

In SafeHandS

Newsletter of the SafeHandS network

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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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INDEX

Editorial	2
What is SafeHandS?	4
Member Profiles	4
Letter Re Surveillance Tool	7
Asia Pacific Business Coalition on AIDS	7
HIV and the Workplace	9
Workplace Wellness Programs	11
Current Resources	13
Calendar of Events	20

Disclaimer

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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 HIV and the workplace.

The next issue will be in March 2008.

Deadline for contributions - 18th February, 2008. Guidelines for contributors can be found on the SafeHandS website.

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Editorial

Why HIV is a business issue

Ariella Mata Luque
Membership Coordinator
Australia Pacific Business Coalition on AIDS

As the number of people in the Asia-Pacific region contracting HIV continues to grow, the private sector can no longer afford to leave responsibility for HIV/AIDS prevention, care and treatment with governments, donors and NGOs. The short time frame in which South Africa's HIV epidemic has affected almost one-third of its population serves as a warning to business people in the Asia-Pacific to take the epidemic seriously and respond with appropriate measures.

Business should respond to HIV not just out of humanitarian concern but for sound economic reasons. The epidemic has the potential to undermine sustained growth of markets in the region because it strikes at the most economically active age groups - the workforce, ages 16 - 49. These costs are not just a concern for public policy makers - they are a matter of serious concern to all businesses trading in the region.

HIV cuts into planned company expenses by increasing costs of employee healthcare, recruitment and training. Firms with employees who become HIV positive may see a reduction in productivity as staff become ill. The disease ultimately reduces company profits as expenses increase, service delivery fails to adhere to planned schedules, and customers change their purchasing plans because of the HIV expenses they incur.

HIV prevalence rates in the Asia-Pacific are still low enough for all businesses to maintain healthy workforces and communities. Workplace HIV interventions have been shown to be relatively inexpensive. Contribution to national HIV responses today will provide a greater cost saving in the future.

There are many ways in which the private sector can engage in the regional fight against AIDS. Becoming a member of a business coalition against AIDS (BCA) enables the private sector to better enhance and coordinate its contribution to the global fight

against HIV and AIDS. BCAs also support the private sector to develop effective workplace HIV and AIDS policies to protect their workforce.

Some examples of the good work undertaken by members of the APBCA BCA network include:

PT Gajah Tunggal Tbk – Member of Indonesian Business Coalition on AIDS (IBCA)

PT Gajah Tunggal Tbk (GT), the largest integrated tyre producer in South-East Asia, joined the campaign against HIV/AIDS in 2003, after members of the founder's family visited multiple AIDS hospitals and townships in South Africa. Following this visit, the Company set up an extensive HIV/AIDS workplace prevention programme at the factory site in Tangerang.

Gajah Tunggal has particular interest in HIV/AIDS prevention, as 95% of Gajah Tunggal's 10,000 employees are in their productive prime (21-50 years), and 94% are male. Furthermore, many of the workers are immigrants from outside the region and live away from their families. Reflecting Gajah Tunggal's commitment to staff and the wider community, the company has become a primary sponsor for the newly formed Indonesian Business coalition on AIDS (IBCA).

Gajah Tunggal's workplace HIV program revolves around compulsory HIV/AIDS prevention training of the employees by peer educators, selected amongst the factory workforce and assisted by non-government organisation partner Yayasan Kusuma Buana. Employees receive two-hour interactive training sessions. During training employees are taught about HIV/AIDS prevention, and are encouraged to ask questions and engaged in discussions.

Essential to the success of the campaign is the commitment of the senior management to implement and maintain the prevention programme. For this, the company received an award from the Indonesian government and the International Labour Organization (ILO) in May 2004. Gajah Tunggal has currently trained all its **10,000** employees, and continues to raise awareness on HIV/AIDS by providing information to all employees.

NASFUND – Members of the Papua New Guinea Business Coalition on AIDS (BAHA)

The National Superannuation Fund of PNG (NASFUND) is the major private sector pension fund in PNG with over 1,300 active employers and over 220,000 employee members. NASFUND therefore has the strongest reach of any organisation in PNG to private sector employers and their workforces.

In 2001, PNG was not talking loudly about HIV/AIDS and yet the early warning signs of an emerging epidemic were clearly beginning to show. Little was being done within the private or public sectors on HIV/AIDS and even the word AIDS conjured up feelings of embarrassment and silence. Given the difficulty of terrain; the myriad of cultures, beliefs and superstitions; and over 800 languages, combating HIV/AIDS was an enormous challenge

As a progressive local company with a large social awareness programme, NASFUND was well placed to become a leading private sector advocate on HIV/AIDS issues and related issues such as the empowerment of women, eradication of domestic violence and TB awareness.

The initial NASFUND program combined posters on both HIV/AIDS and empowerment of women. These posters were in both English and Pidgin and were annually circulated to all employers and to schools. There is widespread use of the posters on staff notice boards and in the schools. They next moved to brochures, handed out via their branches.

In 2004, NASFUND expanded its programs to cover HIV/AIDS awareness discussions delivered by selected NASFUND staff, information on HIV/AIDS in its annual report and, in a first for PNG, a comprehensive HIV policy. NASFUND also delivered information to employers on CD Rom, including ILO codes of practice.

In 2005, NASFUND sponsored a TV commercial addressing widespread ignorance of HIV issues by some community leaders and politicians. The commercial has been running almost daily for the last year.

Since then, NASFUND has continued to

expand its communication program including a Motuan poster on HIV Awareness (6% of the population speak Motuan), radio advertisements, supporting a theatre group and working with Anglicare to develop its 'Stop AIDS' program. It also developed a new TV commercial focussing on the need for young couples to have Voluntary Counselling and Testing for HIV before entering a relationship.

In late 2006, NASFUND entered in to an agreement with the Asia Pacific Business Coalition on AIDS to establish a PNG chapter to encourage and develop the private sector response to HIV in PNG. Much work has gone in to establishing an effective business coalition in PNG including recruiting sponsors and members, building an information rich website and developing best practice policy advice and workplace awareness programs. In-house activities include condom dispensers in bathrooms, posters and annual workplace training.

NASFUND is proud to be a very strong participant in the HIV & AIDS awareness drive throughout Papua New Guinea.

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

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 November 2007, we had 155 members of SafeHandS working in 34 countries.

