures to human immunodeficiency virus (HIV) infected source patients (n=19, including those co-infected with hepatitis B or C virus) was \$2,456 (range, \$907-\$4,838), whereas the overall mean cost for exposures to source patients with unknown or negative infection status (n=8) was \$376 (range, \$71-\$860). Lastly, the overall mean cost of management of reported exposures for source patients infected with hepatitis C virus (n=4) was \$650 (range, \$186-\$856).

Conclusions: Management of occupational exposures to blood and body fluids is costly; the best way to avoid these costs is by prevention of exposures.

Title: **Costs of needlestick injuries and subsequent hepatitis and HIV infection**

Authors: Leigh J, Gillen M, et al.

Date: 25 July 2007

Source: Curr Med Res Opin. [Epub]

Country: USA

Abstract:

Background: Physicians, nurses and other healthcare workers (HCWs) are at risk of blood-borne pathogens infection from needle-

stick injuries, but costs of needlesticks are little studied.

Methods: We used the cost-of-illness and incidence approaches. We used the perspective of the medical provider (medical costs) and the individual (lost productivity). Data on needle-sticks, infections from hepatitis B and C (HBV, HCV) and human immune-deficiency (HIV) among HCWs, as well as data on per-unit costs were culled from research literature, Centres for Disease Control and Prevention reports, and Bureau of Labour Statistics reports. We also generated estimates based upon industry employment and scenarios for source-patients. These data and estimates were combined with assumptions to produce a model that generated base-case estimates as well as one-way and multi-way probabilistic sensitivity analyses. Future costs were discounted by 3%.

Results: We estimated 644,963 needlesticks in the healthcare industry for 2004 of which 49% generated costs. Medical costs were \$107.3 million of which 96% resulted from testing and prophylaxis and 4% from treating long-term infections (34 persons with chronic HBV, 143 with chronic HCV, and 1 with HIV). Lost-work productivity generated \$81.2 million, for which 59% involved testing and prophylaxis and 41% involved long-term infections. Combined medical and work productivity costs summed to \$188.5 million. Multi-way sensitivity analysis suggested a range on combined costs from \$100.7 million to \$405.9 million.

Conclusion: Detailed methodology was developed to estimate costs of needlesticks and subsequent infections for hospital-based and non-hospital-based health care workers. The combined medical and lost productivity costs comprised roughly 0.1% of all occupational injury and illness costs for all jobs in the economy. We did not account for lost home production or pain and suffering costs, however, nor did we estimate benefit/cost ratios of specific interventions to reduce needlesticks.

Title: Hospital work environments, nurse characteristics, and sharps injuries

Authors: Clarke S

Date: May 2007

Source: American Journal of Infection Control 35(5):302-309

Country: USA

Abstract:

Background: A growing body of research links working conditions, such as staffing levels and work environment characteristics, with safety for both patients and workers in health care settings, including sharps injuries in hospital staff nurses.

Methods: Surveys of 11,516 staff nurses from 188 Pennsylvania general acute care hospitals in 1999 were analyzed. Hospital work environments, measured using the Practice Environment Scales of the Nursing Work Index-Revised, and staffing were tested as predictors of experiencing at least one sharps injury in the preceding year, both before and after controlling for nurse risk factors, use of safety-engineered devices, and hospital structural characteristics.

Results: Nurses with less than 5 years of experience, perioperative nurses, and those performing routine venipuncture for blood draws were more likely to be injured. Nurses working in hospitals with the most favourable working environments were one-third less likely to be injured. Staffing levels were not associated with sharps injuries.

Conclusions: Across a large state, nurses working in acute care hospitals with better practice environments had fewer sharps injuries. Work environment conditions and specialty- and setting-specific risk factors deserve continued attention in sharps injury research.

