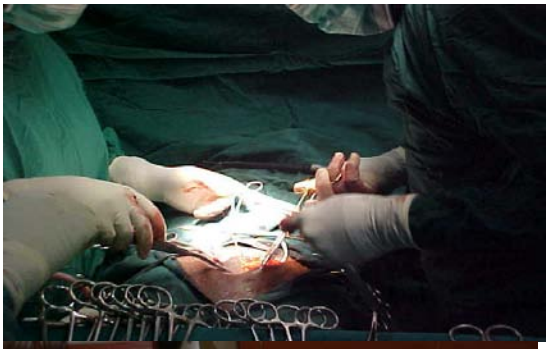
OCCUPATIONAL HEALTH AND SAFETY

POLICY AND GUIDELINES

FOR THE HEALTH SECTOR



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MOH

GHANA HEALTH SERVICE

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ACKNOWLEDGEMENTS

The Ministry of Health/Ghana Health Service in collaboration with the World Health Organization (W.H.O.) country office commissioned the development of this policy and guidelines on occupational health and safety (OHS) of health workers in view of the tremendous risks posed to these workers in the process of rendering invaluable services to mankind. We wish to express our appreciation to the W.H.O. for supporting this effort.

This policy document and guidelines is the outcome of a collaborative effort between health personnel and personnel of the Factories and Mines Inspectorates respectively as well as consultants in Occupational and Environmental Health, and other persons with an interest in OHS who are hereby acknowledged. It is therefore hoped that this collaboration will be enhanced in the implementation of these guidelines with each organization playing its rightful role in order to give the necessary impetus to ensure optimal OHS management for health care workers in Ghana. This it is envisaged will have spin-off effects for other sectors and indeed for workers in Ghana as a whole.

We wish to acknowledge the tremendous contribution of members of the interdisciplinary committee that worked tirelessly to develop the document as well as the valued input and direction throughout the assignment by Dr. (Mrs.) Edith Clarke, Programme Manager, Occupational & Environmental Health Unit of the Ghana Health Service. We also acknowledge the input from Dr E.K. Sory, Director General of the Ghana Health Service, towards finalization of the document, the immense support provided by Dr. T. N. Awuah-Siaw, then Director, Institutional Care, as well as inputs from various health managers in the Ministry of Health and Ghana Health Service.

FOREWORD

Healthcare facilities are potentially hazardous workplaces that expose their workers to a wide range of hazards. Generally, it is assumed among healthcare workers and the general public that the greatest occupational health and safety risk faced by healthcare workers is infection resulting from exposure to blood and body fluids as well as infected air-borne aerosols. Skin contact, infectious fluids (via broken skin, mucous membrane) and droplets aerosols from patients exposes healthcare workers to infectious diseases such as hepatitis, HIV and tuberculosis among many others. Furthermore, the emergence of highly infectious diseases such as SARS and the H1N1 Influenza has the tendency to increase the infection risk dramatically.

In addition to these, health workers are confronted with physical, chemical, ergonomic and psychological hazards. For instance, lifting and rolling immobilized or disabled patients exposes workers especially nurses to back injury. Besides, on call duty, high work load, verbal abuse from disgruntled patients, problematic work relationships, frustrations due to limited resources, poor remuneration among others, exposes healthcare workers to psychological hazards such as stress, depression and burnout syndrome.

It is in view of the fact that the health worker is the most important resource in the process of rendering health care that the sector considers it prudent to provide a safe and healthy working environment as far as reasonably practicable, for its staff in line with the 1992 constitution and the Labour Act 2003, Act 651.

Being a rather new discipline in Ghana, implementation of occupational health services expected to be put in place will largely depend on training in occupational health and on-going information provision for staff. It is in this regard that this policy and guidelines on occupational health and safety for health workers outlines evidence-based measures for adoption by health service managers and staff of institutions in the health sector both within the public and private sub-sectors. Similarly, on-going monitoring of programmes including regular audits is a must if performance of services is to improve progressively.

The importance of ensuring the availability of financial resources to make the system function cannot be overemphasized. It is hoped that all regional and district directors as well as facility managers will include specialist training in occupational health as well as occupational health services for their staff in their list of priorities and consequently make necessary budgetary allocations towards staff training, establishment of health and safety committees and securing tools necessary for efficient operationalisation of OHS services on an on-going basis.

Yeleh Chireh
Hon Minister of Health

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Glossary

Accident	Any unplanned, sudden event which causes or is liable to cause injury to people or damage to buildings, plant, material or the environment.
Incident	The occurrence of an event that interrupts normal procedure(s). It may be a minor event or result in a crisis such as an accident.
Contractors	Includes all contractors and subcontractors.
Emergency Preparedness Plan (or) **Emergency Plan**	A formal written plan which, on the basis of identified potential accidents together with their consequences, describes how such accidents and their consequences should be handled either on-site or off-site.
Employee	A person who is under a contract of employment with an enterprise, including management.
ILO Convention	An international labour standard developed through the ILO tripartite system. ILO Conventions are comparable to multilateral international treaties — they are open to ratification by member States and, once ratified, create specific binding obligations. A member State that has ratified a Convention is expected to apply its provisions by legislation or other appropriate means as indicated in the text of the Convention. The government of the member State is required to report regularly on the application of ratified Conventions; the extent of compliance is subject to examination and public comment by ILO machinery; complaints about alleged non-compliance may be made by the governments of other ratifying States or by employers' or workers' organizations. Procedures exist for investigating and acting upon such complaints. Conventions that have not been ratified have the same value as Recommendations (see ILO Recommendation below).
ILO Recommendation	ILO Recommendations are intended to offer guidelines for action by member States. Often, a particular Recommendation will elaborate upon the provisions of a Convention on the same subject. Member States have certain important procedural obligations in respect of Recommendations — namely to submit the texts to their legislative bodies and to report occasionally at the request of the ILO Governing Body on the measures taken or envisaged to give effect to the provisions. Recommendations have no legal obligations.
Occupational Disease	Any disease caused by exposures in the workplace.
Hazard	An inherent property of a substance, agent, source of energy or situation having the potential of causing undesirable consequences e.g. chemicals, slippery floor, work while standing on a ladder.
Risk	The probability that damage to life, health, and/or the environment will occur as a result of a given hazard (such as exposure to a toxic chemical). Some risks can be measured or estimated in numerical terms (e.g., one chance in a hundred). The risk or probability of injury or ill-health resulting from a hazard(s) is a factor not only of the inherent nature of the hazard, but also of the controls in place to mitigate the hazards.
Risk Assessment	An organised process used to describe and estimate the amount of risk of adverse human health effects from exposure to a toxic chemical or other hazard (how likely or unlikely it is that the adverse effect will occur). How reliable and accurate this process is depends on the quantity and quality of the information that goes into the