Members work in:

Australia, Cambodia, Canada, China, Cook Islands, East Timor, Fiji, 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, Tonga, Turkey, Tuvalu, 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: Anna Holwell

Title: Australian Youth
Ambassador for
Development

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Describe your current job:

I am working with an Australian funded bilateral health program - Tibet Health Sector Support Program (THSSP), in Lhasa, Tibet. The program is jointly managed by The Australian Red Cross and The Burnet Institute. I am working with THSSP for 1 year as a volunteer through the Australian Youth Ambassadors for Development program.

My work here is based at the Regional Number 2 People's Hospital in Lhasa, which is the designated Infectious Diseases hospital for Tibet. I am working on HIV in Clinical Settings and my work has four components- Clinical HIV and AIDS management and treatment; Infection Control; Blood Safety and STI diagnosis, management and treatment.

I am 8 months into a 12 month placement.

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

I'm still quite young, so not really a career path, more of a study path...

I graduated from medicine at The University of Melbourne in 2005, and completed my Intern year at St. Vincent's Hospital in Melbourne in 2006. During my studies I completed a Bachelor of Medical Science in Medical Anthropology, studying gender issues amongst injecting drug users in Nepal. I spent some time in Nepal working in needle exchange programs, and this was the start of my interest in International Health and HIV, and also the Himalayas.

After six years at university and a year of night shifts, weekend work and generally unpleasant hours, deciding to take twelve months off to work as a volunteer was an easy decision. The placement in Tibet was just where I wanted to go, and in an area I hope to continue to work in.... so here I am!

What do you like most about your job?

I'm working a lot on guidelines, procedures and policies, which is a new area for me. As a junior doctor, I'm used to following these things, but have never had a hand in developing them. In my position now I'm getting to learn about why we do things the way we do, and having to explain and reason a lot of things I've always taken for granted - this is one of the things I like most.

I love living and working in another culture-challenging but very refreshing, and I am enjoying learning about Tibetan and Chinese health beliefs and medical systems.

And walking to work past Tibetan pilgrims doing a kora and spinning prayer wheels is pretty amazing; and looking up at the Potala surrounded by snow capped mountains is literally breathtaking.

What do you like least about your job?

Working within a government health system that is very rigid and very different from Australia's.

The low level of importance that infection control has within the health system, although this appears to be gradually changing.

What does health care worker safety mean to you?

Providing an environment in which workers can go about their work without being put at risk.

I think a key aspect is providing workers with the knowledge and training to know what safety means and what it is, thus allowing workers themselves to create a safe environment. However, the setting of the workplace needs to be conducive to allow workers to be empowered to do this.

What are you reading at the moment?

Immortality, by Milan Kundera and Reading Lolita in Tehran, Azar Nafisi

What are you currently listening to?

Community, by Loren and Sam Burke and the Wifey's, by Sam Burke and the Wifey's.

What is your favourite saying?

“Saving lives, one key stroke at a time”

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Title: Teleclass Coordinator

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Describe your current job:

With groups of wonderful volunteers around the world – Aus, NZ, UK, France, Egypt, Saudi, Argentina, Brazil, US, Canada – I help to assemble an infection control lecture series called Teleclass Education. The idea, hatched in 2001 by Prof. Syed Sattar (University of Ottawa Faculty of Medicine) and myself, was intended to bring the best possible infection control information, to the widest possible audience, with the fewest barriers to access. Our short-sightedness at the time prevented us from seeing beyond the few hundred infection control professionals in Canada. We could never have conceived of the tens of thousands of healthcare workers around the world who now regularly access our program. We invite some of the leading thinkers and researchers in infection control to give a 1-hour lecture, accompanied by PowerPoint slides and sometimes other files. The live lectures, delivered over the telephone as a conference call (teleclass), are accessed by hundreds, and often thousands of participants. The free-access, on-line recordings and notes of these teleclass lectures are accessed tens of thousands of times every month, from all corners of the globe. Aside from the organizational and planning aspects of the lecture series, my job is, for most of the teleclasses anyway, to introduce the speaker and act as host for teleclass participants.

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

Some years ago a company that I own acquired the regional rights to a new type of surface disinfectant for which we had high hopes. In the early days of marketing this product I visited with Mrs. Lois Rae, an infec-

tion control professional in a local hospital, a mentor to many in Canada, who introduced me to the greater infection control community. I joined the local and national infection control societies, listened, learned, attended meetings, and felt drawn to play a role in the dissemination of the infection prevention and control message. A chance meeting and conversation with Prof. Sattar in Ottawa planted the first thoughts that would evolve into the Teleclass Education initiative.

What do you like most about your job?

#1 The people who work in infection control are absolutely some of the best people in the world, and I find it intoxicating to hang around with them. #2 Having an excuse to introduce myself to the top thinkers in the field and to hear them describe the source of their passion. #3 Being able to travel to and speak at conferences all around the world ranks high (very, VERY high) as well.

What do you like least about your job?

#1 People who erect barriers around their knowledge with the idea that this makes them more powerful, important, and indispensable - to me, these people are completely dispensable. #2 The paperwork and unending administrative trivia that seems to accompany an international volunteer organization such as this.

What does health care worker safety mean to you?

During the SARS outbreak in Toronto (just 2 hours west of my home), it was healthcare workers who were most vulnerable, and whose lives were permanently impacted. During the Marburg outbreak in Angola, healthcare workers were infected and so many died. Ebola, Monkey Pox, and the worldwide scourge of HIV/AIDS took/take their toll on healthcare workers to an extent far greater than any other occupational group, particularly in resource-poor nations. Infection prevention and control should be seen as protective, not simply administrative.

What are you reading at the moment?

Once or twice a year I will purchase a PD James or some such novel, usually as an air travel distraction. Presently and perpetually I quite enjoy "The Economist" magazine, and my favourite journal, "The Journal of Hospital Infection".

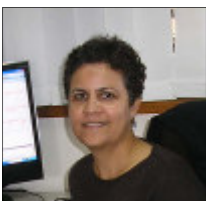
What are you currently listening to?

One wouldn't quite be Canadian if one's car radio wasn't tuned to the Canadian Broadcasting Corporation. To answer the question a little more broadly, "The Blind Boys of Alabama" is in my CD player, and Dr. Elaine Larson's lecture to the ICNA conference in September (also broadcast as a live teleclass – or at least attempted to) is on my computer awaiting editing.

What is your favourite saying?

"If not me, then who? If not now, then when?"