Title: Construction: A model program for infection control compliance

Authors: Kidd F, Buttner, Kressel A

Date: June 2007

Source: American Journal of Infection Control 35(5):347-350

Country: USA

Abstract:

Issue: In the 21st century, one of the most challenging tasks for the infection control practitioner (ICP) is establishing collegiality and trust with contractors, architects, maintenance and engineering personnel. We describe how an urban teaching hospital's infection control program cooperated with contractors during a large demolition, construction, and renovation project in order to protect its large population of immunosuppressed patients.

Project: Most contractors are not accustomed to taking special precautions during demolition. Because of a previous *Aspergillus* outbreak in our heart transplant population, we already had an established infection control (IC) training program for contractors. We expanded and codified it in response to a major hospital renovation. The IC, in-house Design and Construction, and outside contractors meet before the initiation of all major renovation projects to anticipate IC concerns and proactively plan for infection control interventions. Now, all contractors and maintenance staff are required to receive IC training at the time of their employment. A hospital identification badge with attached sticker that indicates the IC training date is required. Infection Control Risk Assessments (ICRA) are initiated by project managers and completed jointly with IC. The ICPs make rounds on all projects at least weekly and large projects are visited daily. We established a team comprised of ICP, project manager, construction manager, and area nurse manager to monitor and make recommendations for improvement continually during the project. Staff are educated about construction so they can help monitor airflow and cleanliness.

Results: Our contractors are more compliant with our IC specifications since they now understand why we insist on them. Through the years of major construction, the workers have jumped on the bandwagon. It is not unusual for construction or maintenance staff to contact IC for advice. There were four years of extensive construction without any hospital acquired *Aspergillus* infections. In the 5th year, after a neighbouring institution started demolition and new construction, we identified two possible nosocomial infections and took immediate steps to make more corrections. There have been no further infections.

Lessons Learned: The IC compliance is based on trust, education, and on-going monitoring. Proactive education and collaboration lead to long-term relationships, trust and patient safety.

Title: **Pandemicflu.gov**
Authors: US Department of Health and Human Services
Date: Ongoing
Source: <http://www.pandemicflu.gov/>
Country: USA

This US Government website is a collection of resources about avian and pandemic influenza. Although designed for the US, there are many resources which could be adapted for local settings – such as preparedness checklists for individuals, businesses and health care facilities.

Title: **Risk of tuberculosis infection and disease associated with work in health care settings**
Authors: Menzies D. Joshi R. Pai M.
Date: June 2007
Source: International Journal of Tuberculosis & Lung Disease 11(6):593-605
Country: Global

Abstract:

Background: Tuberculosis (TB) in health care workers (HCWs) was not considered a serious problem following the advent of effective antibiotic therapy. Interest was re-stimulated by the occurrence of several major nosocomial outbreaks.

Methods: We have reviewed the available published literature regarding prevalence and incidence of TB infection and disease among HCWs in countries categorised by mean income. We included studies published in English since 1960 from low- and middle-income countries (LMICs) and since 1990 from high-income countries (HICs). We excluded outbreak reports and studies based only on questionnaires.

Results: The median prevalence of latent TB infection (LTBI) in HCWs was 63% (range 33-79%) in LMICs and 24% in HICs (4-46%).

Among HCWs from LMICs, LTBI was consistently associated with markers of occupational exposure, but in HICs it was more often associated with non-occupational factors. The median annual incidence of TB infection attributable to health care work was 5.8% (range 0-11%) in LMICs and 1.1% (0.2-12%) in HICs. Rates of active TB in HCWs were consistently higher than in the general population in all countries, although findings were variable in HICs. Administrative infection control measures had a modest impact in LMICs, yet seemed the most effective in HICs.

Conclusions: TB remains a very important occupational risk for HCWs in LMICs and for workers in some institutions in HICs. Risk appears particularly high when there is increased exposure combined with inadequate infection control measures.

