Dear Reader,

This issue of GOHNET deals with the ongoing activities by our collaborators and other institutions around the world with respect to work in the health worker sector. This focus is closely related to devising and implementing policy instruments on workers' health of the WHO Global Plan of Action on Workers’ Health (2008-2017) [link]

Acknowledgements and thanks go to Susan Wilburn from the Occupational Health team. Susan has been instrumental in providing good articles for this issue.

Enjoy your reading!

Evelyn Kortum Editor, ochmail@who.int
TABLE OF CONTENTS

GLOBAL ISSUES
Global Framework for National Occupational Health Programmes for Health Workers
WHO Global Initiative on Radiation Safety in Health Care Settings
The role of health worker trade unions and professional representatives in negotiating safer needle devices
Policy guidelines on improving health care workers access to prevention, treatments and care services for HIV and TB ( TREAT Policy)
Core Components of infection prevention and control programmes
Health worker safety - Ten years of progress through the Safe Injection Global Network (SIGN): from evidence to action.

COUNTRY AND REGIONAL ISSUES
Surveillance of significant occupational exposures to bloodborne viruses in healthcare workers in the UK, 2000-2007
Surveillance data on safety devices from a French hospital network
Protecting healthcare workers from occupational exposure to bloodborne pathogens: the role of WorkSafeBC
New legislation and regulation for safer needle devices in Brazil
Innovative partnership model for preventing occupational bloodborne pathogens infections among healthcare workers
Sharps injuries among Massachusetts hospital workers: findings from the Massachusetts sharps injuries surveillance system, 2002-2007

MEETING REPORTS
Progress on Injection Safety in National Immunization Programs in the America's

ANNOUNCEMENTS & NEWS
2nd International Program in Occupational Health Practice
Practice Experience and Depersonalization in Canadian Physicians: Findings and Implications
NEW PUBLICATIONS

Protecting Workers' Health Series No. 10 - Occupational exposure to vibration from hand held tools

New Quality of Work Initiative (INQA) published 6 brochures for better health and safety of healthcare workers


OTHER TOPICS OF INTEREST

Developments in the Healthy Workplace initiative

Who's who in workers' health in WHO?

WHO Global Network meeting of the WHO Collaborating Centres in Occupational Health

Three reports from WHO workshops held in October 2009

Priorities of the global workplan of the network of CCs in Occupational Health

Directory of WHO Collaborating Centres in Occupational Health

WHO signs the Seoul Declaration
GLOBAL ISSUES


The World Health Assembly Resolution endorsing the Global Plan of Action on Workers Health (WHA 60.26 http://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R26-en.pdf) calls upon Member States to develop national occupational health programmes to protect health workers. WHO, together with occupational health of health worker experts in the WHO global network of collaborating centres in occupational health developed a Global Framework for National Occupational Health Programmes for Health Workers to assist member countries to implement their agreements under the Global Plan of Action.

The framework is consistent with the International Labour Organization Conventions on Occupational Safety and Health (No. C-155), Promotional Framework for Occupational Safety and Health Convention, 2006 (No. C-187) and the Nursing Personnel Convention, 1977 (No. C-149).

The purpose of this Global Framework for National Occupational Health Programmes for Health Workers as directed by the WHO Global Plan of Action (GPA) on Workers’ Health is to strengthen health systems and the design of healthcare settings with the goal of improving health worker health and safety; patient safety and quality of patient care; and ultimately support a healthy and sustainable community.

The Ministry of Health will need to consult and work together with other relevant Ministries on the development of the National Occupational Health Programme for Health Workers such as the Ministry of Labour, Social Security, and/or other organization(s) responsible for the protection and promotion of health worker health and safety in the private as well as public sector.

1. Identify a responsible person with authority for occupational health at both the national and workplace levels.

2. Develop a written policy on safety, health and working conditions for health workforce protection at the national and workplace levels.

3. Establish and provide access to Occupational Health Services and allocate sufficient resources/budget to the program, occupational health professional services, and the procurement of the necessary personal protection equipment and supplies.

4. Create joint labour-management health and safety committees, with appropriate worker and management representation.

5. Provide ongoing (or periodic) education and training that is appropriate to all to all parties, including occupational health practitioners, senior executives, front-line managers, health and safety committees, front-line workers, and the general public.
6. Identify hazards and hazardous working conditions to prevent and control
hazards and manage risks by applying the occupational hygiene hierarchy of controls,
which prioritizes elimination or control at the source.

7. Provide immunization against hepatitis B and other vaccine preventable diseases
at no cost to the employee and ensure all three doses of the hepatitis B immunization
have been received by all workers at risk of blood exposure (including cleaners and
waste handlers).

8. Promote exposure and incident reporting, eliminating barriers to reporting and
providing a blame-free environment.

9. Promote health worker access to diagnosis, treatment, care and support for HIV,
TB and hepatitis B and C.

10. Utilize appropriate information systems, to assist in the collection, tracking,
analyzing, reporting and acting upon data to promote health and safety of the
healthcare workplace and health workforce.

11. Ensure that health workers are provided with entitlement for compensation for
work-related disability in accordance with national laws.

12. Promote research on OHS issues of concern to health workers, particularly with
respect to combined exposures and applied intervention effectiveness research.

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**WHO Global Initiative on Radiation Safety in Health Care Settings.** Maria Perez
& Fehrid Shannoun, Radiation team, Interventions for Healthy Environments, WHO
Geneva

*Ionizing radiation is today a key component of diagnosis and treatment of diseases*
*through the rapid development of diagnostic radiology, fluoroscopic-guided interventions,*
*nuclear medicine and radiotherapy. While the development of modern technology is*
*brining new benefits and medical equipment continues to become safer, some of them*
*may deliver higher radiation doses to patients or staff.*

To mobilize the health sector towards the safe use of radiation in medicine, the
World Health Organization is conducting a Global Initiative on Radiation Safety in Health Care Settings. This initiative brings together key stakeholders, such as health authorities, international organizations, professional and scientific societies in concerted action.

The WHO Global Initiative aims to enhance knowledge and skills for staff using
radiation in treatment and diagnosis, and to raise awareness among health authorities,
hospitals and other medical institutions of the benefits and risks associated with the use
of radiation in medicine. The provision of policy guidance to health authorities and the
development of practical tools for users of radiation in the medical field will enhance
protection of patients and health care workers.

Further information please consult the following WHO website:
The role of health worker trade unions and professional representatives in negotiating safer needle devices. Dr Jorge Mancillas, Public Services International

In 2008, Public Services International, a global federation which includes 231 health workers unions in 154 countries, launched a campaign to promote the switch to safe devices in health care settings. A centrepiece of the campaign has been the promotion of retractable syringes as a device which offers protection from needlestick injuries for health workers and waste handlers and protection for patients from reuse of contaminated syringes. One objective of this coordinated global effort is to reduce the price differential between standard and retractable syringes by creating economies of scale.