Letter re surveillance tool



Dear All

Greetings from Noumea, New Caledonia, I have recently taken up the job of Infection Control Officer with the Secretariat of the Pacific Community (SPC) and I work with the Pacific Regional Influenza Pandemic Project (PRIPP). Before, I moved to Noumea, I worked at the Lautoka Hospital in Fiji and that is where we trialled the use of the HCW safety toolkit.

I would thank the Albion Street Centre (Safe Hands Net work team) for developing the 'Health care worker safety tool for low and middle income countries'. I say this largely because there is very little literature in infection control to suit low and middle income countries.

The tool was very easy and simple to follow however, I was not able to get figures and cost of safety devices. On that note it is not impossible to get the information, it is available. The tool identified the gaps in our infection control program in terms of keeping updated records in education training etc. It is

very helpful in analysing the data we collect on occupational exposures.

My view is that the tool is very useful and should be reflected on the annual Infection Control plan. That way the Infection Control Nurse would have specific time allocated to conduct the different sections in tool.

Margaret Leong

Infection Control Officer
Pacific Regional Influenza Pandemic
Preparedness Project (PRIPPP)

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Editor's Note: *The Draft Health Care Worker Safety Surveillance Tool and Users' Guide* are available from the SafeHandS website at: <http://www.uow.edu.au/health/safehands/UOW037070.html>



Ariella Mata Luque
Membership Coordinator

The establishment of the Asia Pacific Business Coalition on AIDS (APBCA) is a direct response by the Australian business community to the need for greater private sector engagement and coordination in the regional fight against HIV and AIDS. It was launched by President Clinton in February 2006. Its key business partner is Qantas

Airways.

During 2006 an estimated 8.6 million people were living with HIV in Asia and approximately 630,000 people died from AIDS related illness. The International Labour Organization (ILO) estimates that by 2010, there will be more Asians living with HIV than Africans, and approximately 846,900 people throughout Asia will be unable to work due to AIDS related illness. Business should respond to HIV not just out of humanitarian concern but for sound economic reasons. The epidemic has the potential to undermine sustained growth of markets in the region because it strikes at the most economically active age groups - the workforce, ages 16 - 49. These costs are not just a concern for public policy makers - they are a matter of serious concern to all businesses trading in the region.

APBCA aims

- To assist businesses develop and implement best practice HIV workplace policies and programs focusing on non-discrimination, prevention, care and treatment
- To use the resources of business to assist the fight against HIV/AIDS in the region
- Assist in the development and support of new and emerging Business Coalitions on AIDS in countries threatened by an HIV/AIDS epidemic
- To promote best practice responses from our member companies
- To work with international and local organisations to develop strategies and programs to fight HIV/AIDS and care for and support people living with HIV/AIDS.

The APBCA Board of Directors is drawn from some of the world's major Companies, including chair Margaret Jackson (Qantas) and Deputy Chair Lachlan Murdoch (News Ltd). Together the APBCA Board and Members encourage senior private sector leaders to become engaged in HIV and AIDS advocacy, policy and education of private sector workforces.

APBCA acts as a hub coordinating an Asia Pacific network of Business Coalitions on AIDS (BCAs). To date APBCA has BCAs in Thailand, Singapore, Myanmar, Vietnam, Papua New Guinea, Indonesia and Cambodia.

APBCA has many functions within the Asia

Pacific network including, monitoring and evaluation of workplace HIV responses, program development and general support to the network.

APBCA has developed a number of products to assist the private sector's engagement in the fight against HIV/ AIDS.

APBCA envisages that timely best practice will underpin all training, advocacy and education. APBCA's program delivery is centred on work-force participation and is designed to operate within a workplace or business environment.

APBCA's product range features both workplace HIV/ AIDS programs and program monitoring and evaluation standards. The former has been developed to include various training methodologies, which build into a complete HIV awareness training package. The training programs cover train the trainer materials and comprehensive HIV education.

To compliment work place HIV training, APBCA is developing a regional accreditation tool and award based on the AIDS response Standard Organisation (ASO) methodology developed by the Thailand Business Coalition on AIDS. Member companies can use the tool to monitor and evaluate their progress towards becoming a best practice organisation in the field of HIV/ AIDS policy, awareness training and advocacy. APBCA plans to develop the accreditation tool in consultation with the ISO and UN agencies as a global standard and award for companies with world leading HIV/ AIDS programs.

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<http://www.apbca.com>

1 Source: ILO Press release: Issues first global analysis of HIV/AIDS impact on the world of work Estimates 36.5 million working age persons now have HIV, 28 million lost to world labour force by 2005. ILO: *Programme on HIV/AIDS and work: global estimates, impact on children and youth and response 2006.*

HIV and the workplace

By Maggy Tomkins

A survey by the World Economic Forum (World Economic Forum, 2006, *Business & HIV/AIDS: A Healthier Partnership? A Global Review of the Business Response to HIV/AIDS 2005-2006* http://www.weforum.org/pdf/Initiatives/gbs2006_report.pdf) polled the views of 10,993 business leaders from 117 countries in 2005.

Nearly half of the respondents said they expected HIV to have impacts on their business in the following five years. In countries with HIV prevalence rates above 5%, nearly all respondents expected impacts on their operations in the following five years. Despite this, only a small minority of respondents had done a quantitative HIV risk assessment or had written HIV policies. Only if the national prevalence of HIV exceeded 20% did the majority of companies have policies in place. Most policies focused on HIV prevention, with fewer addressing antiretroviral drug treatment or discrimination.

The editorial and article on the Australia Pacific Business Coalition on AIDS in this issue explain why HIV is a serious issue for all workplaces and give some practical examples of business responses. Here are some more resources which will help anyone developing workplace HIV policies and programs to support and protect all workers.

International Labour Organization (2001) **An ILO Code of Practice on HIV/AIDS and the World of Work**. Geneva, <http://www.ilo.org/public/english/protection/safework/cops/english/download/e000008.pdf>

“The objective of this code is to provide a set of guidelines to address the HIV/AIDS epidemic in the world of work and within the framework of the promotion of decent work. The guidelines cover the following key areas of action:

- a. prevention of HIV/AIDS;
- b. management and mitigation of the impact of HIV/AIDS on the world of work;
- c. care and support of workers infected and affected by HIV/AIDS;
- d. elimination of stigma and discrimination on the basis of real or perceived HIV status.”