	process. The four steps in a risk assessment of a toxic chemical are hazard identification, dose-response assessment, exposure assessment, and risk characterization.
Risk Management	Actions taken to achieve or improve the safety of an installation and its operation.
Safety Audit	A methodical in-depth examination of all or part of a total operating system with relevance to safety.
Safety	A situation without unacceptable risks. For purposes of this text, "safety" embraces health, safety and environmental protection, including protection of property.
OHS	Occupational Health and Safety

1 INTRODUCTION

1.1 Nature and Magnitude of Work-Related Injuries and Ill-Health

Health care workers of the Ghana Health Service (GHS) attend various hospitals and clinics when they fall ill. The Service however does not have a system to collect and collate information on hospital attendance and illnesses suffered by its staff. The sector is therefore not in a position to analyze the incidence of diseases among its staff and to tease out those that may have derived from their work and work conditions. The fact that the health workers attend several different health facilities and the potential breach of confidentiality associated with disclosure of medical information of clients makes it difficult to obtain information in this respect. This therefore makes it difficult to determine the contribution of workplace factors to ill-health among health workers.

Health care workers are known to be at a higher risk of infection from blood-borne pathogens than the general population. Those most at risk are those whose activities entail exposure to blood and blood products. Important blood –borne pathogens in this regard include Hepatitis B (HBV), Hepatitis C (HCV) and HIV/AIDS. The World Health Organization (WHO) estimates that Sharps *injuries contribute 30% of new cases of HBV and 2.5 % of annual infections of HIV among health care workers in Sub-Saharan Africa (WHR 2002). Important p*redisposing factors found to account for these trends include needle stick injuries resulting from recapping of needles with two hands and contributory factors such as an overuse of injections. (*Over 75% of injections used in curative sector are deemed unnecessary)*. Other patient and health care worker behaviors' also contribute to sharps injuries. In Ghana, this was borne out by a preliminary assessment of 'injection safety and health care waste management' conducted in 2003 which showed that despite the use of auto disable syringes in the administration of immunizations, a considerable number of immunization staff reported having sustained needle stick injuries which mostly occurred when a child moved suddenly during an immunization. This excludes the curative sector where safe injection devices have not yet been introduced and injections are estimated to be in the region of over five times those administered for immunizations. Staff are therefore considered to be at a higher risk of needle stick injuries. In Uganda and South Africa, needle stick injuries were found to be around 44-55% and 91% respectively among junior doctors over a 6 month period. The risk of needle stick injuries though not known precisely for Ghana may be of similar magnitude. Anecdotal evidence also suggests that a fair number of health workers have contracted and some have died from complications of blood –borne infections particularly Hepatitis and other infectious conditions like tuberculosis which were likely to have been acquired in the work environment.

Some studies carried out by the Occupational and Environmental Health Programme of the GHS show that not only do workers work under conditions that are hazardous to their health, but the staffs are also not sensitized to Occupational Health and Safety (OHS) issues.

i. One of these studies was carried out among female nurses in 2 public health institutions in the Ablekuma sub-metro of Accra namely, Korle Bu Teaching Hospital and Mamprobi Polyclinic to determine the occurrence of musculoskeletal diseases. The study found that nurses consider the spine as the body part mostly affected by their work. The specific parts mentioned in the order of predominance are lower back (65.4%), neck (63%) and upper back (37%). Table 1 shows the nurses' actual experience of the injuries.

Table 1: Musculo-Skeletal Disorders

Body Part	**Nurses mentioning part**	**Nurses who actually suffered injury**
Spine	67.7%	
Lower Back	65.4%	65%
Neck	63.0%	63%
Upper Back	37.0%	37%

Nurses interviewed identified lifting of patients (79%); poor working postures (77.2%); stress (68.5%); slips and falls (48.0%); haulage and transport [e.g., of supplies / food within facility] (45.7%) as activities or situations that constitute hazards in their work place. The study found that 78% of nurses were overweight. This is probably due to the sedentary nature of the work of some, and poor eating habits that may be aggravated by shift work. Whilst 43.1% of the respondents said there were no measures in place to control occupational hazards, as low as between 0.8% to 5.9% of respondents were aware of the measures in place. A summary of the responses in this regard is presented in Table 2.

