

In SafeHandS

Newsletter of the SafeHandS network

September 2008



Volume 3 Issue 2



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.

SafeHandS is funded by AusAID.

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? Contributions

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

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

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

The focus of this issue is: SafeHandS Phase II

The next issue will be in December 2008.

Deadline for contributions - 21st November, 2008. Guidelines for contributors can be found on the SafeHandS website.

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Disclaimer

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SafeHandS

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

Editorial



Professor Gold, the Director of the Albion Street Centre in Sydney, Australia, is a physician and epidemiologist with over 20 years experience in the diagnosis and management of patients with HIV and other infectious diseases. Professor Gold established the national HIV/AIDS surveillance program in Australia and has served on National Advisory Committees related to HIV, infection control and healthcare worker safety. Professor Gold has been involved in curriculum development, teaching and assessment of healthcare worker training in developing countries. He has a particular interest in the implementation of techniques for monitoring and evaluation of health services in these settings to ensure the most effective use of limited resources.

It is now a little more than three years since we launched the SafeHandS program with the aim of supporting healthcare workers (HCW) in Asia and the Pacific to more safely care for patients who may have blood borne infections. This newsletter marks an important point in the SafeHandS story as we are about to embark on the next three year phase of our collaboration with you, our members. Before introducing the new phase it is good to reflect on what we have all achieved over the last three years. We believe the original aim of the program is being fulfilled with the active participation of our members, the dedicated staff who produce our communications, and importantly with the generous support of the Australian Agency for International Development (AusAID). SafeHandS has attracted more than 160 members from 34 countries. Each member is active in patient and staff safety practice, usually at their local hospital or health service. We receive many questions from members and requests to provide educational and training material. The quarterly newsletter which has been produced on-line since June 2005 is our main communication tool. It can be accessed through our website which contains useful and practical information

on all aspects of healthcare worker safety, including instruction sheets and presentations. Our website is being redesigned to make it more user friendly and to respond to suggestions from our members. In order to assist members and their countries in the Region to more accurately monitor and evaluate the scope of the HCW safety situation we are developing and pilot testing a surveillance tool that can be used in resource limited settings. This tool is designed to quantify the scope of the HCW safety situation and to enable you to monitor the effectiveness of any interventions to improve safety and quality of care.

In this issue Maggy, our Coordinator and driving force behind SafeHandS, presents the direction and activities for the next three years. AusAID has generously provided funded for SafeHands to begin new and exiting initiatives, as well as continuing our regular services and newsletter. One of the most important initiatives is our small grants scheme which will provide up to \$5000 for innovative ideas on improving HCW safety in resource limited settings. You are all encouraged to read the terms of reference carefully and submit an application before the closing date of November 30. These grants provide an opportunity to implement small activities and to measure their effectiveness so others can learn from your experience. There will be several repeat openings for grants during the coming three years, so please watch this newsletter for announcements.

Please keep in mind that as our treatments for HIV and other diseases improve and become more available, we will see more patients having contact with the healthcare systems at earlier stages of their illness. This means you have to assume that every patient may have HIV or another blood-borne infection. Therefore you need to be alert and manage your own safety and always practice infection control standard precautions on every occasion of patient contact. The role of SafeHandS is to provide a network of support for you and your co-workers. Please do hesitate to contact us if we can be of any assistance with any issue of safety or infection control. Thank you for being a member of the SafeHandS network and we look forward to working with you for the coming years.

By Professor Julian Gold
Director, Albion Street Centre

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 and other communicable diseases.

We know that health care workers are essential in responding to HIV 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. 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 July 2008, we had 160 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 that the 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 Profile

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



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Describe your current job:

I am working as Public Health Officer for Amungme Kamoro Community Development Institution (LPMK). LPMK is a nonprofit institution located in Mimika regency, West Papua, Indonesia, whose specific aim is the development of the Amungme Kamoro tribes as well as five other neighbouring tribes from the mountainous region of Central Papua, The Damal, Nduga, Moni, Mee and Dani.

My work is focussed on empowering local community to achieve better health status by teaching, training, supervising and running public health services.

The major challenging public health issue in West Papua especially remote areas in highland are the high burden of HIV cases, tuberculosis, pneumonia, diarrhoea and malnutrition.

I am developing integrated health services especially for mother and child in every village. That activity consists of growth monitoring, immunization and health education sessions. I am also teaching health topic for ladies and students every week in every village to increase awareness of the community on healthy living environment. In collaboration with Family Welfare Movement we teach the mothers how to prepare and cook nutritious meals for their family.

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

After finishing Medical School in Samratulangi University in Manado, North Sulawesi, Indonesia, my first assignment was Government Mandatory Services in Primary Health Care, Manokwari province in West Papua, Indonesia for 3 years. Then I moved to Jayapura, West Papua, work as Government Medical Officer in Primary Health Care. Next 2 years I moved to Fakfak province, West Papua, work in Hospital. After attending Workshop on Voluntary, Counselling and Testing (VCT), by Department of Health, Papua Province in Sorong, West Papua I developed a VCT clinic. From 2006 I worked as Public Health Officer for Amungme Kamoro Community Development Institution.

What do you like most about your job?

I like visiting villages, interacting with local community, empower them by improving their health knowledge and seeing community changing to a better health status.

What do you like least about your job?

Working with government health department that is not always supportive. Some local people sometimes give negative responses to what I am doing. Tribal war still happens in this area and will affect our programme. For example, last year the tribal war ended after 4 months, and during that time all our activities were stopped.

What does health care worker safety mean to you?

We should not put ourselves at risk of disease transmission by doing the right step in our work.

What are you reading at the moment?

I am reading The Purpose Driven Life by Rick Warren.

What are you currently listening to?

I like to listen to Church hymn, it gives me strength.

What is your favourite saying?

Serve people with love and open heart, solve problem with open mind.

SafeHandS Phase II: A new three year project from July 2008 – June 2011

SafeHandS has renewed funding until June 2011!

Read about our new activities in this article and see how you can become involved.

At the end of the newsletter there are forms to complete if you are interested in applying for a small grant for a project, becoming a member of our reference group, or recommending an organisation to form a partnership with SafeHandS

SafeHandS is a network for health care worker (HCW) safety in the Asia-Pacific region which has been operating since January 2005. The project, which is managed by the Albion Street Centre (ASC) in Sydney, Australia, was originally funded by the Australian Agency for International Development (AusAID) for three years. Renewed funding will see the next phase of the project continue, maintain and extend the activities of SafeHandS. New activities will strengthen SafeHandS through the founding of an international reference group, the formation of partnerships with regional organisations and the establishment of a grant scheme to support individual health facilities to become demonstration sites for health care worker safety improvement.

Background

Health care workers are essential to the prevention of transmission of human immunodeficiency virus (HIV) and other blood borne viruses as well as to the provision of treatment and care of people living with HIV (PLHIV), including achieving the aim of significantly expanding access to HIV therapy. Current HIV management strategies, including pharmacological interventions, nutrition and counselling can be complex. Committed and well educated HCW are needed to ensure patients are appropriately cared for and that the disease burden is minimised. As well as providing direct care, HCW can provide education for PLHIV, their families and their communities in health maintenance, the prevention of HIV transmission and reduction in stigma and discrimination.

HCW may be anxious about contracting an infectious disease through the course of their work and be fearful of conducting certain procedures or managing certain categories of patients.^{1,2} Fear of HIV infection has been shown to impact on recruitment and retention of HCW.^{3,4} This concern may be justified if

HCW do not have access to knowledge, equipment and resources likely to minimise the risk of transmission. HCW anxieties may mean that infected patients, or those who may be considered at risk of having a blood borne virus, are not provided with optimal health care. Literature from the Severe Acute Respiratory Syndrome (SARS) epidemic in 2003 suggests that nurses who feel confident in control measures are more likely to be willing to care for patients.⁵ Every effort should be made to ensure that all HCW operate in an environment that is as safe as possible for both them and their patients.