International Labour Organization, (2002) **Implementing the ILO Code of Practice on HIV/AIDS and the World of Work: An education and training manual**. Geneva, <http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/kd00131.pdf>

“The manual is designed to help the ILO’s partners understand the issues and apply the ILO Code of Practice on HIV/AIDS and the world of work, which was adopted in May 2001. The Code is at the core of the ILO’s Programme on HIV/AIDS, providing guidance to governments, employers and workers, as well as other stakeholders, on national action plans and workplace policies and programmes to combat HIV/AIDS.”

“This manual is a source of information on HIV/AIDS and the world of work, a reference guide to the ILO Code of Practice and its application in policy development, and a tool for training. It is ideal to use as a reference when planning a policy or strategy. You can work through the whole book or parts of it on your own, in a meeting or as a team exercise. You can see what other people have done, consider whether it could be adapted to your situation, and follow suggestions.”

World Health Organization (2005) **Joint ILO/WHO Guidelines on Health Services and HIV/AIDS**. Geneva, http://www.who.int/hiv/pub/prev_care/healthservices/en/index.html

“The purpose of these guidelines is to promote the sound management of HIV/AIDS in health services, including the prevention of occupational exposure. Furthermore, the purpose is to ensure that health-care workers have decent, safe and healthy working conditions, while ensuring effective care that respects the needs and rights of patients, especially those living with HIV/AIDS. These guidelines rest on the basic principle that the process of policy development and implementation should be the result of consultation and collaboration between all concerned parties, based on social dialogue and including, to the extent possible, persons and workers living with HIV/AIDS.”

World Health Organization (2006) **Taking stock: Health worker shortages and the response to AIDS.** Geneva,
<http://www.who.int/hiv/pub/advocacy/ttr/en/index.html>

“In August 2006, the World Health Organization (WHO) launched a coordinated global effort to address a major and often overlooked barrier to preventing and treating HIV: the severe shortage of health workers, particularly in low- and middle-income countries.

Called ‘Treat, Train, Retain’ (TTR), the plan is an important component of WHO’s overall efforts to strengthen human resources for health and to promote comprehensive national strategies for human resource development across different disease programmes. It is also part of WHO’s effort to promote universal access to HIV/AIDS services. TTR will strengthen and expand the health workforce by addressing both the causes and the effects of HIV and AIDS for health workers.”

“*TREAT* a package of HIV treatment, prevention, care and support services for health workers who may be infected or affected by HIV and AIDS.

TRAIN measures to empower health workers to deliver universal access to HIV services, including pre-service and inservice training for a ‘public health’ approach.

RETAIN strategies to enable public-health systems to retain workers, including financial and other incentives, occupational health and safety and other measures to improve the workplace as well as initiatives to reduce the migration of health-care workers.”

Asian Business Council on AIDS

<http://www.abconids.org>

“The Asian Business Coalition on AIDS (ABC on AIDS) is a regional partnership between companies that aim to prevent and control HIV/AIDS in the workplace and not-for-profit organizations that provide technical services on HIV/AIDS, such as training.”

The website has information such as management handbooks, sample policies and workplace case studies.

Family Health International (2006) **Workplace HIV/AIDS Programs: An action guide for managers**

http://www.fhi.org/en/hivaids/pub/guide/workplace_hiv_program_guide.htm

“The guidebook .. provides practical steps for developing and implementing workplace prevention and care programs that will serve both employees and managers. The guide is designed for use by companies’ human resources managers, medical officers and union representatives.

Readers will find guidance on assessing the real and potential impact of HIV/AIDS on their company, on developing an HIV/AIDS policy to cover the workplace and on designing and implementing HIV/AIDS prevention and care programs for the workplace.

The guide includes a series of checklists to aid in decision-making about particular components of workplace HIV/AIDS programs. It also includes examples and case studies of how other companies have responded to the epidemic.”

Centers for Disease Control (US) - **Business responds to AIDS/Labor responds to AIDS**

<http://www.hivatwork.org>

“More people are living and working with HIV than ever before. HIV has not gone away. Neither have the complex issues it raises. Does your workplace handle discrimination, return-to-work, or employee morale issues? CDC’s Business/Labor Responds to AIDS (BRTA/LRTA) program is a resource for these and many other questions.”

The website has posters, scenarios, presentations – as well as leaders’ kits (below)

Business responds to AIDS/Labor responds to AIDS: Manager’s Kit

<http://www.hivatwork.org/tools/business-managers.cfm>

“The Manager’s Kit includes all the resources businesses need to build comprehensive HIV/AIDS workplace programs. The kit, which is available in English and Spanish, reviews the five components of the BRTA/LRTA programs and enables managers to:

- Develop HIV/AIDS policies for their work-

- places
- Train managers to conduct HIV/AIDS workshops
 - Educate staff/workers about basic facts about HIV/AIDS and its effect on the workplace
 - Educate staff/workers' families
 - Promote community service and volunteerism”

Business responds to AIDS/Labor responds to AIDS: Labor Leader's Kit
<http://www.hivatwork.org/tools/labor.cfm>

“The Labor Leader's Kit includes all the resources labor leaders need to build comprehensive HIV/AIDS workplace programs. It reviews the five components of the LRTA program and helps labor leaders and workers to develop policies on HIV/AIDS to educate workers and their families. The kit encourages all staff/workers to promote community service and volunteerism.

The Labor Leader's Kit provides:

- Basic facts about HIV/AIDS
- Sample contract, resolution, and policy language on HIV/AIDS

Individual brochures also discuss worker training, benefits, and education.”

Business responds to AIDS/Labor responds to AIDS: Assessment tool
<http://www.hivatwork.org/tools/assessment.htm>

“Managers and labor leaders can use this assessment tool to determine whether their workplace has the resources it needs to respond to HIV/AIDS at work and to assess existing policies and programs.”

Workplace wellness programs

By Maggy Tomkins

Wellness can be defined “as a positive, sustainable state that allows us to thrive and flourish.”¹ In the workplace, the employee and the employer should both “take and accept responsibility for wellness.....Workplace wellness programmes have been shown to reduce health care-related costs and worker

absenteeism, plus improve productivity. This mounting evidence indicates that worksite wellness should be part of every strategic plan.”¹

Workplace wellness programs probably began in the 1950s in the US. They are still provided by many companies as a means to help offset the increasing costs of medical cover paid for by US employers. A movement towards workplace wellness programs also exists in various forms in other countries.²

“Wellness programs in workplace settings have been shown to:

- reduce employee stress
- improve employee health
- reduce workforce turnover
- improve employee decision-making ability
- reduce organisational conflict
- reduce absenteeism
- create a healthier organisational culture
- improve employee morale and loyalty”²

Wellness programs address lifestyle issues rather than occupational health and safety programs which target workplace procedures. In well resourced countries, wellness programs tend to concentrate on such topics as smoking cessation, weight loss, nutrition, stress management, exercise and fitness and screening for health problems (for example, diabetes, high cholesterol, or high blood pressure).