Health worker unions affiliated to PSI used a variety of strategies, ranging from advocacy before their Ministries of Health or provincial health authorities, negotiating agreements with organizations of employers or individual employers, inclusion of the issue while negotiating collective bargaining agreements, advocating for legislation at the state or national level and advocating for financing for the purchase of such devices by international financial institutions. In the pursuit of this campaign, PSI affiliates have collaborated with WHO departments, organizations which provide technical expertise, NGO’s and device manufacturers.

Examples of success include a decree by the government of the Democratic Republic of the Congo making the use of retractable syringes mandatory in all settings. This move provides protection for over 54,300 health workers and their patients in a country with high incidence of diseases caused by blood-borne pathogens, like HIV, Ebola, and Malaria. In addition, it is estimated that the high volume of purchases being generated will reduce the global average price of retractables by one cent.

In Guatemala, the Ministry of Health agreed to a clause in the collective bargaining agreement with the health workers union committing to switch to retractable syringes. Significant advances were also obtained through legislation, negotiation and advocacy in South Africa, Nigeria, Angola, Costa Rica and states in Brazil and the United States.

Another positive development is the signing of a framework agreement by the European Federation of Public Services Union (PSI’s regional organization for Europe) and the European Hospital Employers organization, HOSPEEM.

In conclusion, health worker unions can be a significant force in successfully advocating for policies and practices promoting safe injections. They are also an indispensable element in the successful implementation of those practices and the effective use of those devices.

Policy guidelines on improving health care workers access to prevention, treatments and care services for HIV and TB (TREAT Policy). Eileen Petit-Mshana, Department of HIV/AIDS, WHO Geneva
As part of its efforts to deal with the crisis in human resources for health and support the response to HIV and TB, WHO in collaboration with ILO has engaged in formal consultations with the stakeholders and partners towards developing policy to improve health workers' access to HIV and TB services.

The initiative originates from the Treat, Train, and Retain strategy (TTR) that was jointly launched in 2006 by the World Health Organization (WHO), International Labour Organization (ILO) and International Organization for Migration (IOM), to support delivery of HIV/AIDS services towards Universal Access Goal and address the impact of HIV on the health workforce. WHO, ILO and IOM, acknowledge that, "although health workers are at the frontline of national HIV/AIDS programmes, they often do not have adequate access to HIV/AIDS services themselves".

http://www.who.int/hiv/pub/meetingreports/ttr/en/

Apart from looking into the issues of health care worker access to services, TTR strategy is also an important component of WHO efforts in promoting comprehensive national strategies for human resources for health development, which is an integral part of health systems strengthening within PHC renewal context.

Evidence show that HIV and TB together account for considerably high percent of the mortality and morbidity experienced by health workers in high burden countries. Loss of health workers due to HIV/AIDS and TB is becoming urgent and hitting hardest in countries that are already severely affected by the global human resources for health crisis and negatively affecting the goal of universal access to HIV/AIDS services.

It is clearly critical to maintain the health of those providing care to others, and to ensure that health workers as a group that is particularly at-risk or affected have access to prevention, treatment and care (programmes for regular, free, voluntary, and confidential testing for HIV and TB, the provision of free access to ART and TB treatment for those in need: the universal availability of a comprehensive package of prevention and care for all HIV positive persons, including isoniazid preventive therapy and co-trimoxazole prophylaxis, the universal availability of post exposure prophylaxis; and the reinforcement and implementation of existing policies and guidelines on TB infection in the workplace).

A situational analysis that was conducted in 5 African countries in 2007, as well as a recent (2009) country survey on policy practices conducted in 17 countries covering all WHO regions show considerable gaps in the implementation of current policies, especially with respect to health workers' entitlements, rights, and access to HIV/TB prevention, testing and care. Also these studies shows that even when good policies exist at the national level, they do not always percolate to facility level as a consequence of lack of information, lack of resources for implementation, unclear or absent allocation of responsibility. In addition, the studies highlight that health workers are poorly protected against both sexual and occupational transmission of HIV. For example, in some SSA countries up to 68% of health workers report inadequate supplies of gloves, soap, water and safety boxes. Staff report generally good access to ART (less for family members, and less frequently free), but HIV testing remains a critical stumbling block on account of lack of confidentiality, stigma and fear of discrimination by management. PEP
is far from universally available, is not well understood, and avoided for fear of compulsory HIV testing. Stigma issues are greater for testing than for access to ART.

Moreover, evidence show that TB infection control is well understood but poorly implemented. Regular testing of health workers is rare; the main protection offered to HIV positive health workers is assignment to low exposure duties, while the value of ART and IPT is poorly understood.

TREAT policy guidelines will advise all employers of health workers to establish or extend effective comprehensive workplace and out of work programmes to provide prevention and treatment, care and support services for health workers with HIV and TB. The ultimate goal is to contribute to the improved health of health workers and to retain them in the workforce.

In conclusion, there is a critical need to have in place policy implementation strategies and programmes integrated with and supported by existing national HRH plans and financing mechanisms such as MTEF/LTEF, SWAp and other related processes.

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**Core Components of infection prevention and control programmes.** Carmem Pessoa, WHO/BDP (Biorisk Reduction for Dangerous Pathogens), WHO Geneva

Health care-associated infections (HAI) are an important public health problem because they occur frequently, cause morbidity and mortality and represent a significant burden among patients, health-care workers and health systems. HAI occur worldwide and affect all countries, irrespective of their degree of development. A considerable proportion of the burden of disease attributable to HAI is preventable and many interventions that have been proven to be effective are of low cost. In addition, if outbreaks hit health care settings without a culture of safe practices, the risk of disruption to health care system can be high. Among many important lessons derived from the SARS epidemics, being prepared and having a culture of safe health care practices is key to coping with outbreak situations.

Countries and health-care facilities that have established Infection Prevention and Control programmes will be better able to contribute to the prevention of endemic infections associated with health care and to the better management of outbreaks that cause a high morbidity, mortality and economic burden to patients and institutions. Therefore, establishing and strengthening infection prevention and control programmes at national level and in every health facility is essential for a successful response to epidemics and reducing the burden of endemic infections associated with health care.

A huge gap still exists between the knowledge accumulated over the past decades and implementation of infection control practices. This gap is even deeper in poor-resource settings with devastating consequences, and breaches in infection control measures undermine every advance and investment in health care.

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Safe Injection Global Network (SIGN) used the WHO research on the global burden of disease from sharps injuries to health workers to spur action to protect health workers and inclusion of health worker protection in the WHO Global Plan of Action on Workers Health and other policy initiatives. A brief summary of SIGN recommendations regarding health worker protection and a status report on their implementation will be provided.

While from its inception, SIGN's defined a safe injection to be safe for the patient, the health worker, and the environment; initially, attention was focused on patient safety and not preventable needlestick injuries. It took a few years for the growing evidence of the burden of disease from sharps injuries to stimulate action.

Integration of occupational health principles and practices into the SIGN+ network at WHO has resulted in health worker protection inclusion as a key component of Tuberculosis infection prevention and control (IPC) and other IPC guidelines published in 2008-2009 by WHO.