From previous work in the region, ASC staff are aware that HCW are concerned about their safety and that this may mean that patients experience discrimination or inappropriate care. At the same time, exposures such as needlestick injuries are underreported, often because it is perceived no follow up (such as post exposure prophylaxis) is available. It has been observed that a clear understanding of priorities for HCW safety are misunderstood, with some low or no cost safety precautions not being taken and other costly interventions being implemented un-necessarily (such as inappropriate use of chemicals or personal protective equipment) for low risk situations.

Maintenance and support of the health workforce in the light of HIV infection is a current World Health Organization priority.³ In order to engage HCW in the care of patients with HIV and associated communicable diseases it is critical to provide them with a safe working environment where they feel supported. HCW need to be able to talk to and support each other, especially in situations where other support mechanisms are limited. The sense of isolation faced by HCW within large health systems needs to be addressed.

New research and the refinement and im-

provement of clinical practice are taking place constantly and there is a need for easy access to this information for all HCW in the region. There is limited published data which is relevant to HCW operating in resource poor settings, especially in relation to practical experiences and lessons which can be readily adapted and adopted.

SafeHandS Phase I (2005 – 2008)

SafeHandS was established as a 'virtual' network designed to link and support health care workers across the Asia-Pacific region who are caring for PLHIV and other communicable diseases. It was designed as a forum where health care workers could share issues and ideas to encourage and learn from each other to find practical solutions to improve health care worker safety in developing and middle income countries.

Free membership of SafeHandS has included receiving the quarterly newsletter (In SafeHandS), access to a moderated email discussion group, access to a clearinghouse of new resources and publications produced by SafeHandS and other organisations about HCW safety, and inclusion on a database of expertise.

Aim:

To develop a network of health care workers and institutions to promote:

- Sharing of information between health care workers and institutions about health care worker safety
- Policy development and program implementation to improve health care workers' safety
- Optimal care for people with blood borne viruses and other communicable diseases (especially HIV, hepatitis B and hepatitis C)
- Practical steps to deal with issues of stigma and discrimination which might otherwise militate against optimum health outcomes.

Objectives:

1. To link together at least 50 health care workers who are responsible for improving health care worker safety in the workplace in the Asia-Pacific region each year of the project.
2. To provide health care workers with up-to-date information at least every three months about improving health care worker safety in resource limited settings.

3. To provide health care workers with new resources at least every three months which can be implemented in their work place to improve health care worker safety in resource limited settings.

SafeHandS is coordinated by the ASC which is a public health care facility based in Australia for the treatment, care and support of people living with or affected by HIV. The SafeHandS team includes infection control specialists with international experience in health care worker safety.

Lessons learned from SafeHandS Phase I (2005 – 2008)

One of the key lessons learned from the first three years of SafeHandS is the difficulty of having two way communications with members in an online network. There has been little response to formal surveys of members to further determine the types of services, training resources and policies required and already available. Feedback is mostly ad hoc and unsolicited and it is difficult to elicit member contributions to the newsletter and email discussion group.

Face to face contact seems to be the most effective in developing relationships. The majority of members (60%) heard about SafeHandS from "another person" – as opposed to from the website or newsletter.

There have also been many positive lessons learned. Over 160 HCW from 31 countries have joined the network (membership is currently 158). Of these, the majority can access the newsletter and services by email, with only about 20 newsletters being sent by mail. This indicates that providing information and support online is a viable option.

Anecdotal and survey feedback suggest that the newsletter is valued both for finding out the most up to date information and also for reading about colleagues in other countries. Some members who work in the field of infection control indicated that they feel isolated in their workplace and value the regional contacts. The website is valued as a reference source. Members have also indicated that they value the practicality of the resources developed and distributed by SafeHandS and have been able to use them in their workplaces.

Objectives - SafeHandS Phase II

1. To develop the capacity of regional HCW and their organisations to scale up and manage HIV services by facilitating a network to improve health worker safety in the workplace in the Asia-Pacific region
 - To encourage 'ownership' of the existing network by HCW in the region
 - To develop a regional body of knowledge about improving health care worker safety
 - To disseminate knowledge and lessons learnt to HCW throughout the region
2. To develop and maintain a local evidence base on health care worker safety
 - To implement and evaluate health care worker safety strategies at selected sites in the Asia-Pacific region to demonstrate their effectiveness in a resource constrained setting
 - To refine the Health Care Worker Surveillance Tool as an instrument to assist institutions to improve health worker safety from infectious disease
3. To establish and maintain sustainable capacity building partnerships with health worker organisations across the region to improve health care sector response to HIV care and support
 - To identify and liaise with country and regional professional organisations to promote and disseminate information about health worker safety

Project description - SafeHandS Phase II

It has been recognised in the first three years of the SafeHandS project that it is difficult to encourage local ownership of what is essentially an online network. It is therefore proposed to establish a regional reference group; to partner with local organisations and to support the establishment of local HCW demonstration projects to increase members 'ownership' of the network.

Reference group

The regional reference group will be made up of individual members from different countries in the region. The group will provide co-ordination, advice and guidance of the project. An expression of interest will be circulated to all current members. It is envisaged that the group will have at least 10 members from 6 different countries. The proposed terms of

reference for the group are available on request.

Expressions of interest for membership should be submitted on the form at the end of this newsletter. The closing date for submissions of expressions of interest is 30 November 2008. If less than 10 people apply or if members are unable to continue, further calls for expressions of interest will be made twice yearly. In the event of more than 10 people, or more than 2 people from one country, submitting expressions of interest, applications will be assessed by a panel of Albion Street Centre staff and independent experts.

Applications will be assessed on the following criteria:

- The ability to read, write and speak English
- Existing active membership of SafeHandS
- Ability to represent the views and interests of health care workers
- Demonstrated interest in promoting health care worker safety

Successful applicants will be expected to demonstrate the level of commitment outlined in the terms of reference. This will include regular communication by email and occasionally by telephone as well as being available to read and develop documents and provide advice. It is estimated that this will take an average of approximately one hour per week.

Information provided in the applications will be treated as confidential. Information about successful applicants may be published in the SafeHandS newsletter, website and annual report.

Organisational partnerships

Membership of the SafeHandS network has to date been open to individuals. For the continuation of the project it is intended to form partnerships with relevant regional and local organisations concerned with infection control or health worker safety.

The role of partnerships with such organisations is envisaged to be: extending the reach of SafeHandS to more eligible members; disseminating information from SafeHandS; informing SafeHandS about issues of concern to members which are relevant for SafeHandS to address; advising SafeHandS about culturally appropriate

strategies to improve HCW safety; assisting with research into and publications about HCW safety in the region.

One of the areas that may be explored with local organisations is the identification of a regional organisation that will be able to host the network or take a more active role in its ongoing operation, or a group of organisations or individuals who may participate in a rotation system to guide the network.

SafeHandS is currently seeking expressions of interest from organisations who are interested in exploring a partnership and also information about organisations that SafeHandS could approach to form partnerships. There is no pre-determined maximum or minimum number of partnerships that may be entered into.

Expressions of interest or nominations should be submitted on the form at the end of this newsletter. Organisations will be considered according to the following criteria:

- Interest in promoting health care worker safety
- Operating in the Asia-Pacific region
- Ability for the organisation and SafeHandS to cross-promote and add value to each other's aims and activities

Demonstration projects

It is proposed to establish demonstration projects in which selected health facilities will be assisted to implement innovative health care worker safety initiatives.

The sites will be chosen by response to a circulated expression of interest. In year one, two sites will be chosen (one in Asia and one in the Pacific). Additional sites will be selected in years two and three. Sites chosen to host demonstration projects will receive a small grant of A\$5,000 to run the project. Such demonstration projects which can be evaluated for effectiveness in terms of outputs, cost effectiveness and resource efficiency will provide practical examples of what can be achieved in developing countries. This lived experience is expected to be more 'believable' for other developing country settings than theories espoused by developed countries such as Australia or the United States of America.

The sites of the demonstration projects will

need to be evaluated before and after the intervention. It is hoped this will further develop the Health Care Worker Safety Surveillance Tool (already developed by SafeHandS) as an instrument to be able to measure both a baseline and change in HCW safety at a health facility. The projects will provide an opportunity to apply and refine the tool in various facilities across the region and possibly the use of the tool as a research instrument. (In its current form the validity and reliability of the tool have not been established.) This would in turn provide a validated tool for the region which could assist ongoing monitoring and evaluation of HCW safety and related activities.