In countries with a high prevalence of HIV or other infectious disease, wellness programs targeting prevention of transmission of infection can make a big difference. HIV workplace wellness programs appear to be more developed in Africa than in the Asia Pacific region, probably because of the significant effect HIV has had on the workforce in many African countries.

According to UNAIDS: “A growing body of research on the impact of HIV on the world of work strongly supports the ‘business case’ for HIV prevention, care and treatment. A study of the impact of HIV on the financial performance of companies concluded that companies benefit from taking their own action in relation to HIV. A key finding was that based on projections in a high-prevalence setting the value of the venture was more than 5% higher when a treatment programme was provided for employees than without it.”³

A report released last month by the International Organization for Migration concluded that “HIV workplace programmes can save companies money, valuable skills and knowledge among its labour force and improve the health and security of communities at large.”⁴ The study collected data from seven of the biggest companies in Zambia and “calculated the costs of running the HIV programmes (including healthcare, peer education, counselling and testing and staff time spent on the programme) against the costs of HIV and AIDS to the company (including employee turnover, training new staff, loss of productivity, absenteeism and funeral costs).

It found that HIV and AIDS have an enormous impact on all companies big and small, low-skilled and high-skilled, and that benefits outweigh costs, human and financial, by implementing a range of HIV programmes among staff including prevention and treatment. The largest company, for example, saved nearly USD 500,000 in what would have been lost productivity from sick employees.”⁴

The study also “found that knowledge and prevention skills from the workplace programmes were spreading to the surrounding communities with access to information, condoms, and in some cases, treatment.”⁴

A good case study – also from Africa – is the wellness program of Serena Hotels in Kenya.⁵

Serena Hotels has implemented an AIDS workplace and community program in Kenya since 2002. The program had four parts: education and prevention; care and treatment; voluntary counselling and testing; and condoms. In 2007, the program was transformed into a comprehensive Wellness Program with four pillars: (i) active lifestyle; (ii) good nutrition; (iii) healthy lifestyle choices; and (iv) health promotion.

Some significant results of the AIDS program (since 2002) have been identified, including:

- a. “Reduced mortality
- b. Reduction in life insurance premium
- c. Reduced absenteeism and increased efficiency
- d. More knowledgeable and health conscious workforce
- e. Fewer new HIV infections
- f. Improved company image

g. Improved staff morale”⁵

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How to make alcohol handrub

The SafeHandS website: (www.uow.edu.au/health/safehands/index.html) now features a simple recipe with pictorial instructions on how to make a cheap but effective alcohol handrub. We really liked it. If you make it - please let us know the results.

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: Standardization of needlestick injury and evaluation of a novel virus-inhibiting protective glove

Authors: Krikorian R, Lozach-Perlant A, et al

Date: August 2007

Source: Journal of Hospital Infection 66 (4):339-45

Country: France

Abstract: Rubber surgical gloves worn as a barrier to prevent contamination from body fluids offer relative protection against contamination through direct percutaneous injuries involving needles, scalpel blades or bone fragments. To determine the main experimental parameters influencing the volume of blood transmitted by a hollow-bore needle (worst case scenario) during an accidental puncture, we designed an automatic puncture apparatus. Herpes simplex type 1 virus (HSV1), a model for enveloped viruses, was used as a 'marker' in an in-vitro gelatine model.

Of the experimental parameters studied, the most critical influences were found to be needle diameter and puncture depth, whereas puncture speed, puncture angle and glove-stretching feature appeared to be less influential. A single glove reduced the volume of blood transferred by 52% compared with no glove, but double gloving offered no additional protection against hollow-bore needle punctures. Using 'standardized' puncture conditions, the virus-inhibiting surgical glove G-VIR((R)) elicited an 81% reduction in the amount of HSV1 transmitted as compared with single or double latex glove systems.

Title: Clinical case of seroconversion for syphilis following a needlestick injury: why not take a prophylaxis?

Authors: Franco A, Aprea L, et al.

Date: September 2007

Source: Le infezioni in medicina 15(3):187-90

Country: Italy

Abstract: A 47-year-old woman was pricked accidentally with a needle previously used for a neurosyphilitic man. At day 0 she had no positive laboratory results for the infection, while the source, at day 1, had TPHA positive, but no post-exposure prophylaxis (PEP) against syphilis was prescribed. The subject missed the day 30 follow-up, and underwent our visit at day 90, when she showed no clinical signs, but she seroconverted (VDRL = positive 1/2; TPHA = positive 1/320; FTA-Abs IgG and IgM = present). She started antibiotic therapy, and currently her serological status is VDRL = positive 1/2, TPHA = positive 1/160, FTA-Abs IgM = negative.

Title: Risk of facial splashes in four major surgical specialties in a multicentre study

Authors: Endo S, Kanemitsu K, et al.

Date: September 2007

Source: Journal of Hospital Infection 67(1): 56-61

Country: Japan

Summary: This study analyses the results of face-shield blood spatter contamination at six medical facilities to determine exposure risk when facial protection is not used. Blood spatter exposure was evaluated on the basis of overall incidence, location of spatter on face shields, surgical specialty, risk for operating room staff, length of surgery and volume of blood loss. Six hundred face shields were evaluated for blood spatter contamination by visual inspection as well as by staining with leucomalachite green. The face shield was divided into three regions: Orbital (O-region), Paraorbital (P-region) and Mask (M-region). Visual examination detected blood spatter contamination in 50.5% (303/600) of the face shields, whereas leucomalachite green

staining detected blood contamination in 66.0% (396/600). Blood contamination was 36.6% (220/600) in the O-region, 37.8% (227/600) in the P-region and 57.0% (342/600) in the M-region. Among operating room staff, the incidence of blood spatter was greatest among lead surgeons at 83.5% (167/200), followed by the first assistant at 68.5% (137/200) and the scrub nurse at 46.0% (92/200). By specialty, cardiovascular surgery was at highest risk with an incidence of 75.3% (113/150) followed by neurosurgery at 69.3% (104/150), gastrointestinal at 60.0% (90/150) and orthopaedic surgery at 60.0% (90/150).