Table 2: Awareness of Measures to Control Occupational Hazards

	Measure	Nurses Aware of Measure (n=127)
1.	Maintenance of dry floors	0.8%
2.	Training on manual handling of patients	3.6%
3.	Correct and comfortable chairs provided	1.6%
4.	Provision of protective equipment	5.9%
5.	Interrupting writing at short intervals	0%
6.	No measure	43.1%

Considering the fact that the study was carried out in Accra which is the capital of Ghana and covers Korle Bu Teaching Hospital, the premier hospital in the country, the situation in the country as a whole may be considered as unimpressive and calls for urgent action to develop and implement a policy for OHS. Health promotion including information dissemination and education should be an integral part of the implementation of such a policy.
Two other studies conducted by the same unit of the GHS assessed the physical conditions under which staff work, and the practice of OHS in health institutions in Ghana from the perspective of health workers.

ii. The first study which employed observation techniques and environmental measurements in a regional hospital (Ridge Hospital), a district hospital (Tema General Hospital), two polyclinics/Urban Health Centres (Adabraka and Tema), a rural health centre (Amasaman), offices of a district health Administration (Amasaman) and the offices of the head quarters of the GHS was conducted in January 2005. A number of rooms that are in constant use by workers were surveyed for variables such as the area of room, lighting levels, temperature (as proxy for heat) and humidity. The main physical conditions investigated included illumination, temperature, and humidity. Other related factors were ventilation, sources of possible radiation, type and colour of walls, ceilings and curtain materials, air conditioners and fans, the number of windows per unit area of rooms, office space and room occupancy levels. Varying situations were observed between facilities and even within the same facilities thus making generalizations difficult. Illumination was found to be poor with 73% of rooms being inadequately illuminated from natural sources and a comparative 76% being inadequately lit by artificial lighting sources. The colour of walls and the materials used for curtains and the manner of use did not help illumination. Poor lighting conditions may result in straining of the eye, cause headaches, easy fatigability and reduce the ability to quickly detect fast movements thereby increasing the risk of accidents.
Internal temperatures and humidity were considered higher than desirable. Apart from the long term radiation risk associated with the use of computers, particularly for staff working in overcrowded offices and sitting in close proximity to the computers, their prolonged use also results in operator stress, fatigue, eye strain, sore and stiff neck, back and shoulder pains, wrist and hand injury, among others.

iii. The primary objective of the Health and Safety survey in health care institutions carried out between July 1999 and April 2002 was to unearth the prevailing health and safety conditions in health care institutions, identify high-risk groups and to institute appropriate interventions to improve on current practices including a health surveillance plan for staff of the GHS. The cross-sectional exploratory study used structured interviews to assess safety breaches and type of ill health posed by conditions of work and the working environment. A total of one hundred and eighty-nine (189) subjects working in seven (7) government hospitals and health centres in the Greater Accra and Eastern regions of the country were involved in the study. In this survey, only 6% of health workers considered health and safety measures in place at the time of the survey adequate; 48% of the

respondents considered the measures to be poor and an additional 33% said they required improvement. The reasons for the perceived poor health and safety performance included inadequate facilities and lack of safety equipment (18.5%), absence of Health and Safety Policy (14.3%), the cost of drugs being born by health care personnel (6.9%) and the lack of awareness of safety issues (5-8%).

The survey indicated that biological factors (hazards), manual handling of patients and psychological stress were the three most common hazards in health care work. There was some variation in hazards identified among the various professional groups. Personal protective clothing comprising of gloves, facemasks and boots as well as caution at the personal level were the main measures adopted to mitigate the effects of hazards. Most of the personnel were unaware of any corrective measures taken after diseases or injuries have resulted, apart from first aid. There were no measures currently in place to monitor the various hazards on a routine basis to enable corrective measures to be instituted to address them. Though the prevalence of pre-employment medical examinations was over 77%, periodic and special medical examination were sparsely practiced and exit medical examination was and still is non-existent.

1.2 **Legal Context of the Policy**

Section 24(1) of the 1992 Constitution states that "Every person has the right to work under safe and healthy conditions…." This fundamental human right has been upheld by the Labour Act, 2003 (Act 651).

The Labour Act, 2003 (Act 651)

The Labour Act, 2003 (Act 651) established a National Tripartite Committee made up of five representatives each of the Government, employers' associations and organized labour with the Minister for Labour as the chairperson (Section 112) and charged it, among other functions to "advise on employment and labour market issues, including labour laws, international labour standards, industrial relations and occupational safety and health" (Section 113 (1) (b)). Section 115 (1) stipulates that the committee may set up sub-committees of the Committee in such regions and districts as it considers necessary for the performance of its functions.

Section 118 (1) places a duty on the employer to ensure that every worker employed by him or her works under satisfactory, safe and healthy conditions. Subsection (2) of the Section 118 specifies that:

"Without limiting the scope of subsection (1), an employer shall

(a) provide and maintain at the workplace, plant and system of work that are safe and without risk to health;

(b) ensure the safety and absence of risks to health in connection with use, handling, storage and transport of articles and substances;

(c) provide the necessary information, instructions, training and supervision having regard to the age, literacy level and other circumstances of the worker to ensure, so far as is reasonably practicable, the health and safety at work of those other workers engaged on the particular work;

(d) take steps to prevent contamination of the workplaces by, and protect the workers from, toxic gases, noxious substances, vapours, dust, fumes, mists and other substances and materials likely to cause risk to safety or health;

(e) supply and maintain at no cost to the worker adequate safety appliances, suitable fire-fighting equipment, personal protective equipment, and instruct the workers in the use of the appliances and equipment;

(f) provide separate, sufficient and suitable toilet and washing facilities and adequate facilities for storage, changing, drying and cleansing from contamination of clothing for male and female workers;

(g) provide adequate supply of clean drinking water at the workplace; and

(h) prevent accidents and injury to health arising out of, connected with, or occurring in the course of work, by minimizing the causes of hazards inherent in the working environment."

Subsection (3), however, obligates every worker to use the safety appliances, fire-fighting equipment and personal protective equipment provided by the employer in compliance with the employer's instructions. The Act, in subsection (4), further absolves the employer of liability for injury suffered by a worker who contravenes the provisions of subsection (3) where the injury is solely due to non-compliance of the worker.

The Act in Section 119 protects the rights of a worker to remove himself or herself from any situation in the workplace which he or she has reasonable cause to believe presents an imminent danger to his or her life. In such cases, the Act forbids the employer terminating the employment of a worker or withholding his or her remuneration. An employer cannot require a worker to return to work in circumstances where there is a continuing imminent and serious danger to the life, safety or health of the worker. The Act also requires an employer to report occupational accidents and diseases which occur at the workplace as soon as practicable and not later than seven days from the occurrence to the appropriate government agency (namely the Factories and Mines Inspectorates respectively. Diseases should in addition be reported to the MOH / GHS).