Title: **Global Health Facts; Global Health Reporting**
Authors: Kaiser Family Foundation
Date: Ongoing
Source: <http://www.globalhealthfacts.org/>;
<http://GlobalHealthReporting.org/>
Country:

Two sites from the Kaiser Family Foundation offering global health statistics, overviews, country-specific information and the latest news on HIV, TB Malaria and other diseases. Global Health Reporting is available in French, Spanish, Russian, Hindi and Chinese.

Title: **Global plan of action on workers' health 2008-2017**
Authors: World Health Organization
Date: May 2007
Source: World Health Assembly resolution WHA40.26 ` http://www.who.int/gb/ebwha/pdf_files/WHA60/A60_R26-en.pdf
Country: Global

A World Health Organization (WHO) draft resolution on a Global Plan of Action on Workers' Health 2008-2017 was adopted by the 60th session of the World Health Assembly held in Geneva, 14-23 May 2007.

The aim of the Plan is to provide a policy framework for concerted action to protect, promote and improve the health of all workers. The five objectives for action are to devise and implement policy instruments on workers' health, to protect and promote health at the workplace, to improve the performance of and access to occupational health services, to provide and communicate evidence for action and practice and to incorporate workers' health into other policies. The plan includes a commitment by WHO to a global campaign for immunization of health-care workers against hepatitis B.

Title: **The global shortage of health workers and its impact**

Authors: World Health Organization

Date: April 2006

Source: Fact sheet 302 <http://www.who.int/mediacentre/factsheets/fs302/en/index.html>

Country: Global

Headings:

- Who are health workers?
- Extent of the shortage and its consequences
- World distribution of health workers
- The health workforce in the Americas versus sub-Saharan Africa
- A threat to global health
- Millennium Development Goals (MDGs)
- Outbreaks
- Natural disasters
- Conflicts
- Care of the chronically ill
- Tackling the crisis: what is needed

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*

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

Abstract submission closed in June.
For more information visit the website:
<http://www.ific2007.com>

**Safe Injection Global Network Meeting
23-25 October 2007
Geneva, Switzerland**
(From SIGNpost July 18th)

The Registration form can be downloaded from Word [7 K]:

<http://uqconnect.net/signfiles/Files/SIGN2007-RegistrationForm.zip>

Acrobat PDF [8 K]: <http://uqconnect.net/signfiles/Files/SIGN2007-RegistrationForm.pdf>

Abstract submissions closed 30 August 2007

For more information: sign@who.int;
http://www.who.int/injection_safety/sign/en/

**International Commission on Occupational Health (ICOH) Conference on Health Care Worker Health / 2007 State-of-the-Art Conference (SOTAC)
26-28 October 2007
Vancouver, British Columbia, Canada**

“The International Commission on Occupational Health (ICOH) Conference on Health Care Worker Health will be held concurrently with the 2007 State of the Art Conference of the American College of Occupational and Environmental Medicine (ACOEM) in Vancouver, BC, Canada in October, 2007. This conference will bring together key international experts in the United States, Canada, England and other European nations and many developing countries to present emerging scientific information in occupational health. The Conference is designed for physicians who specialize in or have an interest in OEM, as well as for non-physicians who are involved in the field. The 2007 SOTAC/ICOH HCW meeting will offer a global perspective on the recognition and management of health care worker occupational diseases and injuries, as well as strategies for protecting healthcare workers from such conditions.

The International Commission on Occupational Health (ICOH) was established in 1906 and is an international, non-governmental professional society that fosters the scientific progress, knowledge and development of occupational health and safety. Membership is comprised of over 2000 professionals from 93 countries.

In addition to the educational sessions designed to stimulate discussion, there will be work site visits, poster sessions, networking opportunities, receptions, group meal opportunities, pre and post conference sight-seeing, and business meetings.”