Title: **Molecular characterization of an acute hepatitis A outbreak among healthcare workers at a Korean hospital**

Authors: Park J, Lee J, et al.

Date: October 2007

Source: Journal of Hospital Infection 67(2): 175-181

Country: Korea

Summary: The seroprevalence of hepatitis A virus (HAV) antibodies is low in young adults in Korea. From May to July 2005, 17 cases of HAV were reported from healthcare workers (HCWs) in a hospital intensive care unit (ICU). We looked for the presence of anti-HAV IgM from all patients in the medical–surgical ICU with elevated aspartate aminotransferase (AST) and alanine aminotransferase (ALT) and screened AST and ALT levels in all HCWs who came into contact with two suspected index cases. Once the outbreak was confirmed, the molecular subtypes of HAV from the blood of HCWs were determined. Index cases and a transmission route were identified, and intervention strategies applied to control the outbreak. The 17 HCW cases included 13 nurses and four doctors aged 22–32 years, who each suffered acute HAV infection during the study period. The possible transmission of HAV was via the faecal–oral route from bedridden patients with diarrhoea. All HCWs were positive for anti-HAV IgM and eight were positive for HAV RNA. Analysis of the VP1-2A region of each isolate showed genotype IA in five strains and co-circulation of genotypes IA and IB in the others. This HAV outbreak highlights the importance of standard infection control precautions within a hospital.

Molecular study of patients' blood would be useful for clarifying the epidemiology of a suspicious HAV outbreak in a hospital.

Title: **A survey of infection control practices of consultant anesthesiologists in teaching hospitals of Pakistan**

Authors: Yaqub K, Tariq M, et al.

Date: September 2007

Source: Journal of College of Physicians and Surgeons Pakistan 17(9):523-6

Country: Pakistan

Abstract:

Objective: To determine the infection control practices of anaesthesiologists in the teaching hospitals of Pakistan.

Study Design: Cross-sectional survey.

Place and Duration of Study: The survey was conducted from January 2002 to December 2002 in Combined Military Hospital Quetta. The survey was closed after allowing 6 months for return of the replies. Subjects and Methods: A questionnaire was distributed to 170 consultant anaesthesiologist randomly selected from all over Pakistan. Out of these, 90 (53%) were returned and analyzed. To reduce self-report bias, the forms were filled anonymously.

Results: Thirty four percent of the respondents always used masks, and only 9% used gloves in their every day practice. Only 18% of respondents stated that they always washed their hands after every patient contact and 54% reported that they always used aseptic technique for placing an indwelling cannula. Most respondents had a good knowledge of universal precautions for prevention of occupational transmission of infection. Five percent of the anaesthetists reported frequently or always reusing syringes for more than one patient. The practice of reusing syringes was significantly greater when the same consultants were anaesthetizing patients in private clinics rather than in their primary institutions ($p < 0.01$). On a scale of 0 - 10 (10 = high), anaesthesiologist rated their potential for contributing to transmission of infection as > 5 , in 58% of cases.

Conclusion: Whereas most responding anaesthesiologist exhibit appropriate infection control behaviour, there are several potentially hazardous practices that continue unabated.

Title: **Poor knowledge – predictor of nonadherence to universal precautions for blood borne pathogens at first level care facilities in Pakistan**

Authors: Janjua N, Razaq M, et al.

Date: July 2007

Source: BMC Infectious Diseases 7:81
Full text available at: <http://www.biomedcentral.com/1471-2334/7/81>

Country Pakistan

Abstract:

Background: We conducted an assessment of knowledge about blood borne pathogens (BBP) and use of universal precautions at first level care facilities (FLCF) in two districts of Pakistan.

Methods: We conducted a cross-sectional survey and selected three different types of FLCFs ; public, general practitioners and unqualified practitioners through stratified random sampling technique. At each facility, we interviewed a prescriber, a dispenser, and a housekeeper for knowledge of BBPs transmission and preventive practices, risk perception, and use of universal precautions. We performed multiple linear regression to assess the effect of knowledge score (11 items) on the practice of universal precautions score (4 items- use of gloves, gown, needle recapping, and HBV vaccination).

Results: We interviewed 239 subjects. Most of the participants 128 (53%) were recruited from general practitioners clinics and 166 (69.5%) of them were dispensers. Mean (SD) knowledge score was 3.8 (2.3) with median of 4. MBBS prescribers had the highest knowledge score while the housekeepers had the lowest. Mean universal precautions use score was 2.7 ± 2.1 . Knowledge about mode of transmission and the work experience alone, significantly predicted universal precaution use in multiple linear regression model ($adR^2 = 0.093$).

Conclusion: Knowledge about mode of trans-

mission of blood borne pathogens is very low. Use of universal precautions can improve with increase in knowledge.

Title: **On-site influenza vaccination arrangements improved influenza vaccination rate of employees of a tertiary hospital in Singapore**

Authors: Lee H, Fong Y

Date: September 2007

Source: American Journal of Infection Control 35 (7): 481-3

Country: Singapore

Abstract:

Background: On-site vaccination arrangements were introduced in 2005 to improve influenza vaccination rate among employees of a 1500-bed tertiary hospital in Singapore.

Methods: On-site arrangements include mobile teams to 3 distant departments and same-service area vaccination for employees at 4 service areas.

Results: Influenza vaccination rate in 2005 was 66.4% (versus 56.8% in 2004, odds ratio 1.50, 95% confidence interval 1.39–1.62). Employees who attended on-site arrangements had higher influenza vaccination rate (97.0%).

Conclusion: On-site vaccination arrangements improved influenza vaccination rate among hospital employees.

Title: **The effectiveness of a training program on reducing needle-stick injuries/sharp object injuries among soon graduate vocational nursing school students in southern Taiwan**

Authors: Yang Y, Liou S et al.

Date: September 2007

Source: J Occup Health. 2007 Sep;49 (5):424-9.