The health care workplace is a complex and hazardous environment for the health workers and the patients. There has been a misperception that a conflict exists between worker safety and patient safety, whereas in reality, most of what is good for health workers' health and safety is also good for the patient safety. By protecting health workers first through immunizing against hepatitis B and other vaccine-preventable disease and engaging them in the identification and control of hazards, they are motivated/inspired to be proactive for injection safety and better able recognize and manage risks to the community as a whole.

Strengthening health systems by improving the work environment and working conditions means protecting the occupational health of health workers - especially from deadly bloodborne pathogens, disabling musculoskeletal injuries and harmful chemicals and hazardous drugs.

MILESTONES OF PROGRESS IN HEALTH WORKER PROTECTION

- 1999 Launch of Safe Injection Global Network
- 2001 SIGN Recommendation for working group on health worker protection
- 2002 World Health Report: GBD from sharps injuries to health workers
- 2003 Launch of WHO Protecting health-care workers - preventing needlestick injuries project
- 2003 Aide Memoire on Health-care Worker Safety
- 2005 Joint ILO/WHO guidelines on health services and HIV/AIDS
- Beyond behaviour change strategies to hierarchy of controls
- 2005 SIGN meeting held in Vietnam together with occupational health conference
COUNTRY AND REGIONAL ISSUES

Surveillance of significant occupational exposures to bloodborne viruses in healthcare workers in the UK, 2000-2007. Susan Cliffe¹, Sarah Tomkins¹, Fortune Ncube¹

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In the United Kingdom (UK), enhanced surveillance of occupational exposures to bloodborne viruses (BBVs) in healthcare workers (HCWs) was initiated in 1997 in England, Wales and Northern Ireland. The scheme includes exposures to blood or other body fluids of patients positive for HIV, hepatitis C (HCV) and/or hepatitis B surface antigen (HBsAg). All reports where a HCW initiated HIV post-exposure prophylaxis (PEP) are also included.

Between 1997-2007, there were 3773 reported occupational exposure incidents from 194 different centres [1]. In 2007 alone, 431 incidents were reported. The most commonly reported occupational exposures in the healthcare setting were percutaneous injuries involving hollowbore needles (68%), with a large proportion of percutaneous exposures involving hepatitis C positive source patients (48%). Twenty two percent of injuries involved an HIV-infected source patient. In 2007, for the first time, a higher number of occupational exposures were reported from medical professionals (doctors
and dentists) than nursing professionals (200 compared to 191). Amongst the medical professions where a professional grade was stated, numbers of new reported exposures was greatest amongst senior house officers (271/790, 34% in 2000-2007) whilst amongst registrars and consultants exposures were slightly lower (231/790, 29% and 166/790, 21% respectively).

Over three quarters of occupational exposures occurred in the wards, theatres, Accident & Emergency (A&E) or the intensive care unit. Between 2004-2007, 38% (235/612) of incidents in the ward, 37% (60/163) in A&E, 22% (25/112) in intensive care and 21% (46/218) in operating theatres all occurred after the procedure had taken place. Many of these incidents could have been prevented with proper adherence to the safe handling and disposal of sharps and clinical waste. There is guidance in place that details the rationale and steps that can be taken to reduce injuries and exposures to BBVs [2] and Trusts should ensure that HCWs are aware and adequately trained on the implementation in these precautions in order to protect themselves from exposures. Under the Health Act 2006 a specific Code of Practice for the Prevention and Control of Healthcare Associated Infections has been published [3]. Part of this code requires hospital Trusts to implement policies relating to: the safe handling and disposal of sharps; prevention of occupational exposures to BBVs including prevention of sharps injuries; as well as implementation of policies on the management of occupational exposures to BBVs.

A key finding of the survey was that in 2007 only 22% (40/184) of HCWs exposed to HCV positive source patients returned for the appropriate follow-up tests at the correct time points as stated in national guidance [4], highlighting the need for greater awareness among HCWs of the importance of attending follow-up appointments to ensure they know the outcome of their exposure. This finding is of concern since the majority of HCV infected cases show no symptoms of their infection. This demonstrates the continued need to raise awareness of the importance of proper follow-up testing and adherence to national policy.

In 2006-2007 there were four documented patient-to-HCW HCV transmissions following percutaneous exposure. This brings the total number of HCV seroconversions in HCWs reported between 1997 and 2007 to 14 cases in England, with an additional case notified in Scotland in 2007. Fourteen HCWs have cleared the virus, with the 10 healthcare workers who were known to have started treatment achieving a sustained virological response. One HCW is still undergoing treatment.

Encouragingly results found that 78% of HCWs significantly exposed to an HIV-positive source patient did start HIV post-exposure prophylaxis (PEP) in 2007; also the national guidance on the use of HIV PEP was followed in the majority of cases. It is recommended that HIV PEP should be started as soon as possible after such exposures, ideally within an hour, as detailed in guidelines from the Expert Advisory Group on AIDS [5]. Thirty-seven per cent of HCWs exposed to HIV who initiated HIV PEP did so within an hour of their exposure and 89% within 24 hours. Since 1999, there have been no new reported cases of HIV seroconversions following percutaneous exposures of HCWs
to HIV positive source patients. This brings the total number of UK HIV documented seroconversions reported by 2007 to five.

Overall, although much has been achieved in the surveillance of occupational exposures in the UK, data collection needs to be improved by encouraging a greater emphasis on conducting source patient and follow-up testing and reporting of incidents at local and national level. Information is also needed on the evaluation of safety devices that are being introduced into different healthcare settings. A sentinel surveillance system is planned to be implemented in the UK which will be used not only to monitor the use of such devices, but also to evaluate their effectiveness in reducing exposure incidents amongst HCWs.

References


Surveillance data on safety devices from a French hospital network. Elisabeth Bouvet, Infectious Diseases Department, Bichat University Hospital – Paris, and Chair of GERES (Research Group for the prevention of Occupational Infections in HCWs), Paris, France

In France, 14 documented and 34 possible occupationally acquired HIV infections had been notified since the beginning of AIDS epidemic. 13 of documented cases were due to NSIs by hollow-bore needles, of which 10 were used for venous blood sampling, and 7 could have been prevented by application of standard precautions. As in other European countries, the law made employers responsible for assessing risks and preventing them. In 1998 they were recalled to implement a «Blood exposure prevention program» including training, providing safety-engineered devices (SEDs) and surveillance.