For more information visit the website:
<http://www.acoem.org/icoh.aspx>

**International Forum of Crisis Management for Infectious Disease, Union of Risk Management for Preventive Medicine
 17-18 November, 2007
 Tokyo, Japan**

“Since Union of Risk Management for Preventive Medicine (URMPM) was born in Switzerland in 2002, the current members distribute over 70 countries in both of developed countries and underdeveloped countries, including many international regulatory organizations, such as UN, UNU, WHO, OECD, UNEP, ILO. The URMPM hold e-conference for SARS crisis in 2003, which had been accessed by over 6000 around the world.

According to urgent requests by our members in the URMPM, the International Forum of Crisis Management of Infectious Disease now launches in November 2007. The target risk is newly-born infectious diseases.

A time might be the last year before a world storm that several ten million people die by Avian Flu. To share the experiences, the knowledge and the skills of preventive and crisis phases of infectious disease is very clearly important to brush up fine risk and crisis management system in the international and national aspects.

Our URMPM wishes that all of you will join together in the word to elucidate our better cooperation to the coming crisis in our planet.”

For more information visit the website:
<http://www.urmpm.org/Infection2007/>

**The Society for Healthcare Epidemiology of America, 18th Annual Scientific Meeting
 5-8 April 2008
 Orlando, Florida**

For more information visit the website:
http://www.shea-online.org/about/annual_meeting_overview.cfm

**35th Annual Conference, Association for Professionals in Infection Control & Epidemiology
 15-19 June, 2008
 Denver, Colorado, USA**

For more information visit the website:
<http://conference.apic.org>

**13th International Congress on Infectious Diseases (ICID)
 19-22 June, 2008
 Kuala Lumpur, Malaysia**

“Sponsored by the International Society for Infectious Diseases (ISID), a vibrant organization committed to international health, the meeting will continue the pattern of overwhelming successes in recent years in Lisbon, Cancun, Singapore, and Buenos Aires.

Our meeting in Kuala Lumpur hosted by the Ministry of Health, Malaysia will again welcome delegates from over 100 countries. The program will include plenary talks by world renowned experts in the science of infectious diseases and important topics critically presented by international luminaries in our field. Moreover, there will be great opportunities to spend time with leaders in the field, exchange ideas and develop collaborations with scientists from distinguished Medical Centers around the globe. All who are committed to the prevention and control of infections in developing countries will find this a compelling meeting that should not be missed.”

Abstract deadline 15 February 2008

For more information visit the website:
http://www.isid.org/13th_icid/index.shtml

**7th International Infection Control Conference, Infection Control Society,
 17-18th December, 2008
 Pakistan**

For more information visit the website:
<http://www.infectioncontrolsociety.org/index2.html>

New Resources from SafeHandS

Website

The SafeHandS website <http://www.uow.edu.au/health/safehands/index.html> continues to be updated, so it is worth checking in periodically. During a major revision in July, all the links were checked and updated with some new resources added. Guidelines for contributors to *In SafeHandS* can now be found on the “Newsletters” page.

A new page will be added this month called “Resources from SafeHandS” where you can access the resources developed by the SafeHandS team. These include the *Guidance Note on Health Care Worker Safety from HIV and other Blood Borne Infections*, infection control posters and fact-sheets and the two new resources below.

Draft Health Care Worker Safety Surveillance Tool

In response to requests from health care workers in the region, the Albion Street Centre has developed a draft tool for measuring health care worker safety.

It is often difficult for health care workers to demonstrate the benefits of health care worker safety strategies to managers or funding agencies because there are no data to identify the extent of the problem or to use as a baseline to demonstrate change over time. This tool attempts to assist in gathering baseline data.

The tool is in draft form and we are hoping to attract funding to develop it further and pilot it in several countries in the region. In the meantime, we are hoping our members will review it and use it and provide us with feedback that will help to refine it further.

PowerPoint presentation: *What is Health Care Worker Safety?*

This is a 30 minute presentation in the form of PowerPoint slides which can be used by members to explain health care worker safety concepts. It briefly covers the following topics:

- What is health care worker safety?
- Why is it important?
- How can it be improved?
- How can it be measured?
- What will it cost?

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:

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