Finally the Act mandates the conduct of labour inspection to:

(a) secure the enforcement of the provisions of the Act relating to conditions of work and the protection of workers at their workplaces, including the provisions relating to hours of work, wages, safety, health and welfare of the workers and the employment of young people;

(b) provide technical information and advice to employers and workers concerning the most effective means of complying with the provision of the Act;

(c) bring to the notice of the Labour Department or the Commission any defects of the Act; and

(d) report to the Labour Department or the Commission other unfair labour practices or abuses not specifically provided for by the Act.

Workmen's Compensation Law

The Workmen's Compensation Law, 1987 consolidates, with amendments, the law relating to compensation to workmen for personal injuries caused by accidents arising out of and in the course of their employment. It brings together the law on compensation to workmen. The basic provision is the principle of compulsory payment by an employer of compensation in respect of death or disablement of a workman as a result of an accident occurring in the course of his employment – independently of negligence on the part of the employee or fellow worker.

The Law deals with the liability of employers for the payment of compensation to workmen as defined in the Law in respect of injuries resulting from accident, the amount of compensation to be paid in the various cases which can arise, the method of calculating the workmen's earnings for the purpose of determining the compensation payable and the persons to whom it is to be paid. The position with regard to occupational diseases is dealt with by a legislative instrument under Section 31 of the Law. Thirteen of such diseases are listed in the Third Schedule to the Workmen's Compensation Regulations, 1967 (L.I. 546), for workmen's compensation purposes. The Law empowers the Minister responsible for Labour to extend the provisions of the Law to incapacity or death certified as caused by any disease specified in an instrument made under this section.

International Conventions

International declarations to which Ghana is a signatory also provide frameworks for effective promotion and enforcement of OHS standards. Examples of such international declarations ratified by Ghana include the following conventions of the International Labour Organization (ILO):

i. Convention 81 - Labour Inspection (02/07/59)
ii. Convention 115 - Radiation Protection Convention (07/11/61)
iii. Convention 119 - Guarding Machinery (18/03/65)
iv. Convention 120 - Hygiene (Commerce and Office) (21/11/66)
v. Convention 148 - Working Environment (Air Pollution, Noise and Vibration) (27/05/86)

The provisions on occupational safety and health within Labour Act 651 are consistent with ILO Conventions 155 of 1981 on Occupational Health and Safety and the Working environment, and Convention 161 of 1985 on Occupational Health Services, which Ghana is yet to ratify.

Related Policies

There are some other policy documents of MOH that this policy should be used in conjunction with. These provide more specific measures for dealing with the respective issues they cover. Examples of such policies are:

- Workplace HIV/AIDS Policy and Guidelines of the MOH
- Infection Control Policy of the MOH
- Health Care Waste Management Policy and Guidelines of the MOH

Other policies of relevance in this regard are yet to be developed and should be consulted when they become available. These include policies on:

- Manual Handling
- Personal Protective Equipment
- Compensation

Unfortunately, the laws that have operated in the country until the new Labour Law have been parochial in scope and did not cover the services sector including the health sector and other sectors like Agriculture. At the same time, there have not been adequate policy guidelines in place by the Ministry of Health nor the Ministry of Manpower, Youth and Employment to address OHS issues.

2 OBJECTIVES AND SCOPE OF POLICY

2.1 Policy Objectives

The objectives of this policy are to:

- Achieve and maintain the overall well-being, quality of life and work performance of health sector staff in order to minimize the impact of work on their physical and mental health
- Promote a safe and healthy work environment, work practices and procedures for all staff of the health sector in order to minimize work-related injuries and illnesses.
- Promote a culture of safe and healthy attitudes and practices
- Provide safe work environment, work practices and procedures for all health sector workers in order to minimize work-related injuries and illnesses.
- Ensure that health and safety management in the workplace constitutes a core management function of health sector institutions that is on-going and promotes a culture of co-operation between the major stakeholders (government, employers and their employees) in the spirit of tripartitism.
- Put in place and continually review structures and remedies that totally remove or mitigate risks posed by workplace hazards.
- Promote the incorporation of OHS educational programmes aimed at reducing workplace hazards and risks into the work plans of health facilities.
- Facilitate compliance to OHS policy and legislation by contractors and suppliers to all health facilities.
- Educate contractors, suppliers and the general public about health and safety programmes and protocols of the health sector and how they can comply with them.
- Institute measures aimed at ensuring adequate financing of occupational health services.

2.2 Scope of the Policy

This policy and technical guidelines apply primarily to:

i. all employees within the health sector (government, quasi-government, private as well as NGO's);
ii. prospective employees of the health sector; and
iii. clients, patients and visitors to all health facilities.
iv. Health institutions including students on practical attachments

The provisions of this policy and technical guidelines apply to all health institutions and administrative units within the health sector. The provisions are meant to aid managers of health sector facilities in the implementation of the OHS policy which have been written with the laws of the country and other international OHS protocols in full view. Implementation of the policy and guidelines therefore should result in compliance with the requirements of the health and safety laws of the country. Health and safety inspectors and practitioners seeking to secure compliance with the Labour Act 2003, (Act 651), may refer to this guidance as illustrating good practice. They are also intended to serve as a reference guide to the health worker in the field.

In summary, the policy sets the objectives for, and provides the framework within which, OHS management in the health sector will be operated in order to ensure the health and safety of workers of the health sector. It also provides helpful technical guidelines for health staff.

3 POLICY STATEMENT

The MOH is committed to creating a safe work environment that promotes health and safety practices and that seeks to prevent the occurrence of hazards associated with work and the work environment, reduces exposure and mitigates effects of hazards as far as reasonably practicable. The manager within the health sector and other employees shall therefore support the implementation of this policy in accordance with their roles and responsibilities.