Country: Taiwan

Abstract: Needlestick/sharp injuries (NSIs/

SlIs) are a serious threat to medical/nursing students in hospital internships. Education for preventing NSIs/SlIs is important for healthcare workers but is rarely conducted and evaluated among vocational school nursing students. We conducted an educational intervention for such students after their internship rotations before graduation. This program consisted of a lecture to the students after the internship training and a self-study brochure for them to study before their graduation. This study used the pre-test questionnaires completed by all students and the post-test questionnaires completed by 107 graduates after work experience as licensed nurses to assess the effectiveness of the intervention. After educational intervention, the incidence of NSIs/SlIs decreased significantly from 50.5% pre-test to 25.2% post-test, and the report rate increased from 37.0% to 55.6%, respectively. In conclusion, this intervention significantly reduced the incidence of NSIs/SlIs and

Title: Handling needles in the waste and recycling industry

Authors: Health and Safety Executive (UK)

Date: August 2007

Source: <http://www.hse.gov.uk/pubns/waste19.pdf>

Country: United Kingdom

6 page practice guide, "written in consultation and with the support of the Waste Industry Safety and Health Forum (WISH). It does not aim to be comprehensive but gives examples of good practice within the industry.

It is for managers and employees working in the waste management and recycling industry, and aims to reduce the risks of blood-borne virus infection from syringe needles (often referred to as 'sharps' or 'needlestick injuries'), which form part of drug-related litter."

Title: Pandemic Flu: Infection control training material

Authors: Health and Safety Executive (UK)

Date: Updated October 2007

Source: http://www.dh.gov.uk/en/PandemicFlu/DH_078752

Country: United Kingdom

"A range of new infection control training materials has been produced, including a summary of the guidance for infection control in healthcare settings during an influenza pandemic, posters on the correct use of personal protective equipment (PPE), and a short training video. Also included are posters demonstrating effective hand hygiene to remind staff, patients and the public on how to do this correctly. We hope that they will also prove useful when teaching healthcare staff how to minimise the transmission of health-care-associated infections generally."

Title: Recommended practices for surveillance. Association for Professionals in Infection Control and Epidemiology, Inc.

Authors: Lee T, Montgomery O, et al.

Date: September 2007

Source: American Journal of Infection Control 35 (7): 427 - 40

Country: USA

No abstract.

Title: Raising standards while watching the bottom line: making a business case for infection control

Authors: Perencevich E, Stone P, et al.

Date: October 2007

Source: Infection Control and Hospital Epidemiology 28: 1121-1133

Country: USA

Abstract: While society would benefit from a reduced incidence of nosocomial infections, there is currently no direct reimbursement to hospitals for the purpose of infection control, which forces healthcare institutions to make economic decisions about funding infection control activities. Demonstrating value to administrators is an increasingly important function of the hospital epidemiologist because healthcare executives are faced with many demands and shrinking budgets. Aware of the difficulties that face local infection control programs, the Society for Healthcare Epidemiology of America (SHEA) Board of Directors appointed a task force to draft this evidence-based guideline to assist hospital

epidemiologists in justifying and expanding their programs. In Part 1, we describe the basic steps needed to complete a business-case analysis for an individual institution. A case study based on a representative infection control intervention is provided. In Part 2, we review important basic economic concepts and describe approaches that can be used to assess the financial impact of infection prevention, surveillance, and control interventions, as well as the attributable costs of specific healthcare-associated infections. Both parts of the guideline aim to provide the hospital epidemiologist, infection control professional, administrator, and researcher with the tools necessary to complete a thorough business-case analysis and to undertake an outcome study of a nosocomial infection or an infection control intervention.

Title: **Help or hindrance? Is current infection control advice applicable in low- and middle-income countries? A review of the literature**

Author: Zimmerman P-A

Date: October 2007

Source: American Journal of Infection Control 35 (8): 494-500

Country: Global

Abstract:

Background: High-income countries with established infection control programs have demonstrated effective control of infection transmission in health care settings. The guidelines and advice underlying these effective control programs have been produced by high-income countries for their own social, economic, and health environments. These have also been adopted by low- and middle-income (LMI) countries, but these countries appear to have a limited ability to apply these principles using the same methods.

Methods: A systematic search for literature published in English was conducted exploring the relationship between the available infection prevention and control advice and the capacity of LMI countries to apply this guidance in their health care settings. Articles relevant to this exploration were identified and

subsequently informed further search terms and identified other significant documents.

Results: Infection control guidelines designed for high-income countries are being utilized by LMI countries, with varying degrees of success mainly because of physical, environmental, and socioeconomic factors. There is a lack of published studies exploring the implementation of comprehensive infection control advice and programs, including the minimal advice, which is designed specifically for resource-limited settings.

Conclusion: What is evident from the literature is that there is a need for the development of infection control and prevention guidelines based on evidence but adapted to the specific needs of health care workers in LMI countries. This must be done in collaboration with those same LMI countries' health care workers. Equally, because of finance and health priorities, health care facilities should choose those interventions most relevant to the needs of their population and workers to prevent infection transmission. Opportunities for further research into application of available infection control advice in LMI countries are identified. Through such research, more appropriate advice may be devised to assist with the development of infection control programs in these settings.

Title: **My five moments for hand hygiene: a user-centred design approach to understand, train, monitor and report hand hygiene**

Authors: Sax H, Allegranzi B, et al.

Date: September 2007

Source: Journal of Hospital Infection 67(1): 9-21

Country: Global

Summary: Hand hygiene is a core element of patient safety for the prevention of healthcare-associated infections and the spread of antimicrobial resistance. Its promotion represents a challenge that requires a multi-modal strategy using a clear, robust and simple conceptual framework. The World Health Organization First Global Patient Safety Challenge 'Clean Care is Safer Care' has expanded educational and promotional

tools developed initially for the Swiss national hand hygiene campaign for worldwide use. Development methodology involved a user-centred design approach incorporating strategies of human factors engineering, cognitive behaviour science and elements of social marketing, followed by an iterative prototype test phase within the target population. This research resulted in a concept called 'My five moments for hand hygiene'. It describes the fundamental reference points for healthcare workers (HCWs) in a time-space framework and designates the moments when hand hygiene is required to effectively interrupt microbial transmission during the care sequence. The concept applies to a wide range of patient care activities and healthcare settings. It proposes a unified vision for trainers, observers and HCWs that should facilitate education, minimize inter-individual variation and resource use, and increase adherence. 'My five moments for hand hygiene' bridges the gap between scientific evidence and daily health practice and provides a solid basis to understand, teach, monitor and report hand hygiene practices.

Title: **New Journal - The Journal of Infection in Developing Countries (JIDC)**

Date: The first edition (August 2007) is available at:

Source: <http://www.oloep.org/jidc/content.asp?id=958>, or
http://www.oloep.org/uploadedFiles/jidc/issues/2007_08/JIDC_01_01_2007_08.pdf

From the website: "The Journal of Infection in Developing Countries (JIDC) is a new, independent, on-line publication with an international editorial board and open access.