An important follow up to the demonstration projects will be dissemination of results – through the SafeHandS newsletter and website and a regional conference.

A call for applications for the first projects to be funded follows this article. There is an application form at the end of this newsletter.

Ongoing activities

SafeHandS will continue to maintain an informative website, publish a quarterly newsletter, moderate an email discussion group for members, maintain a clearinghouse of resources and publications on HCW safety, maintain a database of expertise in HCW safety and infection control, and develop resources for HCW safety.

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SafeHandS Small Grants Scheme: Health Care Worker Safety Demonstration Projects

Call for applications for 2009

This should be read in conjunction with the previous article SafeHandS Phase II.

1. About the proposed demonstration projects

It is proposed to establish demonstration projects in which selected health facilities will be assisted to implement innovative health care worker safety initiatives.

The sites will be chosen by response to a circulated expression of interest. In year one of this SafeHandS project, two sites will be chosen (one in Asia and one in the Pacific). More sites will be selected in years two and three. Sites chosen to host demonstration projects will receive a small grant of A\$5,000 to run the project.

It is intended that the demonstration projects will be evaluated for effectiveness in terms of outputs, cost effectiveness and resource efficiency and so be able to provide practical examples of what can be achieved in developing countries. This lived experience is

expected to be more 'believable' for other developing country settings than resource intensive strategies proposed by countries such as Australia or the United States of America.

2. Eligibility

Proposed projects must:

- be based in the Asia-Pacific region
- be from developing countries, countries with economies in transition, or middle income countries which have resource constraints for providing health care
- address protecting health care workers from blood borne or respiratory infectious diseases
- be able to be achieved within the budget

3. Technical assistance and support

While projects are encouraged to develop their own resources, SafeHandS can provide sample policies, training resources, the HCW Safety Surveillance Tool, assistance with a monitoring and evaluation framework, assistance with publication of findings and other technical assistance and support. One site visit by a SafeHandS staff member is possible before, during or after the project.

4. Timeline

30 November 2008:
Close of applications

December 2008:
Successful applicants notified

January – March 2009:
Project plan, development of protocols, staff training, monitoring and evaluation framework, baseline data collected and collated

April – June 2009:
Implementation of proposed HCW safety intervention

July – August 2009:
Post intervention data collection and evaluation, project report, preparation for publication of findings

Strict adherence to the timeline is essential to allow other projects to benefit from the results and findings. Note that the project is to be completed within eight months of notification of successful grant application.

5. Funding arrangements

Each project selected for funding will receive A\$5,000 to complete the project.

The grant will support the direct costs of conducting the project and is to be used during the period of the project. The project should commence within two months of the date of the letter of contract.

The date(s) of payment of the grant will be determined by project needs. The final payment will be made on receipt of the final report.

The grant is to support the project described in the application. It is limited to A\$5,000. There is no scope for increasing the level of grant awarded. The expenditure must conform to the budget items outlined in the approved proposal. A summary of expenditure will be required as part of the project completion report.

Funding will be provided to a host institution which will be the fund holder and legal entity for contractual purposes. This should be the main affiliated institution of the principal investigator. Eligible institutions include universities, hospitals, community based or nongovernmental organisations, government departments and collaborating centres.

6. Application process

Final date for applications is 30 November 2008. Applications received after this date will not be considered.

Applications should be submitted on the form at the end of this newsletter.

7. Assessment process

Applications will be assessed by a panel of Albion Street Centre staff and independent experts.

Applications will be assessed on the following criteria:

- whether the eligibility criteria are met
- how well the project addresses health care worker safety issues
- the originality and innovation of the project
- whether objectives are practical and measurable
- the appropriateness of the project for resource constrained settings

- the potential for sustainability of the project if successful
- the monitoring and evaluation plan
- a realistic budget

SafeHandS will inform all applicants of the outcome of the selection process.

Unsuccessful applications may be resubmitted for the grants which will be made available in years two and three of the project.

8. Responsibilities of successful applicants

The designated leader for each selected project will be responsible for:

- Adhering to the conditions specified in the letter of contract
- Applying for local ethics and/or research committee approvals if necessary
- Obtaining permissions for the project from the host institution and Ministry of Health, if required
- Coordination, implementation and completion of the project within the specified timeframe unless unforeseen circumstances arise
- Reporting on project activity and finances at agreed times (usually at four months and at the end of the project) in the required format
- Providing information to SafeHandS to allow dissemination of information and lessons learned from the project to peers throughout the Asia-Pacific region
- Publication of original information learned from the project in a regional or international journal

9. Confidentiality

Information provided in the applications will be treated as confidential. Information about successful applications, such as the project leader, name of the institution, the title of the project, the funding awarded and the key findings, may be published in the SafeHandS newsletter, website and annual report.

For enquiries or to submit an application contact:

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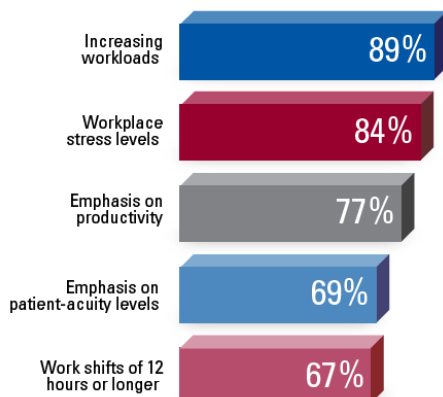
American Nurses Surveyed on Workplace Safety

In April 2008, the American Nurses Association (ANA) conducted an online survey of over 700 nurses' views on workplace safety and needlestick injuries. The following information is from the June press release announcing the findings.

According to the results, nearly two-thirds (64 percent) of U.S. nurses say needlestick injuries and blood borne infections remain major concerns. "An overwhelming majority of nurses (87 percent) say safety concerns influence their decisions about the type of nursing they do and their continued practice in the field. This study exemplifies the serious concerns expressed by nurses across the country. Concerns that may prompt nurses to leave the bedside, exacerbating the growing nurse shortage. To enhance the safety climate of all healthcare workers, improvements need to be made to the workplace environment and staffing levels," said ANA President Rebecca M. Patton.

According to the study, the vast majority of nurses (89 percent) say increasing workloads and workplace stress levels (84 percent) impact workplace safety. When asked how their employer ranks key issues, 35 percent of nurses perceive patient care and organizational reputation as first, followed by patient safety, infection control, healthcare worker safety and staff productivity. Results of the survey underscore the reality of nurses' stereotypical self-sacrificing nature. When asked if they put patient care first before their own personal safety at work, the vast majority of nurses (82 percent) say "yes."

Nurses in the survey said the following issues impacted in their workplace safety:



Needlestick Injuries

Sixty-four percent of nurses in the survey reported being accidentally stuck by a needle while working. When asked how nurses attained their most recent needlestick injuries, the top three responses include: while giving an injection (28 percent); before activating the safety feature (19 percent); and during the disposal of a non-safety device (19 percent).

While the overwhelming majority of nurses (91 percent) are familiar with their workplace's protocol regarding needlestick injuries, 79 percent of those accidentally stuck by a needle while working say they reported the incident.

Nearly half (46 percent) of those who have been stuck say, during their most recent needlestick injury, they received an evaluation or were treated within one to two hours; yet more than one-third (39 percent) state they were not evaluated or treated at all. Nine percent say they were treated within four hours; two percent within the first eight hours; three percent the next day; and one percent more than 24 hours afterwards. Ninety-five percent of nurses report taking a Hepatitis B vaccine to protect them from Hepatitis B infection due to occupational exposure.