To facilitate compliance with this policy, all health institutions, their managers and other staff shall:

a) Ensure that staff of the health sector are trained and accountable for preventing work-related injuries and illnesses;
b) Design, operate and maintain the work environment, work processes and procedures in a manner that controls and reduces occupational health and safety hazards and risks.
c) Support health promotion programmes that contribute to productivity, health and well-being of employees;
d) Maintain an effective management system that integrates occupational health and safety into service delivery and decision making processes. To this end, the health institutions and facilities (management and staff) shall establish the appropriate objectives and targets, regularly monitor their performance, and work towards continual improvement.
e) Ensure that the institutional and facility operations comply with relevant national occupational health and safety laws and regulations.
f) Provide clear and accurate information about the occupational health and safety aspects of their operations to employees, clients, the public and relevant regulatory authorities.
g) In collaboration with appropriate national and international institutions establish a mechanism for sustainable training schemes to ensure that adequate numbers of skilled personnel are trained to deliver effective occupational health services.
h) Inform suppliers, partners and contractors of the sectors' occupational health and safety standards and encourage them to adopt sound occupational health and safety management practices.
i) Use sound scientific principles to contribute to occupational health and safety policies, initiatives and regulations. This includes the provision of appropriate facilities as well as premises for performing OHS activities including laboratories for carrying out performance testing and research as far as reasonably practicable.
j) Use sound scientific management principles in the management of OHS at the institutional /facility level.
k) Develop and implement appropriate strategic action plans (SAPs) to achieve the desired outcomes for service delivery including effective control of risks.

l) Extend the provisions of this policy to the protection from injury of clients that visit the health facilities.

m) Institute a system for regular reporting on OHS at all levels of the health sector institutions and facilities and developing and circulating an annual report on the occupational health and safety situation in the health sector.

4 TECHNICAL GUIDELINES

4.1 General Principles

Health and Safety management in the workplace is an on-going process that should constitute a core management function. Its success requires management commitment to health and safety, professional independence of the service, confidentiality and consultation among workers and management. In general, the integration of occupational health and safety (OHS) functions into the existing health sector structure is advised. The Labour Act 2003, and ILO Convention 155 on Occupational Health and safety and Convention 161 on Occupational Health Services, which require the employer to ensure that the work environment as well as systems of work are without risk to employees, and spell out components of comprehensive occupational health services. In the light of the hazards posed by work and work environment, and in line with the above tenets, the principles espoused below will constitute the essential characteristics of OHS management in health institutions and facilities throughout the country.

The following general principles will therefore guide the operations of OHS:

- Joint participation of employers and employees in the development of programmes for the improvement of the working environment;
- Professional advice on planning and organization of work including the design of workplaces, the selection and maintenance of machinery and other equipment and substances used in health care work and its allied services;
- Periodic reviews of occupational health and safety policy and guidelines based on new knowledge and research findings. Such periodic reviews will seek to identify major problems with the policy as a whole or in respect of particular areas, and evolve effective methods for dealing with the problems. The initial review should take place after the first 2 – 3 years' of implementation of this policy

4.1.1 Management Commitment

The health and safety of employees is the responsibility of management of institutions and health facilities at all levels of the health sector which will make health and safety a core managerial function and an integral part of their business. Leadership and genuine commitment of management provide an essential foundation for an effective health and safety programme. This should be reflected in the management's knowledge of the particular health and safety needs of the organization and the conviction that high standards are attainable. This policy document will be signed by a high-ranking member of management such as the Director General of the service. Similarly, any health and safety guidance documents developed by health facilities/institutions to complement this health policy must be signed by the chief executive or head of the facility/institution. Management commitment should also be reflected in the allocation of adequate resources (material, human and financial) to ensure success in implementation of the policy.

4.1.2 Professional Independence in Delivery of Occupational Health Services

Professional independence is the main ethical bedrock on which Occupational health services operates. This is demonstrated by who the occupational health personnel owes loyalty to, reports to and confidentiality. It must be clear that the primary responsibility is to his/her client who is the health worker. Any information about the worker patient can only be divulged to management with the consent of the worker. However pre-placement (pre-employment) medical exams by their nature imply the automatic consent of the worker.

4.1.3 Confidentiality

Information regarding the health status of an individual health worker, obtained in the course of the discharge of OHS function shall be treated with the utmost confidentiality as should characterize health service delivery.

4.1.4 Consultation

Consultation, which in this context refers to equitable participation of workers and management in OHS management, is an integral part of good management. It is a means by which employers and employees work together to improve health and safety in the workplace. In the spirit of bi and tripartitism, it should promote the culture of co-operation between the major stakeholders – government (MOH), employers and employees. This will translate into joint participation of employers and employees (bi-partisan) in the development of programmes for the improvement of the working environment. Consultation will lead to improved health and safety practices, as employees are most likely to know the risks associated with their work, and may be able to suggest effective solutions. Employee involvement in problem identification and related workplace changes also helps to ensure that employees are committed to changes. Opportunities should therefore be sought whenever possible for management-worker consultation through Health and Safety Committees.

The following are examples of situations in which consultation may be employed:

- Development of policies, procedures and action plans for the identification, assessment, and control of hazards in the workplace;
- Review of accident statistics;
- Solving of OHS problems;
- Discussions on major Occupational Health and Safety issues; and
- Procedures and methods for sharing information relevant to the health and safety of workers as it relates to their work.

This list is however not exhaustive.

4.1.5 Professional Advice

Professional advice will be sought on planning and organization of work including the design of workplaces, the selection and maintenance of machinery and other equipment and substances used in health care work and its allied services.