The Journal is intended to publish original research papers, research notes and reviews covering different aspects of human, animal and environmental Microbiology and infections in developing countries with particular emphasis on emerging and re-emerging etiological agents, diagnosis, and epidemiology and public health. The aim of the journal is to provide all infectious disease researchers from developing countries with an international forum for publishing their research findings.

The Journal is of interest to medical and clinical microbiologists, virologists, parasitologists, mycologists, immunologists, epidemiologists, pharmacologists, clinicians and public health workers.

The Journal publishes original research manuscripts and state-of-the art review articles as; full research articles, short reports, letters to the Editor, public health reports, case studies, meeting reports and book reports.

The journal has a policy of manuscript evaluation, and each manuscript is evaluated by selected referees who are experts in their respective fields. If necessary the editorial board will provide advice on preparing and submitting manuscripts to the Journal, and will act as external expert reviewers. Articles within the remit of the journal will either be accepted or guidance will be given on improving the presentation or the scientific content. Manuscripts submitted for publication must be written in English.

The Journal welcomes

- a. Articles concerning research performed in tropical countries and developing countries
- b. Articles done in collaboration with scientists in developing countries
- c. Articles regarding main transmissible diseases, in developing countries, carried out by scientists in developed countries."

Title: **AIDS epidemic update**

Authors: UNAIDS/WHO

Date: December 2007

Source: http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

Country: Global

"The AIDS epidemic update reports on the latest developments in the global AIDS epidemic and has been published annually since 1998. The 2007 edition provides the most recent estimates of the epidemic's scope and human toll and explores new trends in the epidemic's evolution."

"Epidemic update 2007 – essential findings

Every day, over 6800 persons become

infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services. The HIV pandemic remains the most serious of infectious disease challenges to public health. Nonetheless, the current epidemiologic assessment has encouraging elements since it suggests:

- the global prevalence of HIV infection (percentage of persons infected with HIV)
- is remaining at the same level, although the global number of persons living with HIV is increasing because of ongoing accumulation of new infections with longer survival times, measured over a continuously growing general population;
- there are localized reductions in prevalence in specific countries;
- a reduction in HIV-associated deaths, partly attributable to the recent scaling up of treatment access; and
- a reduction in the number of annual new HIV infections globally.”

Antivirus – a cap to protect against needle infections

“INDEX: is a global non-profit network organization that focuses on Design to Improve Life – e.g. design that substantially improves important aspects of human life – worldwide. INDEX: AWARD is the biggest design award in the world and is presented every two years in Copenhagen.”

The winner of the 2007 People's Choice Award was Antivirus – a cap to protect against needle infections (Denmark), designed by Hân Pham.

“The designer of Antivirus – a cap to protect was inspired by her own experience as a young girl in a Singaporean refugee camp, where she received a vaccination with an infectious needle, making her sick for a long time.



The cap is mounted on readily available beverage cans for segregation and isolation of used needles which are secured inside the permanently sealed can, preventing re-use of needles. The design embodies an element of sustainability in that it uses a waste product available even in low income countries.”

<http://www.indexaward.dk/2007/default.asp?id=706&Article=2599&Folder=2599>

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*

International Conference on Emerging Infectious Diseases 16-19 March, 2008 Atlanta, Georgia, USA

"The International Conference on Emerging Infectious Diseases was first convened in 1998; ICEID 2008 marks its sixth occurrence. The conference brings together public health professionals to encourage the exchange of scientific and public health information on global emerging infectious disease issues. The program will include plenary and panel sessions with invited speakers as well as oral and poster presentations on emerging infections.

Major topics to be included are current work on surveillance, epidemiology, research, communication and training, bioterrorism, and preventions and control of emerging infectious diseases, both in the United States and abroad.

Major subjects to be covered include:

- Antimicrobial Resistance
- Bioterrorism and Preparedness
- Foodborne and Waterborne Illnesses
- Global Health
- Molecular Diagnostics and Epidemiology
- Nosocomial Infections
- Socio-economic and Political Factors
- Vectorborne Diseases
- Zoonotic Diseases"

Abstract submission deadline was November 2007.

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

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

"The mandates and challenges faced by professionals in healthcare epidemiology today require members of this community to integrate science, cost containment realities, theoretical threats, and local pressures into our practice. The past several years have brought new approaches and technologies as well as higher standards to study and assess the efficacy of infection control measures. The 18th Annual Scientific Meeting will join the efforts and expertise of top clinicians, scientists, and epidemiologists from around the world to discuss the latest advances in healthcare epidemiology practice, study, and preparation. To bring you the most important and relevant information, we have invited an expert international faculty to address healthcare epidemiology issues within plenary, symposia, workshop, and meet-the-consultant formats. Our goal is to support SHEA's mission for the promotion, development, and application of scientific principles to healthcare epidemiology to advance education, foster safe healthcare environments, and improve patient outcomes. Our program will provide you with the very latest information, including cutting edge updates on new and emerging issues such as resistant tuberculosis, problematic outbreaks, and cost-effective infection control, as well as point-counter-point discussions on controversial topics, and reviews of the science and practice related to longstanding issues of concern, such as antibiotic resistance, *Clostridium difficile*, advances in epidemiologic methods, hand hygiene, surveillance (including NHSN updates,) and healthcare worker and patient safety. Many of our expert invited speakers are from outside North America and will ensure these issues are addressed from a global perspective."

Abstract deadline 4 January 2008

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

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Abstract deadline 15 February 2008

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

XVII International AIDS Conference

3-8 August, 2008

Mexico City, Mexico

AIDS 2008 will provide many opportunities for the presentation of important new scientific research and for productive, structured dialogue on the major challenges facing the global response to AIDS. Conference organizers are developing a wide variety of session types that meet the needs of various participants and support collective efforts to expand delivery of HIV prevention and treatment to communities worldwide. Central to many of these sessions will be the transfer of knowledge and sharing of best practices.

In addition to the conference sessions there are a number of activities, including satellite meetings, exhibitions, the Global Village and the Cultural Programme, that are integral to delegates' experience at the conference.

For more information visit the website:
<http://www.aids2008.org>

Hong Kong Infection Control Nurses' Association: 3rd International Infection Control Conference

30th August – 1 September, 2008

Hong Kong SAR, China

“Breakthrough in Infection Control”

Abstract submission deadline 15 June 2008

For more information visit the website:
<http://www.hkicna.org/education.html>

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>