To assess the impact of preventive measures implemented, the GERES conducted in 2000, ten years after a first multicenter prospective study, a new survey with the same methods and in a similar hospital network. The mean NSI rate for all relevant nursing procedures was found to be 4.72 per 100,000 procedures, with a 75% decrease since 1990 (p<0.01). Decreases in the NSI rates for each procedure were strongly correlated with SEDs use (r²=0.77 ; p<0.02). Particularly, the use of SEDs during phlebotomy procedures was associated with a 74% risk reduction.
The GERES therefore conducted in 2005-2006 an observational multicenter survey to assess the efficacy of different types of SEDs. Device-specific NSI rates were compared using Poisson approximation. The 95% confidence interval was used to define statistical significance. The overall low NSI rate of 2.05 /105 devices demonstrated the efficacy of SEDs. We found that some SEDs were more effective than others in preventing NSIs. Passive devices were associated with the lowest NSI incidence rate. Among active devices, those with a semi-automatic safety feature were more effective than those with a manually activated toppling shield (usually requiring a one-handed activation), which in turn were more effective than those with a manually activated sliding shield (usually requiring a two-handed activation). The same gradient of SED efficacy was observed when the type of procedure was taken into account.

GERES surveys demonstrated in France the key role of SEDs in the risk reduction and showed passive devices to be the most effective. Risk factors of transmission are well known and NSIs from hollow needles placed in veins or arteries must be targeted in prevention policies. There is nonetheless still considerable room for improvement in reducing injuries in all countries, and above all in developing countries where access to SEDs to address safety issues associated with phlebotomy must be given top priority.

Protecting healthcare workers from occupational exposure to bloodborne pathogens: the role of WorkSafeBC. Martin CW(1), Locke S(2), Sagar M(2), Symon S(2), Pelman G(1) and Noertjojo K(1).

(1)Evidence-Based Practice and Outcome Research Group, Clinical Services, Worker and Employer Services, WorkSafeBC. (2)Industry and Labour Services, Worker and Employer Services, WorkSafeBC

Background: Healthcare workers are at risk of exposure to pathogens from contact with human blood and body fluids from patients in acute care, community care, and long-term care facilities.(1) Percutaneous injuries (PI), i.e. puncture or laceration of the skin by needles or other sharps, (5) are one of the most common occupational accidents suffered by healthcare workers. Injuries may occur when workers handle, disassemble, or dispose of needles and sharps. When not disposed of properly, used needles and sharps sometimes become concealed in linens or garbage and subsequently injure other workers, such as housekeeping staff, and even visitors who encounter them unexpectedly. (2,4) Contaminated needles and sharps can transmit more than 20 dangerous bloodborne pathogens including HIV, hepatitis B, hepatitis C, cytomegalovirus, human T lymphotrophic retroviruses, Epstein Barr virus, and others. (1)

It is estimated that around 400,000(3) to 800,000(7) percutaneous injuries (PI) occur annually among hospital-based healthcare workers in the US. In the UK,(1) it was reported that PI accounted for 17% of accidents involving NHS staff and were the second most common cause of injury after moving and handling (18%). A study from France(6) reported an incidence rate of 8.9 PI per 100 hospital beds, 2.2 per 100 full time equivalent (FTE) physicians, and 7.0 per 100 FTE nurses. A report from Australia(8) showed a rate of 19 PI per 100 occupied beds. Canadian Needle Stick Surveillance
Network (CNSSN) reported an incidence rate of 14.22 PI injuries per 100 beds\(^{(9)}\) and 3.2 PI injuries per 100 FTE.\(^{(10)}\) Further, CNSSN\(^{(11)}\) reported that the majority of these injuries occurred among nurses/nursing assistants (56%), medical residents (8%), and physicians (7%). Recent data from British Columbia (BC), based on WorkSafeBC-related compensation data, showed that the incidence of needlestick injuries was estimated to be 17.4 per 1000 person-years and other sharps to be around 3.0 per 1000 person-years.\(^{(2)}\) At 130.1 injuries per 1000 person-years, the study\(^{(2)}\) identified laboratory assistants as experiencing the highest incidence of needlestick injuries. Registered Nurses (RN) (33.8 injuries per 1000 person-years) and Licensed Practical Nurses (LPN) (33.4 injuries per 1000 person-years) had the second and third highest incidence of needlestick injury. For other sharps injuries, the study found that LPN (8.1 injuries per 1000 person-years), medical technologists (6.5 injuries per 1000 person-years) and care aides (3.7 injuries per 1000 person-years) had the highest incidence.\(^{(12)}\) It should be noted that this data from BC\(^{(2)}\) did not record injuries occurring among physicians or students (medical and nursing), nor contract workers such as cleaners, laundry, and security workers. These studies\(^{(1,3,6-11)}\) showed the high incidence of PI among healthcare workers, yet experts identified potential under reporting\(^{(1,2,7,8,12-16)}\) of PI among healthcare workers. Trim and Elliott\(^{(14)}\) estimated the rate of under reporting from as low as 26% to as high as 90%.

Data showed that the majority of PI caused by hollow bore needles incurred primarily after use and during disposal of the needle.\(^{(12,17)}\) Even though about 55% of PI caused by suture needles occurred during the use of the needle, almost 45% of these injuries occurred before use, between steps, after use, while putting the suture needle into the disposal, and during other steps that offer direct potential mechanisms for preventing PI.\(^{(12,17)}\) Only about 30% of scalpel injuries occurred during use, whilst the rest of the injuries occurred before use, in disassembly, preparing for re-use, and putting it into the disposal container.\(^{(12,18)}\) These data suggested that the majority of risks of PI are preventable.\(^{(19)}\) Risk control measures to prevent healthcare workers’ exposure to infectious agents may include:\(^{(20,21)}\) engineering controls such as safety engineered medical devices, administrative controls including work practices and elimination of the source of exposure, and personal protective equipment. At present, majority of safety engineered medical devices cover hollow-bore needles with integral sharps protection that can be activated manually or automatically, cannulae, self adhesive anchoring devices, needle free intravenous (IV) system and scalpel with retractable blade and safety sheath\(^{(7)}\).

The United States was among the first countries in the world requiring employers to ensure that employees have access to needleless systems and safer sharps in order to reduce the risk of contracting bloodborne pathogens (Needlestick Safety and Prevention Act).\(^{(22)}\) This legislation was fully enforced in July 2001 and since then declines have been observed with regard to reported PI\(^{(3,23,24)}\) with a range of reduction between 22% to 100%. A study from Spain\(^{(4)}\) showed 93% reduction in the relative risk of PI in areas where safety-engineered devices were employed. Even though safety-engineered devices are now in wide spread use, the majority of these safety devices require an activation step before the safety feature is engaged. Anecdotal evidence has
shown that failure to correctly activate this safety feature still put healthcare workers at risk of PI.\(^{(25)}\)

**WorkSafeBC Occupational Health and Safety Regulation Part 6 Section 36 (1.1) and (1.2):** It is estimated that, overall, there are 5000 needlestick injuries sustained by British Columbia (BC) health care workers each year. In response to these injuries, on January 1, 2008, WorkSafeBC introduced some changes to BC’s Occupational Health and Safety Regulation (OHSR), in particular OHSR part 6 section 36 (1.1) and (1.2)\(^{(26)}\) on Biological Agents: Controls.

OHSR part 6 section 36 states that any medical procedure that involves the use of hollow bore needles requires safety-engineered needles or needleless systems. These procedures include withdrawing body fluids, accessing veins or arteries, administering medications or fluids, and any other procedure, for example, immunizations, involving the potential for an exposure to accidental parenteral contact, for which a needleless system or safety-engineered needle system is available.