4.1.6 Policy Dissemination

The policy will be widely disseminated and copies provided for all staff at post as well as new ones who join the service

4.2 Components of the Occupational Health Service

In the light of the hazards posed by work and work environment, and based on the Labour Act 2003, (ACT 651), ILO Convention 155 on 'Occupational Health and Safety and Working Environment' and Convention 161 on Occupational Health Services respectively, which spell out the components of comprehensive occupational health services, the following five broad strategies will be adopted in the provision of occupational health services to staff of the health sector:

1. Preventive activities aimed at preventing the occurrence of injury and disease. Key elements of this include identification, evaluation and control of hazards.
2. Promotional activities including provision of information and education to employees to enhance their safety behaviours and adoption of habits that favour healthy lifestyles.
3. Curative activities that offer treatment and advice regarding injuries and diseases.
4. Rehabilitation activities in the event of disability following an injury or disease, essential to help the affected persons regain their skills or acquire new ones that will enable them return to work.
5. Research activities which entail investigations and studies on the work environment, and into diseases and injuries as they relate to work and conditions of work.

4.2.1 Preventive Actions

The preventive actions to be adopted are varied and go to complement each other in facilitating health and safety. They include the following:

4.2.1.1 *System for Hazard Identification, Assessment, and Control*

Managements of the health sector shall ensure that hazards in the work environment are recognized through ONE SYSTEM that can be applied at all levels within the sector. This system should remain uniform throughout all facilities and institutions within the service to ensure that there is no confusion in the management of occupational hazards and risks. Each facility / institution should have an Occupational Safety and Health plan which shall outline the processes that staff and managers will utilize to identify, assess, and control hazards in

their working environment. The guidelines in Annex II will enable staff to assess the risk from hazards in the workplace.

4.2.1.2 *Control of Hazards*

Once the hazard is known and the risk of it causing injury or disease is determined, then control measures should be applied in a hierarchical fashion.
In taking action, the issues to address are:

a) Can I get rid of the hazard altogether?
b) If not, how can I control the risks so that harm is unlikely?

The principles below should then be applied as far as possible in the order in which they are listed:

- Try a less risky option
- Prevent / limit access to the hazard (e.g. to isolation ward, radiation exposed areas, guarding of beds with side rails to limit falls etc)
- Organize work to reduce exposure to the hazard
- Issue and ensure the use of personal protective equipment
- Provide welfare facilities (e.g. washing facilities for removal of contamination and first aid).

Caution – It is important to ensure that the control recommended / instituted does not pose another hazard

4.2.1.3 *Monitoring the Control of Hazards*

Monitoring is defined as any action taken to determine the current state of a workplace, or worker, in relation to a significant hazard. Thus the monitoring function has the aims of determining the state of:

- The work environment i.e. it assesses the intensity or level of identified hazards (physical, chemical, biological, & psychosocial) in the workplace environment; or
- Workers' exposure to physical, chemical, biological hazards or psychosocial the workplace and come up with a Hazard Management Plan
- The effect of the hazard on the worker manifest through ill health or injury. The objective is to detect as early as possible any deviations from health.

4.2.1.4 *Medical Surveillance*

Medical surveillance is a means of monitoring the health of employees. It is a planned programme of systematic regular medical examinations designed to enable the early detection of disease or ill health related to particular types of work. It facilitates the ascertainment of the effectiveness of control measures. All staff members are expected to

undertake it. The types and frequencies of examinations undertaken are to be determined by the nature of work to be/being undertaken by the individual and other factors such as age and sex. Each institution is to have a surveillance plan which spells out the types and frequency of examinations to be undertaken and the different categories of staff to undertake the examination in the various sections of the institution, based on the likely potential hazards as listed in Annex 1.

The medical monitoring protocol should be divided into 4 key areas namely: pre-placement, periodic, post sickness absence and exit. Each of the examinations will consist of the following procedure:

- Completion of medical history form
- Physical examination
- Special Tests/laboratory investigations
- Final assessment

The emphasis in these examinations should be on ensuring that workers are fit for work in those areas for which they have been employed. A sample medical surveillance from is found in Annex 4.

Informed consent is required from each employee before personal monitoring of his/her health is undertaken. As with any medical record, unless an employee gives specific permission (best given in writing) for results to be made available to the employer, the results of health surveillance / biological monitoring carried out on an employee remain confidential between the employee and the person who carried out the monitoring. The only results to which an employer shall normally have access are group results with personal identifiers removed.

The various types of health screening are described below:

i) Pre-placement (Pre-employment) Examination

This examination is to ensure that the employee is fit to undertake the job without risk to himself or his colleagues. The baseline medical examination conducted at the start of employment will define the initial health status: Subsequent examinations will be used to evaluate the evident health effects of the work environment and other working conditions.

ii) Periodic Examination

This consists of examinations conducted periodically to identify vulnerable groups among the staff which can be of immense value to prevention. The frequency and types of examinations will be determined for each vulnerable group based on nature of work, ages and sex of the group members.

iii) Post Sickness Absence Examination

This is to ensure that an employee who has been absent with a medical condition for a considerable length of time is fit to undertake his/her usual job. On the other hand, it will facilitate the rehabilitation or temporary or permanent resettlement of those who are not fit to return to their usual occupations.

iv) Exit Medical Examination

This is to provide data on employees at the point of exit from a particular occupation or workplace. The advantage to employees is that it provides the opportunity for employees with ailments which have a causal relationship to any factor in the work environment to continue to receive assistance for managing it after they have left the employment or moved on to another schedule.

4.2.1.5 *Prevention of Communicable Diseases*

All efforts should be made to limit the transmission of infections in the work place.
Measures towards achieving this include the following:

i) Immunization Strategy

The GHS will implement a comprehensive occupational immunization programme for its employees who handle patients. Due to the risks of contracting infectious diseases from the work environment, all staff and potential staff members will be made aware and provided with appropriate immunizations. The most important diseases to be vaccinated against are:

- Hepatitis B
- Tetanus
- Yellow Fever & Cerebro-Spinal Meningitisand other diseases where occupationally relevant

For staff who have not been vaccinated in childhood (e.g. by virtue of coming from abroad), vaccination against the following may also be required and needs to be discussed with the occupational health department (or designated staff member) of your institution.