Summary of findings

<http://nursingworld.org/MainMenuCategories/OccupationalandEnvironmental/occupationalhealth/OccupationalResources/2008SafetyandNeedlestickStudy.aspx>

Press release

<http://nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/2008PR/WorkplaceSafetyTopConcerns.aspx>

World Health Organization – Priority interventions

The World Health Organization (WHO) released a new publication at the International AIDS Conference in Mexico in August 2008: *Priority interventions: HIV/AIDS prevention, treatment and care in the health sector*

The accompanying press release states that: “*Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector* is a compilation of WHO-recommended priority HIV/AIDS health-sector interventions. It includes everything from how to expand condom programming to the latest in treatment recommendations, guidelines and standards. The publication is designed to be a ‘living’ web-based document that will be periodically updated with new recommendations based on the rapidly evolving experience of the health-sector response.

‘This document responds to a long-standing country need,’ says Dr Kevin M. De Cock, Director of the WHO HIV/AIDS Department. ‘In one place it captures WHO’s best guidance on what the global HIV/AIDS health sector response needs to deliver.’

To that end, WHO has developed this package to promote the more efficient use of existing recommendations specifically aimed at resource-limited settings. This, its authors state, will help enable countries to meet their commitment made two years ago at the United Nations General Assembly High-Level Meeting on AIDS to provide universal access to HIV prevention, treatment, care and support by 2010.

The purpose of *Priority Interventions* is to:

- describe priority health-sector HIV/AIDS interventions that are needed to achieve universal access to HIV prevention, treatment and care;
- guide the selection and prioritization of interventions for HIV prevention, treatment and care; and
- direct readers to key WHO resources and references containing the best available information on the health-sector response to HIV/AIDS.

The scale-up of HIV treatment in the world’s poorest countries is greatly strengthening the

health sector in many ways such as the establishment and expansion of infrastructure, including labs and clinics, a stronger health workforce, more efficient procurement and supply management systems and sustained financing.

WHO is initially launching the document on a CD-Rom but will make it available in several formats, including in hard copy and on the web. The intent is to share information and allow partners to learn from, and contribute their expertise to, the health-sector response to HIV/AIDS.”

The four main chapters in the publication are:

1. The priority interventions for HIV/AIDS prevention, treatment and care in the health sector
2. Strengthening and expanding health systems
3. Investing in strategic information
4. Operationalizing the health sector response

This is what chapter 1 says about the occupational health of health care workers:

“For healthcare workers, exposure to the blood of people receiving care most often occurs via accidental injuries from sharps such as syringe needles, scalpels, lancets, broken glass or other objects contaminated with blood. Poor patient care practices by HIV-infected medical staff may also carry a risk of infection for the patient. Also, when injecting and other equipment is poorly sterilized, HIV may be carried from an HIV-infected to an uninfected patient within the health care setting.

Protecting the occupational health of health-care workers and ensuring health-care workers know their status and receive HIV treatment as appropriate is an important priority for the health sector. A good occupational health programme aims to identify, eliminate and control exposure to hazards in the workplace.

Summary of recommendations:

- Designate a person to be responsible for the occupational health programme.
- Allocate a sufficient budget to the programme and procure the necessary supplies for the personal protection of healthcare workers.

- Provide training to health care workers and involve them in the identification and control of hazards.
- Promote healthcare worker's knowledge of their own HIV, hepatitis and TB status through employment/pre-placement screening.
- Provide immunization against hepatitis B.
- Implement standard precautions.
- Provide free access to post exposure prophylaxis for HIV.
- Promote reporting of incidents and quality control of services provided."

And on occupational post-exposure prophylaxis (PEP):

"Post-exposure prophylaxis (PEP) is a necessary secondary prevention measure in health care settings, since there will always be rare instances in which primary prevention fail and healthcare workers or patients may be accidentally or through unsafe procedures be exposed to the risk of HIV transmission. The vast majority of incidents of occupational exposure to blood borne pathogens, including HIV, occur in health care settings. PEP for HIV consists of a comprehensive set of services to prevent infection developing in an exposed person, including: first aid care; counselling and risk assessment; HIV testing and counselling; and, depending on the risk assessment, the short term (28- day) provision of antiretroviral drugs, with support and follow up.

Summary of recommendations:

- WHO recommends that PEP be provided as part of a comprehensive prevention package that manages potential exposure to HIV and other infectious hazards.
- Occupational PEP should also be available not just to healthcare workers but to all other workers who could be exposed while performing their duties (e.g., social workers, police or military personnel, rescue workers, and refuse collectors).
- There should be appropriate training for service providers to ensure the effective management and follow up of PEP.
- ARVs for PEP should be initiated as soon as possible after exposure within the first few hours and no later than 72 hours.
- ARV drugs for PEP should not be prescribed to people already known to have

been infected with HIV prior to the exposure incident.

- HIV testing is recommended. The administration of ARV drugs for PEP should never be delayed because of testing procedures.
- If the first test is negative it should be repeated after three and six months.
- WHO recommends that the PEP ARV regimen contain two NRTI drugs. If drug resistance is suspected the addition of a protease inhibitor(PI) may be considered.
- ARVs for PEP should be administered for a duration of 28 days.
- Any occupational exposure to HIV should lead to an evaluation of the working environment and procedures and, when appropriate, improvement of working conditions and safety precautions."

World Health Organization, HIV/AIDS Department. *Priority interventions: HIV/AIDS prevention, treatment and care in the health sector.* August 2008


http://www.who.int/hiv/pub/priority_interventions_web.pdf

Press release:

<http://www.who.int/mediacentre/news/releases/2008/pr25/en/index.html>

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: **Three successful interventions in health care workers that improve compliance with hand hygiene: Is sustained replication possible?**

Authors: Whitby M, McLaws M-L, et al

Date: June 2008

Source: American Journal of Infection Control 36(5):349-55

Country: Australia

Abstract: Hand hygiene (HH) compliance by health care workers has been universally disappointing. Two major programs (Washington and Geneva) have demonstrated interventions that induce sustained improvement. The introduction of alcohol-based hand rub (AHR) together with education also has been reported to improve compliance.

Methods: These interventions were replicated concurrently for 2 years in selected wards of an 800-bed university teaching hospital, with compliance assessed only within, not between, programs.

Results: No significant improvement in HH compliance was observed after the introduction of AHR (incidence rate ratio [IRR] = 1.11; 95% confidence interval [CI] = 0.93 to 1.33; $P = .238$) or substitution of AHR for a similar product (IRR = 1.10; 95% CI = 0.91 to 1.32; $P = .328$) with concomitant education. The Washington program achieved a 48% (IRR = 1.48, 95% CI = 1.20 to 1.81; $P < .001$) improvement in compliance, sustained over 2 years. The Geneva program failed to induce a significant increase in HH compliance in 3 wards, but achieved a 56% (IRR = 1.56; 95% CI = 1.29 to 1.89; $P < .001$) improvement over the already high HH rate in 1 ward (infectious disease unit).

Conclusions: The Washington program demonstrated effectiveness in achieving sustained improved HH compliance, whereas the effect of the Geneva program was limited in those wards without strong medical leadership. Introduction of AHR without an associated behavioral modification program proved ineffective.

Title: **Why don't doctors wash their hands? A correlational study of thinking styles and hand hygiene**

Authors: Sladek R, Bond M, Phillips P.

Date: August 2008

Source: American Journal of Infection Control 36(6): 399-406

Country: Australia

Abstract:

Background: The World Health Organization has identified cognitive determinants of hand hygiene as an outstanding research question.

This study investigated whether doctors' preferences for a rational thinking style or an experiential thinking style are associated with hand hygiene compliance.

Methods: This was an observational study of hand hygiene practices of 32 doctors in 2 teaching hospitals in South Australia. Compliance rates were correlated with self-reported thinking styles. The doctors were observed by a trained observer during a ward round or outpatient clinic and were unaware that hand hygiene was under observation. The main outcome measures were hand hygiene compliance (hand hygiene compliance tool) and thinking style (Rational-Experiential Inventory).

Results: An overall mean compliance rate of 7.6% (standard deviation \pm 7.2%) was found. Compliance was significantly positively correlated with experiential/automatic thinking ($r = .46$; $P = .004$) and the observational setting of ward rounds (vs clinics) ($r = -.47$; $P = .003$). No significant relationship was found between compliance and a rational/deliberate thinking style ($r = -.01$; $P = .472$).