This OHSR change applies to all workplaces in the province. This includes medical offices, clinics, hospitals, long-term care facilities, and patients’ homes where medical practitioners treat or care for a person. There are two instances where conventional needles can still be used for medical procedures: when a safety-engineered needle is not commercially available to replace the conventional needle and no alternative system, such as a patch or jet injector, is available to eliminate the use of the needle; or when the use of a safety-engineered needle or needleless device is not clinically appropriate because either the medical practitioner or patient would be at increased risk of injury. This determination can be made by educated, trained, and experienced persons, such as medical practitioners, who are knowledgeable about the work and hazards involved and the means to control these hazards. The use of safety-engineered needles or needleless devices may require modification of a medical procedure. This alone does not necessarily mean that the use of the required device, needle, or sharp compromises patient care or safety, or worker safety.

Further, the OHSR states that if there are two or more types of safety-engineered needles commercially available that are clinically appropriate for a medical procedure, medical practitioners must select the device that provides the highest level of protection from accidental parenteral contact. It is suggested that these factors should be taken into consideration: evidence of reduced risk of exposure, consideration and review of the different types of engineering controls that are commercially available, information provided by manufacturers or independent testing agencies, objective product evaluation, or other reliable sources. Periodic review is required to ensure that the devices selected are appropriate based on the most current scientific knowledge regarding protection from sharps injuries.

Since October 1, 2008, any medical sharp, including sutures, scalpels, and lancets, used to treat or care for a person must be a safety-engineered medical sharp. The same criteria and exceptions that apply to hollow-bore needles are also applicable here. As was experienced in the United States,\(^{(27)}\) resistance, such as a letter published
in BCMJ was also encountered in BC during the introduction of safety-engineered medical sharp regulations.

At present, WorkSafeBC OHSR part 6 section 36 (1.1 and 1.2) is enforceable and we are following up on its impact with regard to medical sharps-related claim registration.

References

New legislation and regulation for safer needle devices in Brazil. Cristiane Rapparini, Coordinator, Project Riscobiologico, Innovative Control Technologies, Rio de Janeiro Brazil

Healthcare workers (HCW) frequently face the risk of occupational infection from bloodborne pathogens following exposure to blood and body fluids. Brazil has implemented different efforts and policy initiatives to reduce the risk of infection related to these exposures during recent years.

Hepatitis B vaccine has been available free of charge, provided by the Ministry of Health, for all HCW since the nineties and antiretroviral drugs for occupational exposures to HIV are widely available since 1996 when the first US PEP for HIV Guidelines were published.

Epidemiological data on exposures to blood are essential for targeting and evaluating interventions at the local and national levels. Until very recently, there was no national surveillance system of occupational exposures to bloodborne pathogens among HCWs. In 2004, the Ministry of Health passed a law, mandating the report of these exposures, which are now considered a reportable condition.

In 2005, the Ministry of Health passed a law, named “Norma Regulamentadora NR32”, which had a tripartite regulatory system and addressed several issues regarding the occupational health and safety of HCW, including exposures to blood and bodily fluids. It required healthcare employers to implement safety-engineered sharp devices in order to reduce employees' occupational exposure to bloodborne pathogens.

For the national implementation of safety devices, some important questions have been addressed by the Committee of NR32, such as which safety devices were available in Brazil, what costs were involved and what was the lead time from customer order to delivery.

The strategy adopted by the committee to address all those pending and very important questions was to convene two associations – one representing the
manufacturers of medical and dental products and the other representing importers of medical equipment, products and supplies. They represent the most important companies in the healthcare-medical equipment sector in Brazil.

After the data collected was analyzed, a complementary Law (“Portaria MTE N.° 939, November 11th, 2008”) was passed and amended the citation of safety devices article of NR32, establishing the deadline for compliance. According to it, employers must promote the use of safer devices in no more than 24 months (October 2010): an interval of 6 months to disseminate and train and 18 months afterwards for implementation and market adjustment.

Additional efforts have also been implemented by the Ministry of Social Security, such as tax benefits for facilities that implement prevention programs and are able to reduce the incidence of exposures.

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**Innovative partnership model for preventing occupational bloodborne pathogens infections among healthcare workers.** Dr María Sofía Lioce-Mata, Assistant Coordinator of NIOSH Global Collaboration Program, Atlanta Georgia USA

In Latin America the attributable fraction of infections among health care workers due to sharps injuries reaches about 80% for Hepatitis B, 53% for Hepatitis C, and 2.5% for Human Immunodeficiency Virus. In 2005, the World Health Organization (WHO), the Pan American Health Organization (PAHO) and U.S. National Institute for Occupational Safety and Health (NIOSH and Latin-American partners developed a model project for the Region. Venezuela agreed to conduct the pilot project. The WHO toolkit “Protecting Healthcare Workers: Preventing Needlestick Injuries” was culturally and linguistically adapted to Latin American audiences.

In 2007, international, national and state partners participated in national and train-the-trainer workshops. The partners agreed to have Aragua State as a model for the country. The key partners in Venezuela who have been working in the implementation of the needlestick project are: 1) Institute of Public Health Advanced Studies Dr. Arnoldo Gabaldon (IAES) the highest scientific institute of the Ministry of Health;

2) CORPOSALUD the autonomous health institute attached to the Governor of State; 3) PDVSA, Petróleos de Venezuela, S.A. the Venezuelan state-owned petroleum company; and 4) IVSS the Venezuelan Institute of Social Security.

The key tools used are (1) Train-the-Trainer Program (WHO CD Toolkit ). Prepares leaders in healthcare (frontline workers, occupational safety and health committees, and management and worker representatives) to prevent exposure to bloodborne infections, (2) Surveillance system for needlestick injuries using the EPINet Program, (3) Tool for evaluation of sharps with safety devices, and (4) Hepatitis B immunization of healthcare workers campaigns.

The approach seeks to achieve sustainable expertise within academic institutions, employers, frontline workers, and ministries. The pilot project started in 4 hospitals in
Aragua State, Venezuela in 2007. Today, this Train-the-Trainer Program has reached 210 healthcare facilities and 8 universities in 15 states. It is estimated that about 30,000 healthcare workers have been reached. Recently, a surveillance system using EPI-Net has been added. In 2008, the project was implemented in Peru jointly with a national campaign to provide Hepatitis B immunizations to healthcare workers. To date, about 1,200 healthcare workers have been trained. About 75% of the 300,000 healthcare workers are immunized. In September 2009 the “First Regional Encounter for Latin America and the Caribbean: Health Protection of Health Care Workers” was held in Venezuela. International representatives from Brazil, Canada, Cuba, Colombia, Ecuador, United States, Guatemala, Jamaica, Peru, Dominican Republic, Trinidad & Tobago attended the meeting.