- Tuberculosis
- Poliomyelitis

The immunization programme will have robust arrangements for record keeping and recall for boosters.

ii) Prevention of other Communicable Diseases

The patient charter of the MOH recognizes the right of all patients/clients to receive appropriate care regardless of the condition or circumstances giving rise to their need for care. MOH is committed to maintaining as far as possible the independence, dignity, privacy and confidentiality of clients while simultaneously assuring the safety of her staff. To ensure this, good practice of infection control based on the universal precautions approach should be followed at all times, not just where a specific risk is known. This

includes ensuring the highest standards of cleanliness, waste disposal whilst making provision for all the basic equipment, disinfectants, personal protective equipment and other consumables required for this. (Refer to the MOH Policy on Infection Control for the details).

iii) HIV/AIDS and Hepatitis

There will be appropriate screening for the blood borne pathogens with access to advice and support for healthcare workers who may be infected with the HIV, Hepatitis B or Hepatitis C. Such advice or support may be spelt out in appropriate policies e.g. HIV /AIDS workplace policy and other guidance relating to provisions for care and compensation for ill or injured staff proposed in this document and any others on staff welfare in use by sub-sectors, institutions and facilities. If exposure to Hepatitis or HIV/AIDS in the work environment through needle stick injuries or other factors resulting in contact with blood, blood products or body fluids is suspected, the incident needs to be reported immediately. Post-exposure prophylaxis should be provided and other actions taken as spelt out in the MOH HIV/AIDS policy and as detailed for potential exposures to HIV and Hepatitis in Annex of this document.

4.2.1.6 *Protection of Employees from Harassment and Abuse*

In the event that an employee suffers from or is threatened with physical, sexual, or psychological abuse from a client/patient or his/her representative, the employee should immediately or at the earliest opportunity report to his/her supervisor who is to ensure an investigation of the matter and appropriate action taken. In serious cases, it may necessitate the withdrawal of services from the client/patient.

4.2.1.7 *Accident and Incident Reporting*

A critical link in the health and safety programme is the ability of supervisors to investigate accidents and incidents (with the potential to progress into accidents) occurring in the workplace. The ultimate objective is to review all unsafe conditions to determine whether there are any control measures in place and whether they are performing as they should. Documentation of accidents and incident investigations should be done on forms appropriately designed for that purpose and communicated to staff and management. It is also a statutory obligation that accidents should be reported to the appropriate authorities. This action then leads on to finding solutions to prevent future occurrences.

All accidents to staff, patients, and visitors reported through the Incident reporting system will be followed up and, where necessary, a new risk assessment undertaken.

4.2.2 Health Promotion

Health promoting strategies to be adopted by the sector include education and training, counselling services and information provision in general lifestyle issues and on specific workplace exposures.

4.2.2.1 *Education and Training*

Occupational Health and Safety training will be emphasized to ensure that staffs adhere to the appropriate practices which minimize adverse health and safety impacts. The training will also include reasons for the use of and care for PPE as well as information on diseases which are influenced largely by lifestyle factors e.g. Diabetes Mellitus, hypertension and HIV/AIDS.

Managements are required to provide education and training in health and safety as part of their responsibility to provide a healthy and safe workplace. Managers should provide such training at all levels to ensure that management and employees are able to fulfil their roles and responsibilities. Occupational Safety and Health training shall be integrated in the facility's/institution's plan for in-service training. To ensure that all training needs have been identified in relation to hazards in the workplace and how to deal with them, an evaluation will be carried out as part of the regular review of the facility's health and safety programme.

Occupational Safety and Health training will be incorporated into:

- Induction training for new employees which should be carried out within the first 2 weeks of employment (including information about workplace standards, hazards, risks, controls, the use of personal protective equipment, accident reporting system, and emergency procedures);
- In-service training;
- Management/supervisor training; This is on-the job training aimed at helping employees to understand the health and safety implications of procedures to be undertaken on the job, hazards and risks posed by chemicals and other substances to be handled as well as substances to be discarded or disposed of; understand routine health and safety management practices i.e. health and safety inspections, good housekeeping, job safety practices and implications for maintenance and repair.
- Training for those with designated roles and responsibilities such as health and safety coordinators and representatives, health and safety committee members, emergency wardens and first-aiders.

Supervisors will be responsible for ensuring that on-going training is provided for personnel in safe working practices. They will also ensure that safety equipment, tools and clothing provided are made available to staff.

Records shall be kept of training provided for each employee, the skills they have attained and any further training that could be needed. Training records should be reviewed regularly with employees to ensure that they are kept up-to-date.

4.2.2.2 *Provision of information*

Managers must provide information to employees to ensure that current legislative requirements are known, and that relevant, up-to-date information is given regarding:

- All identified hazards;
- Control of significant hazards (i.e. the steps taken to reduce the likelihood that these hazards will be a source of harm);
- The use of and care for personal protective equipment where necessary;
- Any hazards that employees may create during work and how to control the likelihood of harm to themselves or others;
- The review of any new work processes, products or equipment, where hazards have been identified and the measures taken to control any likelihood of harm;
- Standards for work practices; and
- The emergency procedures for the healthcare facility.

The dissemination of health and safety information can be conducted through a wide range of activities. Some suggested ways of communicating include utilizing existing management and other staff meetings to provide and promote health and safety information, the development of new or changed job descriptions and duty statements, development of OHS handbook for staff, displays on notice boards, inclusion of OHS in induction programmes, supervisors' instructions to employees, and arranging for a health and safety representative in each work area. The information should be presented in an appropriate form, taking into account the literacy and the language needs of the employees. Information may need to be introduced, explained, and the understanding of information by employees may need to be checked.