Conclusions: Hand hygiene is more experiential than rational. Findings suggest that certain promotional strategies appealing to the experiential thinking mode may improve compliance, and that traditional approaches based on logic and reasoning alone probably will not work.

Title: **More safety: A resource manual for health and safety in infrastructure projects**

Authors: Asia Development Bank; Marie Stopes International; Baolong Healthy and Safe Action Project

Date: March 2008

Source: <http://www.adb.org/Documents/Manuals/Health-Safety-Resource-Manual/Health-Safety-Resource-Manual.pdf> (10Mb)

Country: China

Although this manual was written for construction projects in rural China it includes many resources that can be adapted for any workplace, including risk assessment tools, worksite HIV prevention plan, HIV information materials and sample policies.

Purpose. More and more construction

companies working on infrastructure projects recognize that the HIV/AIDS epidemic is a serious threat to productivity and profitability. **More Safety: A Resource Manual for Health and Safety in Infrastructure Projects** is a practical easy to use guide book for preventing HIV/AIDS in infrastructure. This manual is designed to give straightforward HIV prevention tools and skills to Project Managers, Occupational Health and Safety Officers, Worksite Health Workers, and other Managers on the worksite responsible for the health and well being of workers.

More Safety has been written specifically for infrastructure projects that are located in rural parts of China; however the principles outlined in this manual can be adapted to infrastructure project in both rural and urban areas throughout China and in other parts of South East Asia.

The manual draws on the practical experience of infrastructure HIV prevention projects in China and other parts of the world. Users will find the manual helpful to: (I) assess the real and potential risks of HIV/AIDS in the worksite; (II) gain practical skills for easy to do workplace HIV prevention interventions and activities; (III) learn where to get more information and support for HIV prevention efforts in the worksite and (IV) discover the commitment, creativity and innovation of champions of HIV prevention in infrastructure projects through real case-studies and stories."

Title: **How effective are hand anti-septics for the post contamination treatment of hands when used as recommended?**

Author: Kampf G.

Date: June 2008

Source: American Journal of Infection Control 36(5): 356 - 60

Country: Germany

Abstract:

Background: Alcohol-based hand antiseptics are often tested using 3 or 5 mL per application, but smaller volumes are likely to be applied in clinical practice. For that reason, we investigated the efficacy of 2 different volumes of 4 marketed hand rubs when applied to contaminated hands.

Methods: Hands of 16 volunteers were contaminated with *Serratia marcescens*. Hand rub A (85% ethanol), hand rub B (60% ethanol), hand rub C (62% ethanol), and hand rub D (61% ethanol) were applied as blinded formulations, each in single applications of 2.4 or 3.6 mL. Hibiclens (4% chlorhexidine gluconate) served as the reference treatment. Each hand rub was rubbed into the hands until dry. Pre-intervention and post-intervention bacterial populations were obtained by the glove juice method. Neutralization of residual activity was validated.

Results: A 2.4-mL aliquot of a hand rub product was sufficient to cover both hands in 96.9% of the subjects. Applied in that volume, hand rubs produced a log₁₀-reduction in bacterial populations of 2.79 for hand rub A, 2.26 for hand rub C, 1.96 for hand rub D, and 1.90 for hand rub B. Application of 3.6 mL was significantly more effective for hand rubs B, C, and D. The reference treatment reduced test bacteria by 2.39 log₁₀. Analysis of variance revealed that both the type of hand rub and the applied volume had a highly significant influence on the mean log₁₀ reduction on artificially contaminated hands ($P < .001$).

Conclusions: Hand rubs applied in amounts sufficient to cover both hands may not reduce the bacterial density by even 2 log₁₀ steps. Based on our findings, the general trend toward alcohol-based hand rubs should not overlook evidence of significant differences in efficacy that appear to be related primarily to a product's overall concentration of alcohol.

Title: **HBV and HCV infection in Japanese dental care workers**

Authors: Nagao Y, Matsuoka H, et al.

Date: June 2008

Source: International Journal of Molecular Medicine 21(6):791-9

Country: Japan

Abstract: Protective measures against occupational exposure to the hepatitis B virus (HBV) and hepatitis C virus (HCV) must be taken in order to prevent infection in dental care workers. To determine the best way to protect these workers, our study examined viral hepatitis infection in dental care workers in regions with a high prevalence of HCV

infections in Japan. In total, 141 dental care workers (including dentists, dental hygienists and dental assistants) were enrolled. After a questionnaire to elicit demographic information was administered by an oral surgeon, hepatitis B surface antigen (HBsAg), antibody to HBs (anti-HBs), antibody to hepatitis B core antigen (anti-HBc) and antibody to HCV (anti-HCV) were measured. When necessary, HBeAg, anti-HBe, levels of HBV DNA, anti-HBc IgM and HCV RNA in serum were measured. Of the dental care workers included, 68 (48.2%) had been immunized with a HBV vaccine. Only 9 wore a new pair of gloves for each new patient being treated, 36 changed to a new pair only after the old gloves were torn and 24 did not wear any gloves at all. No one was positive for HBsAg or anti-HCV, though 73 (51.8%) and 17 (12.1%) workers were respectively positive for anti-HBs and anti-HBc. The positive rate of anti-HBc varied directly with worker age and experience. Of the 68 workers immunized with HBV vaccine, 51 (75%) were positive for anti-HBs. Of the 63 workers who were not so immunized, 17 (27%) were positive for anti-HBs and 15 of these were also positive for anti-HBc. Immunized workers were more protected against HBV infection than non-immunized workers, indicating that HBV vaccine was a useful measure for protection against the infection. The anti-HBc positive rate was significantly higher among dental care workers than general blood donors, suggesting that frequency of exposure to HBV was greater in dental care workers. HBV vaccination should be made compulsory for all dental care workers who handle sharp instruments.

Title: **Factors relating to acceptance of hepatitis B virus vaccination by nursing students in a tertiary hospital, Pakistan**

Authors: Mengal H, Howteerakul N, et al.

Date: March 2008

Source: Journal of Health Population and Nutrition 26(1):46-53

Country: Pakistan

Abstract: This cross-sectional study aimed at assessing the prevalence of, and factors relating to, the acceptance of hepatitis B virus (HBV) vaccination by nursing students in a tertiary hospital in Pakistan. In total, 210

nursing students of Year 2 to Year 4 were invited to participate in the study; of them, 196 (93.3%) returned completed questionnaires. Overall, the prevalence of acceptance of HBV vaccination among them was 75.0%. Of these, 37.2% (73/196) were completely vaccinated, and 25.0% (49/196) had not been vaccinated at all. More than half (27/49, 55.1%) of the unvaccinated nursing students stated that they would accept vaccination if offered. Multiple logistic regression analysis indicated three variables significantly related to acceptance of HBV vaccination: history of accidental exposure to blood or blood products, acceptable knowledge about HBV infection, and adequate budget for HBV vaccination. Health institutions should allocate adequate budgets to vaccinate their nursing students. Effective intervention programmes designed to increase knowledge about HBV infection and adhering to universally-accepted precautions are needed

Title: **Needlestick and sharps injuries in a tertiary hospital in the Republic of Korea**

Authors: Park S, Jeong I, et al.

Date: August 2008

Source: American Journal of Infection Control 36(6):439-43

Country: Republic of Korea

Abstract:

Background: The high incidence of hepatitis B virus (HBV) in the Republic of Korea has focused attention on monitoring the occurrence and characteristics of needlestick and sharps injuries (NSIs) as part of an effort to reduce the occupational exposure to blood-borne pathogens such as HBV. This study investigated NSIs reported in a tertiary referral hospital in Busan, Republic of Korea over a 6-year period (2001 to 2006).

Method: Data on the number of NSIs, places where NSIs occurred, devices causing injury, purpose of using sharps, and circumstances surrounding NSIs were collected from the study hospital's NSI database. The incidence of NSIs per 100 full-time equivalent (FTE) employees was calculated by year and by profession.