**Sharps injuries among Massachusetts hospital workers: findings from the Massachusetts sharps injuries surveillance system, 2002-2007.** Angela K. Laramie, MPH; Vivian Pun, MPH; Letitia K Davis, ScD, MPH; Massachusetts Sharps Injury Surveillance Project, Occupational Health Surveillance Program, Massachusetts Department of Public Health

Sharps injuries are a serious hazard faced by anyone working in the healthcare setting. It affects not only clinicians, but also housekeeping staff and others working in the facility. In Massachusetts, there are approximately 10 such injuries reported in hospital settings each day.

Data on injuries from contaminated sharps are collected each year from all acute and non-acute care hospitals, as well as any satellite units (e.g., community health centers) licensed by the Massachusetts Department of Public Health. All individuals providing care or working in these settings are included in the population under surveillance.

More than 3,000 injuries have been reported each year among workers in Massachusetts hospitals since the inception of the program. While the number of sharps injuries has remained relatively steady, rates per 100 licensed beds have consistently decreased over time. In addition, rates for specific devices have decreased over time as the adoption of devices with sharps injury prevention features has increased. However, for some devices such as hypodermic needles / syringes, just under half of the injuries involve devices lacking sharps injury prevention features. This is of particular concern, as safer devices have been on the market for more than a decade.

There is continued need for adoption of devices with sharps injury prevention features. Barriers in the procurement process need to be identified and addressed. In addition, research needs to move beyond comparisons of devices with sharps injury prevention features to those without, with a focus on the various mechanisms of sharps injury prevention features. The proportion of injuries involving devices with sharps injury prevention features raises the question of whether additional training on the use of devices, or better device design is needed.
MEETING REPORTS

Progress on Injection Safety in National Immunization Programs in the Americas. Nora Lucia Rodriguez, Regional Advisor, WHO/AMRO, Washington DC USA

PAHO’s immunization safety initiative is one of the fundamental components of the injection safety program and requires the use of safe and quality syringes. To implement the initiative, PAHO developed a regional plan for accomplishing the objectives of the plan.

Since 2004, the Unit of Immunization and the Unit of Essential Medicines, Vaccines, and Health Technology have developed a Regional Plan to verify the quality and safety of syringes. The plan was originally based on compliance with international ISO regulations (specific to AD and disposable syringes and needles). This program was extended to include the whole shelf life cycle of the product, from its procurement, including storage, distribution, and safe use, to its final disposal. The objectives of the plan include: injection safety, the development of capacity at national level, the organization and establishment of laboratory capacity to verify quality of syringes, and strengthen national immunization programs and the transferring of the accumulated knowledge, infrastructure and expertise on syringe management to countries and strength National Regulatory Authorities.

In 2007 40 samples provided to PAHO’s by manufacturers were evaluated by PAHO’s reference laboratory (WHO/PAHO collaborating center). The testing revealed that 5 manufacturers had syringes with deviations and nonconformities with reference to ISO standards related to proper labeling. In addition, three manufacturers had syringes that did not meet the standards for ‘accuracy’ and three manufacturers had syringes with nonconformity in relation to dead space.
In order to improve the capacity for verification of the conformity of syringes, efforts are under way with the national regulatory authorities to establish quality control laboratories in six countries. In November 2009 a Workshop on GLP on syringe assays and preparation on ISO/IEC 17025 for accreditation was carried out in Nicaragua, November, 2009.

A notification system and database have been set up to register and monitor incidents reported by countries in relation to quality and safety of syringes. Documentations of such problems allow for follow up, research activities and posting of alerts based on the results.

Injection Safety workshops were held in Nicaragua and Honduras in July 2008 and November 2008 respectively. Funds for workshops were provided by GAV and technical collaboration for the workshops was provided by: WHO, the US Centers for Disease Control (CDC) and NIOSH.

During the 2009 Regional Immunization Week (April) many countries targeted health care workers for protecting them from vaccine preventable diseases, nearly 27,675 health workers were vaccinated against measles and rubella, and hepatitis B and yellow fever in Bolivia, El Salvador, Dominican Republic and Suriname. Dominica complemented their vaccination week campaigns by training health care workers on occupational health and infection control measures.

Taking advantage of the introduction of the H1N1 influenza pandemic vaccine in the Region, training activities made special efforts to update remind participants to
follow safe injection practices as part of preparedness planning for vaccinating the targeted populations.

Sustaining investments in the areas of supervision and training underpin the Regional plan to protect the health care worker from occupational health risks. Likewise improving the safe collection, transport and final waste disposal used injection equipment as well as ensuring the availability of safe technology and personal protection equipment (PPE) will require continuous investments by the governments.

Each country should develop regulations and codes to govern management of health care waste and support best practices for Injection Safety. Investments will be required to support: establishment of the required infrastructure (logistics, land fills, incineration equipment & human resources); develop and maintain the required processes to support the infrastructure, and train and update health care workers. Evaluation and monitoring activities will be critical for measuring compliance and for documenting the impact, as well as, indispensable for achieving and protecting the gains.

ANNOUNCEMENTS & NEWS

Infection Prevention and Control Africa Network (IPCAN). A new vision for IPC in Africa. Shaheen Mehtar, Chair of IPCAN, Head of Unit for IPC, Tygerberg Hospital and Stellenbosch Uni, Cape Town.

Infection prevention and control (IPC) is a process of evaluating and strengthening systems which will reduce disease transmission to healthcare workers and patients. It includes healthcare facilities and the home.

It is one of the corner stones of quality health care practice. It is a broad umbrella which encompasses “Duty of Care”- a concept which is pivotal to good clinical practice. In most African countries IPC is in its infancy and is being developed in vertical programmes. Usually, IPC falls under Quality Assurance, the other aspects being Occupational Health, Environmental Health and Health and Safety. In most countries legislation provides the framework for Quality Assurance, Occupational Health and Safety and its implementation requires certain expertise.

While it is recognised that there is much to be learnt in best practices for healthcare in Africa, there are resources in IPC related to knowledge, skills and research opportunities specifically aimed at the African continent and its health issues. The disease profile and burden differs from other (well established IPC) countries; specifically HIV and TB are a huge burden on the healthcare budget. There is, however, a lack of information regarding general healthcare profiles, nosocomial transmission of blood borne viruses such as HIV, hepatitis B & C, tuberculosis and healthcare worker safety. Further, IPC guidelines specifically aimed at the African health programmes are required.
IPCAN is a fledgling, not for profit (Section 21 Company) organisation which provides a platform for opinion leaders from the various participating countries to contribute equally towards the development of healthcare support programmes pertinent to their countries specifically and Africa as a whole. Since problems within the continent are common, joining forces and pooling resources would greatly improve patient care and lead to relevant best practices.

The aim of IPCAN is to bring together opinion leaders from the African continent to establish and support teaching and training, skills and capacity building, conduct relevant research and investigation and finally, to draw up guidelines and recommendations relevant to the prevailing healthcare burden of disease. It is committed to supporting both patients and healthcare workers by empowering them with good safe practices so that they may be able to function optimally with minimum risk. It is not the aim of IPCAN to take over any existing programmes, either at country or regional level, donor or government supported but to supplement such programmes by building capacity and skills to further enhance these programmes. A further aim is to establish and support a private-public partnership which is sustainable.