Results: A total of 221 NSI cases were

reported during the study period. Overall incidence was 2.6 cases per 100 FTE employees per year, with the highest rate occurring in interns (17.7 cases per 100 FTE interns per year). Some 34% of cases occurred in the ward, needles were the most common device causing injury (73%), and the most common circumstance surrounding an NSI was after sharps use and before disposal (24%).

Conclusion: The pattern of NSI occurrence found in this study was comparable to that reported in previous studies. However, the overall incidence of NSIs was significantly lower than that in previous studies, apparently related to underreporting of NSIs. Further research to investigate reasons for this underreporting is recommended. Considering the high incidence of NSIs in interns, in-service training for this group should be enhanced.

Title: **Outbreaks of influenza A among nonvaccinated healthcare workers: implications for resource-limited settings**

Authors: Apisarnthanarak A, Puthavathana P, et al.

Date: August 2008

Source: Infection Control and Hospital Epidemiology 29(8):777-

Country: Thailand

Abstract: We identified 3 outbreaks of influenza A (attack rates, 18%-24%) among Thai healthcare workers in intensive care units. All outbreaks were epidemiologically linked to an index patient with pneumonia due to influenza A virus (subtype H3N2). The investigations of these outbreaks incurred costs that exceeded the estimated costs of healthcare worker influenza vaccination by more than 10-fold.

Title: **The reporting of needlestick injuries sustained in theatre by surgeons: are we under-reporting?**

Authors: Au E, Gossage J, Bailey S.

Date: May 2008

Source: Journal of Hospital Infection 70 (1):66-70

Country: United Kingdom

Abstract: Surgeons frequently sustain needlestick injuries when operating. The aim of this study was to evaluate the incidence and reporting rate of needlestick injuries at one institution. A questionnaire was distributed anonymously to 69 surgeons of all grades and specialties in a district general hospital in the UK. The questionnaire was returned by 42 surgeons (60.9%). There were 840 needlestick injuries over two years, of which 126 caused bleeding. Senior surgeons who spent more hours operating per week had a higher rate of needlestick injuries compared with junior surgeons (29.1 vs 6.59 injuries per surgeon over two years). Of the total number of injuries, 19 (2.26%) were reported to Occupational Health according to the surgeons questioned, but only six reported incidents were found in the Occupational Health records. Junior surgeons were significantly more likely to report needlestick injuries than senior surgeons (9.82% vs 1.10% of injuries reported, $P=0.0000045$). The main reasons for failure to report needlestick injuries were due to the lack of time and excessive paperwork. Seventy-three percent of surgeons did not routinely use double gloves when operating, mainly because of decreased hand sensation. The rate of needlestick injury reporting by surgeons at this institution is extremely low. Previous studies have shown a higher reporting rate suggesting that, despite awareness of blood-borne infections, surgeons are still not following recommended protocols.

Title: **Inverse correlation between level of professional education and rate of handwashing compliance in a teaching hospital**

Authors: Duggan J, Hensley S, et al.

Date: June 2008

Source: Infection Control and Hospital Epidemiology 29 (6):534-538

Country: USA

Abstract:
Objective: To evaluate educational level as a contributing factor in handwashing compliance.

Design: Observation of hand washing opportunities was performed for approximately

12 weeks before an announced Joint Commission on Accreditation of Healthcare Organizations (JCAHO) visit and for approximately 10 weeks after the visit. Trained observers recorded the date, time, and location of the observation; the type of healthcare worker or hospital employee observed; and the type of hand hygiene opportunity observed.

Setting: University of Toledo Medical Center, a 319-bed teaching hospital.

Results: A total of 2,373 observations were performed. The rate of hand washing compliance among nurses was 91.3% overall. Medical attending physicians had the lowest observed rate of compliance (72.4%; $P < .001$). Nurses showed statistically significant improvement in their rate of hand hygiene compliance after the JCAHO visit ($P = .001$), but no improvement was seen for attending physicians ($P = .117$). The compliance rate in the surgical intensive care unit was more than 90%, greater than that in other hospital units ($P = .001$). Statistically, the compliance rate was better during the first part of the week (Monday, Tuesday, and Wednesday) than during the latter part of the week (Thursday and Friday) ($P = .002$), and the compliance rate was better during the 3 PM–11 PM shift, compared with the 7 AM–3 PM shift ($P < .001$). When evaluated by logistic regression analysis, non-physician healthcare worker status and observation after the JCAHO accreditation visit were associated with an increased rate of hand hygiene compliance.

Conclusion: An inverse correlation existed between the level of professional educational and the rate of compliance. Future research initiatives may need to address the different motivating factors for hand hygiene among nurses and physicians to increase compliance.

Title: **Making straight suture needles a little safer: a technique to keep fingers from harm's way**

Author: Nelson B.

Date: February 2008

Source: Journal of Emergency Medicine 34 (2): 195-7

Country: USA

Abstract:

Straight suture needles are commonly employed to secure arterial and venous catheters to the skin. These needles have been demonstrated to be more dangerous than curved or blunt suture needles, with a higher rate of injury for health care workers.

This article describes a technique for using the straight needle that may reduce the chances of injury. By utilizing the plastic needle sheath present in most central venous line kits as a "thimble," counter pressure and skin puncture may be achieved without bringing the fingers near the sharp end of the suture.

Title: **Hepatitis B virus, hepatitis C virus and other blood-borne infections in healthcare workers: guidelines for prevention and management in industrialised countries**

Authors: FitzSimons D, François G, et al.

Date: July 2008

Source: Occupational and Environmental Medicine (7):446-51

Country: Global

Abstract: The Viral Hepatitis Prevention Board (VHPB) convened a meeting of international experts from the public and private sectors in order to review and evaluate the epidemiology of blood-borne infections in healthcare workers, to evaluate the transmission of hepatitis B and C viruses as an occupational risk, to discuss primary and secondary prevention measures and to review recommendations for infected healthcare workers and (para)medical students. This VHPB meeting outlined a number of recommendations for the prevention and control of viral hepatitis in the following domains: application of standard precautions, panels for counselling infected healthcare workers and patients, hepatitis B vaccination, restrictions on the practice of exposure-prone procedures by infected healthcare workers, ethical and legal issues, assessment of risk and costs, priority setting by individual countries and the role of the VHPB. Participants also identified a number of terms that need harmonization or standardisation in order to facilitate communication between experts.

Title: Infection control posters

Authors: Webber Training

Source: <http://webbertraining.com/freeposterdownloads97.php>

Country: Canada

The Webber Training website has 35 professionally designed infection control posters available for free download.

Title: CDC sharps injury prevention program

Authors: Centers for Disease Control

Source: <http://www.premierinc.com/safety/topics/needlestick/cdc-sharps-injury-prevention.jsp>

Country: USA

The CDC Workbook for designing, implementing, and evaluating a sharps injury prevention program has been revised, with a 2008 version now available.

“The 155 page CDC Workbook is based on a model of continuous quality improvement, an approach that successful healthcare organizations are increasingly adopting. The Workbook provides a program plan that is designed to integrate into the performance improvement, infection control, and safety programs that already exist within healthcare facilities. The program plan also draws on concepts from the industrial hygiene profession, in which prevention interventions are prioritized based on a hierarchy of control strategies. The plan has two main components: organizational steps are listed for developing and implementing a sharps injury prevention program, and operational processes (activities) that are considered vital to the success of a sharps injury prevention program are discussed. The Workbook provides detailed information and a variety of tools (e.g., surveys, worksheets, data collection forms) to facilitate the implementation of organizational steps and development of operational processes. An initial version of the Workbook was launched and available on the CDC Web site in 2004.”

The following resources are available from this webpage:

- CDC NIOSH posters on needlestick

prevention for healthcare settings to download

- CDC Sharps safety education pamphlet for healthcare professionals. 2-page tri-fold; easy to download and print.(335 KB)
- Premier Safety Institute's needlestick brochure 12-page, easy-to-read brochure for worker training (925 KB)
- Revised (2008) *CDC Workbook for designing, implementing, and evaluating a sharps injury prevention program* to download: high quality print version (2MB) or lower quality view/email version (636KB)
- 2008 workbook on CD-ROM, including workbook, video, educational slides, posters, and 2-page CDC worker training pamphlet to order Premier Safety Institute, Research summary of sharps safety devices: summary of articles from 1987 to 2008 on selection, testing or evaluation of safer needle devices.

Information from the XVII International AIDS Conference, held in Mexico City from 3 - 8 August, 2008

Information including webcasts, transcripts, press releases, interviews and daily conference newspapers is available from these sites:

<http://www.aids2008.org/>

<http://www.kaisernetwork.org/aids2008/>

Title: HIV and human resources: competing priorities or interconnected solutions?

Chairpersons: Sir George Alleyne, UN Secretary General's Special Envoy for HIV/AIDS in Latin America, Caribbean-Jim Yong Kim, Director, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health
Dr. Mubashar Sheikh, Executive Director, The Global Health Workforce Alliance

Date: 3 August 2008

Source: Available as podcast, transcript, or video from:
http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2855

Country: Global

"Health workers are the cornerstone and drivers of solid health systems - and yet, the world is facing a devastating shortage. This serious shortage across the world is recognized as one of the critical bottlenecks to reaching international health and development goals, including the goal of universal access to HIV treatment, prevention, care and support. Conversely, the HIV epidemic has further exacerbated the health workforce crisis, by significantly increasing workload, while simultaneously devastating existing workforces. The interconnectivity of these two issues is increasingly recognized - as is the need to address them in parallel, and not independently. Resolving the health workforce crisis will have a positive impact not just on the AIDS response but across all health outcomes. Learning from the AIDS response is critical. The AIDS community has blazed a trail, securing the high on the political agenda at the national, regional and global level and driving large scale financing. Civil society involvement has been at the heart of the AIDS response from the very beginning. And its presence there has been vital. Not only does civil society activism mobilize action, but community members are an invaluable source of knowledge about what works and about how to reach people. All of which is equally crucial to addressing the health workforce crisis. This satellite session, hosted by the Global Health Workforce Alliance as part of its work to identify and implement solutions to the health workforce crisis, aims to advance global thinking about AIDS, health and development to foster mutually beneficial outcomes. The session will unpack the synergies between the AIDS and health systems agendas, using their interconnectivity to forge a common agenda, in support of national scaling up towards universal access to HIV prevention, treatment, care and support and achieving the Millennium Development Goals. The Satellite will include presentation of a 'compact' between health workers associations and civil society, including people living with HIV, which aims to combat AIDS-related stigma and discrimination within the health professions and to ensure greater support for health workers living with HIV."

Opening statements

Peter Piot, Joint United Nations Program on HIV/AIDS (UNAIDS)

Margaret Chan, World Health Organization

Sigrun Møgedal, Ministry of Foreign Affairs,

Norway

Panel 1: HIV/AIDS

Ambassador Mark Dybul, Office of the U.S. Global AIDS Coordinator

Anandi Yuvaraj, International Community of Women Living with HIV/AIDS

Gregg Gonsalves, AIDS and Rights Alliance of Southern Africa

Jacqueline Bataringaya, International AIDS Society

Panel 2: Human Resources for Health

Dr. Tedros Adhanom Ghebreyesus, Ethiopian Ministry of Health

Tesfa Ghebrehiwet, International Council of Nurses

Pat Daoust, Physicians for Human Rights

Julio Frenk, Bill & Melinda Gates Foundation, Grupo Carso Health Institute

Conference posters

Title: **Implementing joint ILO/WHO guidelines on health services and HIV/AIDS**

Authors: Alli B.

Date: January 4th 2008

Country: Global

Abstract:

Issues: A national HIV/AIDS response requires health systems capable of providing sustainable prevention, treatment and care. However, the epidemic affects these services, causing losses among health professionals and increasing the burden on health systems.

Description: The ILO and WHO produced joint guidelines on health services and HIV/AIDS to: promote sound HIV/AIDS management in health services; provide decent, safe and healthy working conditions for health-care workers; and provide effective and appropriate patient care.

The guidelines cover policy development, labour relations, occupational safety and health, non-discrimination, and training needs. This paper elucidates the ILO's two-pronged approach for implementing the guidelines, focusing on capacity challenges within the health sector and risk factors for health workers.

Lessons learned: The following activities have been undertaken in several countries as part

of the ILO's Decent Work Country Programmes:

National level:

1. assisting ministries of health/labour to establish a policy framework for HIV/AIDS and human resources and review legislation;
2. building capacity of nurses' associations and health workers' unions to implement HIV/AIDS programmes;
3. assessing health worker retention schemes and introducing measures to address HIV/AIDS human capacity challenges, including migration.

Workplace level:

1. building capacity of health workers in selected health facilities through prevention programmes tailored to health workers' needs, as well as through training for health care workers on occupational health, universal precautions, PEP, stress management, psychosocial support and human rights issues;
2. assisting health facilities to establish HIV/AIDS committees to implement workplace policies and programmes; and
3. scaling up training for alternative health cadres from communities on health functions related to HIV/AIDS management.

Next steps: The outcomes, to be widely replicated globally, include: implementable national and workplace policies on health services and HIV/AIDS in place; national legislation reviewed; capacity of health cadres enhanced; fewer cases of stigma/discrimination; and reduced AIDS morbidity and mortality amongst health care workers.

Title: **Developing a competency-based curriculum in HIV for nursing schools in Haiti**

Authors: Knebel E, Prismsy M, et al.

Country: Haiti

Extract: "A national oversight committee, consisting of leading education and health officials, formed a curriculum working group that was made up of nurse educators and HIV experts. The working group adapted international HIV/AIDS competencies to the Haitian context and then defined over 350 knowledge, skill, and attitudinal learning

objectives for nursing students to achieve during their 4 years of education"

"This activity brought different administrators, nurse leaders, and faculty from four geographically dispersed nursing schools to collaborate on a shared goal using a process that could be easily replicated to integrate any new topic in a resource-constrained, pre-service institution."

<http://www.go2itech.org/pdf/p04-co/IAS2008/IAS2008ENI-1.pdf>

Title: **Government hospital nurses in India work towards strengthening infection control practices**

Author: Goldman D.

Country: India

Abstract:

Issues: World Health Organization (WHO) funded Bio Medical Waste Management trainings were conducted at the Government Hospital of Thoracic Medicine (GHTM) at Tambaram, Chennai in Jan-Feb 2006. GHTM Training of Trainers (ToT) nurses, who have conducted staff trainings in the past, helped to facilitate these trainings. In late 2006, a facility infection control survey conducted by GHTM management and International Training and Education Center (I-TECH) found there were still gaps in proper infection control practices including disinfection methods and appropriate needle disposal. A nurse education program on infection control was considered an effective measure to bridge these gaps.

Description: With technical assistance from I-TECH, GHTM ToT nurses worked after duty hours to develop content and pilot a curriculum using a practical, skill oriented approach. The purpose of the infection control education programme is 1) to prepare nurses at GHTM to train other hospital staff in best practicable infection control practices and 2) improve infection control practice at GHTM.

Lessons learned: One of the many challenges faced by a large HIV Center of Excellence such as GHTM is improving infection control practices. Given that infection control is largely the nurse's domain, nurses can play a significant role in strengthening hospital infection control systems. Staff nurses in this Government setting have little extra time,

training or incentive to take on extra work. However, when given opportunity and direction, they are willing and best suited to understand and address the challenges they face.

Next steps: With technical support from I-TECH to GHTM nursing staff, this education program on infection control is ready to be implemented and evaluated. Evaluation measures include a pre and post test for trainees and a facility infection control checklist to be implemented before and after implementation of training.

Title: Universal work precautions (UWP): is the compliance among nursing students adequate?

Authors: Pradeesh C, Divakaran B.

Country: India

Abstract:

Background: Nurses are at the greatest risk for incurring accidents in the hospital settings and the student period is the appropriate time to inculcate in them the importance of adhering to UWP.