The objectives are:

1. To increase general awareness among all HCW by building skills and capacity through accredited IPC training.
2. To equip managers and administrators to procure medical devices and supplies which support best practice.
3. To conduct appropriate research, surveillance and/ audit of healthcare practices which will provide appropriate insight into existing and future best practice.
4. To draw up recommendation and/ or guidelines which are evidence based and support training and skills development.
5. To act as a resource for government, academia, and other policy makers using evidence.
6. To establish a wide network and communication with mutual benefit and support.
7. To provide the most cost-effective and best health care possible for our population and healthcare staff.

The First African IPC Congress, held in Kampala, Uganda in August 2009 proved to be a great success. Established IPC societies such as the International Federation of Infection Control and World Health Federation of Sterile Supplies participated actively. The World Health Organization (WHO) supported the conference with both financial and scientific input. The Centers for Disease Control (CDC) were also represented. The joint efforts of these organisations demonstrated the need and willingness to support an emerging African IPC body.

The next conference will be held at Spier Estate, Cape Town from the 29th August to 1st Sept and will be a joint meeting with the International
**Federation of Infection Control**: there is already much interest, but we invite all the readers to come and support the conference by presenting scientific papers.

*A website* has been established which will publicise the activities and newsletter. IPCAN has immediately moved into action by setting up several task teams to look at pertinent topics including education, audit and surveillance, good practice and research aimed at making appropriate recommendations for the African region.

The first conference has given us hope and fired us with enthusiasm—there is much to do, that can be done with good support to the African continent—IPCAN is there to provide that support in IPC.

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**2nd International Program in Occupational Health Practice**

The University of Illinois at Chicago (UIC) announces its 2nd “International Program in Occupational Health Practice” starting Sept 2010. The program is 100% online and no travels are required. It is designed as a strong introduction to OH for company health professionals (doctors, nurses and others) worldwide who work in developing countries and do not have a formal academic training in OSH. It is open for other professionals as well such as engineers, technicians or managers who want to strengthen their competencies in occupational health.

Teaching is in English but assignments can be sent back in four languages (English, French, German, and Spanish).

Currently, participants come from 16 countries around the world such as Cambodia, Nepal, Pakistan, Nigeria, Botswana, Argentina, Ecuador, Peru, and Chile.

**The 2nd Program starts on September 6th 2010 and runs till May 2011. Enrollment is open NOW.** The Program offers three courses over a nine month period:

- Foundations in Occupational Health Practice (10 weeks)
- Clinical Occupational Medicine and Medical Surveillance (8 weeks)
- Management in Occupational Health Practice (8 weeks)

Detailed information is available at [http://www.uic.edu/sph/glakes/ce/IntPrgOHP.html](http://www.uic.edu/sph/glakes/ce/IntPrgOHP.html)

Several discount options for companies with multiple participants are available. Course can be taken individually. Program brochures for download are in English, Spanish and French.

**Contact**: syn@uic.edu and nlwagner@uic.edu; Wagner Norbert MD, PhD
Program Director "International Program in Occupational Health Practice"
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**Practice Experience and Depersonalization in Canadian Physicians: Findings and Implications**
A number of personal and work-related risk factors contribute to burnout in physicians. Doctors-in-training with minimal clinical or practice experience were found to have higher levels on the depersonalization dimension of burnout, although with increased years of practice, these levels generally decreased. [1] In our recent study of Canadian physicians, we had similar findings, with no difference between male and female physicians. [2] Depersonalization occurs when the stress and strain resulting from their practice become overwhelming and leads to an unhealthy detachment while interacting with others.

Variability in depersonalization levels was the highest among physicians with ten or less years of experience, the lowest among those with 20 to 30 years of experience, and increased again among those with 30 or more years of experience. Overall, physicians with less than 10 years experience or more than 30 years experience had higher depersonalization levels than those between 20 to 30 years of experience, indicating a curvilinear trend with years of practice and depersonalization.

Research indicates that high levels of depersonalization are due to both professional and personal factors, and suggest a need for targeted interventions at different career stages. Emotional communications with patients, particularly having to withhold emotions, were found to increase depersonalization. In contrast, using a wide range of emotions to actively engage with patients was found to decrease depersonalization. In their personal lives, work life conflict was strongly associated with emotional exhaustion and physical symptoms of stress, which in turn, led to greater depersonalization.

How can organizations improve physician wellbeing and patient outcomes? Our research indicates that unhealthy detachment may be lessened with a range of professional development seminars such as management of emotions and balancing one’s personal and professional life. Many of the physicians in our study expressed a desire to participate in interventions that would provide ways to help better manage their careers. [3] These interventions should be implemented to promote the development of healthy coping mechanisms for physicians in the early career stage, and support healthy ageing and engagement for those in the late career stage.

References

NEW PUBLICATIONS

Protecting Workers' Health Series No. 10 - Occupational exposure to vibration from hand held tools

A teaching guide on health effects, risk assessment and prevention

This guidance document is the ninth in a series of occupational health documents entitled: Protecting Workers’ Health, published by the WHO within the Programme of Occupational Health. It comes with teaching materials and an evaluation form.

The overarching aim of this document is the promotion of the translation of policy and knowledge into practice. As such, guidance is provided in relation to key issues including risk assessment, social dialogue and employee participation, key indicators, best practice interventions and corporate social responsibility in the factsheets listed on this website: http://www.who.int/occupational_health/publications/Protecting_Workers_Health_Series_No_10/en/index.html

This document is primarily targeted at employer and worker representatives but will also be useful to occupational health professionals and experts and to policy makers. Such a framework, bringing together a number of key issues in the area and providing guidance on them, has so far been lacking and is necessary for employer and worker representatives to take effective action to address the issues of concern.

New Quality of Work Initiative (INQA) published 6 brochures for better health and safety of healthcare workers

These brochures address the most common work organization and psychosocial risks for employees - time pressure in healthcare, leadership, communication and interaction, compatibility of family life and professional life, nursing patients with dementia and the de-bureaucratisation of nursing.

The brochures can be downloaded free of charge at www.inqa.de.

http://www.inqa.de/Inqa/Navigation/root,did=252646.html

The New Quality of Work Initiative (INQA) is a joint project of the German Federal Government, the States, social insurance institutions and the social partners. All members of the Initiative approach the promotion of a new quality of work as a very important goal, and equally common challenge for the future. Healthy work conditions for nurses and caregivers are the aim of the initiative.

Endorsing the Global Plan of Action on Workers' Health in 2007, the 60th World Health Assembly stressed "that the health of workers is an essential prerequisite for productivity and economic development." It also urged countries to incorporate measures to protect workers' health in economic development policies. But how all these statements can be put into practice?