Methods: The study was conducted with the objective of determining the level of knowledge and practices regarding UWP among nursing students. This descriptive study conducted among nursing students of 2 undergraduate nursing colleges in Kerala state of India comprised of students posted in the clinics, willing to participate in the study. A pre-tested semi-structured questionnaire was used for collecting information

Results: Only 35% knew the components of UWP. 24% considered potentially infectious the blood and body fluids of patients only diagnosed or suspected. 50% of students felt necessary to wash hands after examining patients, 10.4% did so only occasionally. Washing of hands after contact with blood and body fluids of the patients was not practiced by 3%. Only 86% always used gloves when coming into contact with the blood and body fluids of patients, 34% when using sharps and 9% upon contact with patients. Only 72% recap and dispose sharps. Even though 89% claimed that the best way to dispose sharps was by putting in a closed puncture resistant basket, 8.1% threw into open basket, 1.7%

threw it to the ground. Single hand recapping of needles was practiced only by 86%. Use of protective devices like aprons, masks and goggles was always practiced by 77%, while occasionally by 9.8%, never by 1.7%. Around 2% did not feel the importance of UWP in their profession.

Conclusions: The study finds lack of adequate knowledge and compliance among nursing students with regard to UWP and recommends need for taking adequate steps to impart knowledge as well as cultivate a positive attitude to practice UWP.

Title: State of universal work precautions (UWP) among medical undergraduates: act now or repent later

Author: Pradeesh C.

Country: India

Abstract:

Issues: The new wave of nosocomial infections arising from various medical settings is raising much concern. It has specifically necessitated the need for a preventive approach to be instilled in the practices of the health care professionals.

Description: The study was conducted to determine the knowledge, awareness and practice of UWP among medical students. It was conducted in two tertiary care hospitals in Kerala state of India, among medical undergraduate students in the clinical postings willing to participate in the study. A semi-structured questionnaire was used to collect data from the students.

Lessons learned: 15% of the students have not heard about UWP. Only 19.3% knew the components of UWP. Even though 98% took Hepatitis B vaccine, only 45% knew its schedule. 1.4% of the students never washed their hands after examining patients, 0.9% did not do so after coming into contact with blood or body fluids of patients. 22.5% got splashes of blood or body fluids in their mouth or eyes but nobody responded to the action taken immediately after it. 15% of the students used gloves while examining patients but 1.4% used the same glove for more than one patient. 13% believed that lab coats are a marker of profession, 40% felt it useful in

prevention of transmission of infection. 53.1% recap needles by single hand whereas others do it by both the hands. The necessity of practicing UWP in their profession was acknowledged by all.

Next steps: The study finds a poor knowledge and practice of UWP among medical students and recommends urgent curriculum based steps to impart knowledge and awareness so that the future medical professionals put into practice the components of UWP from the present time itself, thus ensuring occupational safety in the health care settings.

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 Federation of Infection Control, 9th International Congress 14 – 17 October, 2008 Santiago, Chile

“The International Federation of Infection Control (IFIC) is an umbrella organization of societies and associations of healthcare professionals in infection control and related fields worldwide. The goal of IFIC is to minimize the risk of infection within the healthcare setting world-wide through development of a network of infection control organizations for communication, consensus building, education and sharing expertise and the IFIC mission is provides the essential tools, education materials and communication that unite the existing Infection Control societies and foster development of Infection Control organizations where they are needed.

For the first time in its history, IFIC will hold its annual congress in a Latin American country with Santiago in Chile chosen as the host venue. This summit will be held in parallel with the Chilean and Pan American congresses in infection control, making it possible to exchange experiences and information among the different delegates taking part in all these events.

IFIC and the Chilean Society of Infection Control and Hospital Epidemiology extend an

invitation to all the professionals involved in the fields of infection control, hospital epidemiology and quality improvement to gather in Santiago in 2008. Together we will build a better future for infection control and patient safety everywhere. International experts will give keynote lectures and participate in symposia.”

Abstract submission deadline 11 July

For more information visit the website:
<http://www.ific2008.cl>

South Asian Association of Regional Co-operation (SAARC), Second Conference on TB, HIV/AIDS and Respiratory Diseases 15 – 18 December, 2008 Kathmandu, Nepal

Theme: Working together to fight against TB, HIV/AIDS and respiratory diseases.

Abstract submission deadline 30 June

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

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

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

International Meeting on Emerging Diseases and Surveillance (IMED 2009) 13 – 16 February, 2009 Vienna, Austria

ProMED, the Program for Monitoring Emerging Diseases, is pleased to invite you to the International Meeting on Emerging Diseases and Surveillance 2009. Along with our cosponsors, the European Centers for Disease Control, the World Organization for Animal Health, the European Commission, and the Wildlife Conservation Society, we are developing a conference that will bring together the public health community, scientists, health care workers and other leaders in the field of emerging infectious

diseases.

Abstract submissions close on 1 December.

For more information visit the website:

<http://imed.isid.org/>

**The Society for Healthcare Epidemiology in America: 19th Annual Scientific Meeting
19 - 22 March, 2009
San Diego, California, USA**

SHEA's Annual Scientific Meeting is the premier scientific meeting for healthcare epidemiologists and other individuals working in the field of healthcare epidemiology and infection prevention and control.

Abstract submissions close 17 November

For more information visit the website:

http://www.shea-online.org/about/annual_meeting_overview.cfm

**Asia Pacific Society of Infection Control,
4th International Congress
5 – 9 July, 2009
Macau SAR, China**

“Controlling Infection for Safer Hospital and Safer Community”, the theme of the Congress, explains a close connection between hospital and community. The organizing committee is delighted to hold this international infection control congress co-jointly with the Asia-Pacific Society of Infection Control. This congress offers the delegates great opportunity to meet leading speakers from all over the world who will share excellent thoughts, experience and scientific information in this field.

For more information visit the website:

<http://www.apsic2009.org>

**Annual Meeting of the Safe Injection Global Network (SIGN)
13 – 15 October, 2008
Moscow, Russian Federation**

The members of this Network meet annually to exchange information and review progress on ensuring the safe and appropriate use of injections worldwide and to decide on action

points for the members of the alliance. SIGN is constituted by UN organizations (WHO, UNICEF, UNFPA), ministries of health, industry through its umbrella organization IASIT (International Association for Safe Injection Technologies), CDC, USAID, research institutes, etc.

The specific objectives of the 2008 Meeting are to:

1. Review progress of the various injection safety projects at global and country level, including progress on infection prevention and control activities
2. Provide updates on global policy documents and guidelines on best practices for injections and related procedures under development by WHO
3. Discuss how ensuring rational and safe use of injections worldwide will help achieve the Millennium Development Goals
4. Discuss best ways to integrate injection safety and related infection control activities into Health Systems in countries
5. Inform members on and discuss WHO recommended waste disposal options and health-care workers' protection

For more information visit the website:

http://www.who.int/injection_safety/en/

Registration form:

http://www.who.int/injection_safety/Registrationform08.pdf

Provisional program of work:

<http://tinyurl.com/6htclt>

Visa application Russian Federation:

<http://tinyurl.com/6arsnk>

Checklist. Have you ensured the following?

- Project can be completed within A\$5000
- Project meets eligibility criteria
- Project can be completed within eight months as specified in the timeline
- Enough information is included to assist assessment by criteria identified in *Call for applications for 2009*
- Contact details are complete
- Application form is no more than six pages long

For enquiries or assistance with applications contact:

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Fax: +61 2 9332 4219
Phone: +61 411232777
Albion Street Centre
150 Albion Street
Surry Hills NSW 2010
Australia

Applications should be submitted by mail or email to:

Maggy Tomkins
safehands@sesiahs.health.nsw.gov.au

Albion Street Centre
150 Albion Street
Surry Hills NSW 2010
Australia

**Expression of interest for organisations
to form a partnership with SafeHandS**

Organisation

Name of organisation

Areas of work

Number of members

Location of members (country or region)

Contact details (email, phone, fax, mailing address)

Person proposing the organisation

Name

Position

Country of work

Are you a member of this organisation? yes / no

Address

Contact details (email, phone, fax, mailing address)

Reasons for potential partnership

Please attach any extra information

Please return this form to by email (preferably) or mail to:

Maggy Tomkins
safehands@sesiahs.health.nsw.gov.au

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150 Albion Street
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Australia