The answer to this question may be inside the new book "Occupational Safety and Health for Development" edited by Kaj Elgstrand and Nil F Petersson. The two leading scientists from the Swedish Royal Institute of Technology have managed to bring together an impressive team of 44 experts from Sweden, Finland, Denmark, Costa Rica, Brazil, India, Egypt, South Africa, Australia and New Zealand to provide us with a truly international perspective on occupational health and development. The book is based on the training materials developed under the international programmes for training on occupational health and safety that were supported by the Swedish International Development Cooperation Agency (SIDA). It is a comprehensive text for anyone who wants to learn about the content of occupational health and how it can support human development.

The book starts with an overview of history and culture of the risk concept and the way occupational safety and health has been organized. It continues with presenting the most important occupational health and safety risks - manual work, physical, chemical, biological, psychosocial risks. The remaining chapters cover some of the newest and most exciting concepts of enterprise survival, work organization and management. Particular attention is devoted to the challenges of child labour, gender and migrant workers as well as to the implementation of occupational safety and health at the enterprise. Policymakers will certainly benefit from the chapter on national planning on occupational safety and health. Finally, the global perspective and the actions for change prove a wealth of food for thought for the international community.

Over the last several months I carried with me the 1+ kilo of wisdom to read on planes and trains and it was worth reading - it was both fun and professional enjoyment. The book is well written, the messages are straightforward, the content is useful. Therefore, it was a pleasure to see the book on the desk of my colleague, Dr Salma Burton, from the WHO Regional Office in South East Asia, proof that it is really about occupational safety and health in development. I am sure it would be very useful for doctors, psychologists, engineers, public health specialists, workers, employers and
anyone who needs a modern fresh look into occupational health along with ideas and inspirations for new initiatives, programmes and opportunities.

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**OTHER TOPICS OF INTEREST**

**Developments in the Healthy Workplace initiative**

E. Kortum, Occupational Health, WHO/HQ

The WHO healthy workplace initiative is gaining momentum. After a successful workshop in October 2009 at WHO headquarters in Geneva with international experts, collaborating centre colleagues, trade unionists, and employers, we are now close to finalizing a synthesis report of the WHO healthy workplace framework and model. This report provides information on why WHO developed a framework, what a healthy workplace is, and describes the four-circle model of the framework covering health protection and promotion including community action. The report also describes the steps for implementing a healthy workplace programme. Besides the establishment of a large expert network including international experts, employers, worker representatives and other stakeholders, WHO plans to develop global WHO guidance.

Based on the global WHO guidance, collaborating centres will be involved in the development, review, and piloting of guidance documents adapted to different culture, country, community, and company (organization, team, division, worker) contexts. The more detailed way forward discussed at the Geneva workshop can be viewed here.
The successful workshop on healthy workplaces which was held in WHO headquarters, Geneva, Switzerland, from 21-23 October 2009, resulted in a number of future actions. Participants felt these needed to be accomplished in the next few years in close collaboration with a network of experts within and outside of WHO, other international Organizations in particular the ILO, employers and worker organizations, as well as other interested partners.

- Organize awareness raising campaigns (e.g. 28 April: World Day for Safety & Health at Work)
- Create partnerships with other stakeholders, existing networks (e.g., NCD & regional networks), World Economic Forum, International Organization of Employers (GOSH Network), Trade Unions. (The ILO and a number of Collaborating Centres in Occupational Health are already part of the expert network.)
- Develop practical global guidance on Healthy Workplaces to be peer-reviewed
- Adapt guidance to culture, country, community, company (organization, team, division, worker)
- Pilot guidance in different country settings
- Collect case studies and good practices to be published in an official WHO publication
- Interview businesses that implemented components of the healthy workplace model
- Develop training modules & train-the trainer programmes to be peer-reviewed
- Collect and develop assessment tools and methods (including criteria and context-applicable methods for evaluation)
- Develop an indicator model
- Research cost-benefit models easily to be undertaken by employers to obtain “return on investment” indicators
- Map the global framework on the ICF (International Classification of Functioning, Disability and Health)
- Organize a global consultation through the WHO Cairo Regional Office (prospectively end of January 2011)

A WHO website is under way at this link: http://www.who.int/occupational_health/healthy_workplaces/en/index.html. It will contain resource materials and sites from other WHO programmes and regions, the ILO and the background documentation that is being developed right now.

Should you wish to join the network, you can access this link: https://extranet.who.int/datacol/survey.asp?survey_id=1355
Username: healthy workplaces
Password: healthy
Also WHO offices of the Americas and the Eastern Mediterranean have started work on healthy workplaces and the first workshop on healthy workplaces was held in Cairo on 20 January 2010 with the objective to prepare a plan of action and a declaration including the concept of healthy workplaces and the role of the government to activate the healthy workplaces initiative in Egypt.

*Meeting to adopt the Healthy Workplaces Initiative in Egypt, January 2010, WHO/EMRO*

The document promoting the framework and process model of healthy workplaces will be launched on 28 April this year for the World Day of Workers' Safety and Health in WHO headquarters and several WHO regions.

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**Who's who in workers' health in WHO?**

*Group picture taken on 19 October 2009 prior to the start of the Global meeting of Collaborating Centres in Occupational Health*

From left: Said Arnaout (Regional Adviser EMRO - Cairo); Carlos Dora (Coordinator - Geneva); Hisashi Ogawa (Regional Adviser WPRO - Philippines); Salma Burton (Regional Adviser SEARO - New Delhi); Rokho Kim (Regional Adviser EURO - Bonn); Maritza Tennessee (Regional Adviser AMRO - Washington); Susan Wilburn (Workers’ Health team in Geneva); Marie-Claude Lavoie (Workers’ Health team in Washington); Ivan Ivanov and Evelyn Kortum (Workers’ Health team in Geneva) (absent: Thebe Pule (Regional Adviser AFRO - Brazzaville))
WHO Global Network meeting of the WHO Collaborating Centres in Occupational Health

The Global Network Meeting takes place every three years. This was the first meeting to be held at WHO in Geneva and was the largest ever held. The participants were pleased to be hosted by WHO. The dedication, energy and spirit of commitment of the Collaborating Centres and all participants enabled a very successful Network meeting.

Final meeting report:
http://www.who.int/occupational_health/final_4_Jan_cc_report.pdf

Agenda and presentations:
http://www.cdc.gov/niosh/programs/global/whoccmeeting09.html

Three reports from WHO workshops held in October 2009

Health workers:

Global framework for national occupational health programmes for health workers:

Healthy workplaces:

Capacity building:

The priorities of the global workplan of the network of CCs in Occupational Health can be found here:
http://www.who.int/occupational_health/priorities_global_work_plan.pdf

Directory of WHO Collaborating Centres in Occupational Health
http://www.who.int/occupational_health/network/cc_directory.pdf

WHO signs the Seoul Declaration: 30 October 2009 Dr Maria Neira, Director for Public Health and Environment signed the Seoul Declaration on Safety and Health at Work on behalf of WHO:  http://www.who.int/occupational_health/en/