4.2.2.3 *Information for Visitors to the Workplace:*

A system should be developed to ensure that visitors (such as delivery drivers, volunteers, trades people and those visiting patients or residents) are made aware of and comply with the health and safety requirements for the facility.
This should include:

- Emergency procedures for the facility; (Emergency Plans should not only be prepared and shelved). There should be periodic emergency drills to pre-determine staff behaviour under emergency conditions and measures taken to address them)
- The observance of all instructions and warning
- The use of suitable safety warning signs in areas where there are hazards; and
- The exclusion of visitors from certain work areas where they may be adversely affected
- Organization of periodic campaigns to create awareness on potential emergency situations that could arise and how to handle them.

4.2.2.4 *Other Health Promotion Actions*

Health education and other promotional activities all aimed at ensuring a healthy work force will be conducted for staff on issues such as healthy diet, food hygiene, exercise, smoking, alcohol, drug abuse, cancer, HIV/AIDS, TB etc.

The development of health promotion material and activities in the workplace will in addition to preventing harm caused by work activities, also encourage healthy behavioural practices that can have a positive impact outside the place of work.
The emphasis of health promotion activities is on:

- Self responsibility;
- Prevention of illness and injury;
- Enhanced health status;
- Participation; and
- Equity and access.

4.2.2.5 *Counselling Service*

The health sector will ensure access for all employees to a confidential counselling service when warranted. This counselling service will be available for workers with psychological/psychosocial problems associated with the organization of work, relational issues, stress and other factors. Employees can be self-referred to this service through their occupational health unit, other attending physician or supervisor.

4.2.3 Curative Strategies

Curative strategies consist of the following:

4.2.3.1 *Curative Care*

The health sector will take all necessary measures to detect and facilitate the management of ill-health among its employees including occupational diseases (as defined by the 2nd Schedule of the Workmen's compensation Law and updated in ILO Convention No. 121 of 1964 – The Employment Injury Benefits Convention. (The list of 1964 as amended in 1980 contains 29 diseases).

Provisions will be made to facilitate access to care by relevant medical specialists (including Physician Specialists, Occupational Physicians, and Occupational Psychologists etc) as far as possible when required. Managements/supervisors shall assist in obtaining referrals for their staff. Facilities for self-referral will also be available to enable employees obtain confidential advice.

4.2.3.2 *First Aid*

In all departments of health institutions and facilities, it is important to have adequate and competent first aid cover throughout the working week. The sector will therefore ensure that nominated employees have adequate training /are trained as first aiders. This includes employees in both clinical and non-clinical support service areas.

- Periodic updates will be provided for all certified first aiders every 2 years at the lapse of their certificates.
- First aid facilities will be provided in all work areas.

4.2.3.3 *Collection and Maintenance of Ill-health Statistics*

A system of health records will be established that is simple yet enables accurate and efficient retrieval of information. Where serial measurements are taken on employees, these will be kept in a way that permits serial group analyses as well as the following of changes within an individual. For the purposes of identification of problem areas for preventive action, all attendances at the health facility should be analyzed on a regular basis.

Health records for individual employees which must also include details of their birthdates, employment dates and places of work, with results of any environmental measurements that may be available, should be retained for 25 years after the individual leaves employment, or a minimum period which may be reviewed from time to time by the Minister of Health.

Personal information regarding the health of an employee must be kept under the control of the doctor and or nurse in charge of the occupational health service. No such information or records should be divulged to any third party, including management, without the prior consent (which should be best obtained in writing) of the individual concerned, except when legally required. Records of accidents and injuries, or occupational diseases, but not the full medical details must be available to management.

The medical records will be analyzed to provide relevant statistics annually to demonstrate trends and problem areas for the purposes of instituting preventive measures.

4.2.4 Rehabilitation Strategies

Employers/ managements in the health sector will facilitate the return to work of workers with disabilities following disease/ injuries via:

(i) Ensuring access to rehabilitation services e.g. physiotherapy, occupational rehabilitation, counselling services etc.

(ii) Appropriate compensation where indicated

Retirement on medical grounds will be granted where necessary. It will be facilitated on grounds of ill-health or injury (which may have been contributed to by work) and will ensure the payment of appropriate benefits.

5 EMERGENCY PROCEDURES AND CONTINGENCIES

These guidelines are meant for the management of emergency situations that may arise in relation to situations such as fire explosions, flooding, earthquakes and electrical accidents. Persons involved are:

- Unit/Area Safety/Emergency Warden or Health and Safety Officer.
- Staff at and nearest to the place of accident/disaster.
- All sectional supervisors / ward in-charges.
- Quality assurance managers.

5.1 **Preparedness Readiness Measures**

Telephone numbers of Fire Service, Police and other emergency service agents, e.g. NADMO should be posted at prominent places on walls of the facility.

- An Alarm system, with a unique sound for emergencies, should be provided and maintained at the facility level. Workers on the premises should be trained to react appropriately to the alarm.
- **Encourage people to remain calm and orderly as they leave the building**
- **Set out escape plan indicating:**
    - Designated escape routes from each work location within a building. Divide staff numbers to ensure optimum use of escape routes and to avoid congestion
    - Escape doors should be indicated and appropriately lit
    - Assembly Points
    - Whom to report to once at the Assembly Point

- Indicate high risks areas such as kitchen, autoclave/ boiler/refrigeration rooms and hazardous material storage area on a diagram of the building/service facility
- Designate duties of individuals, such as shutting down equipment, checking floors and corridors, etc., and train accordingly
- Search and rescue team
- Appropriate PPEs (suits, breathing apparatus, etc.), emergency lighting systems (e.g. torch lights with batteries, etc.),

5.2 **Emergency Response and Evacuation**

The following command order shall be adhered to in case of emergencies:

i. Upon discovering or in case of a disaster due to fire explosion, flooding or any threatening situation e.g. a bomb, immediately notify the sectional supervisor or sister in charge / safety warden, switch board or fire service .

ii. Power supply to any machines in affected area should be switched off immediately.

iii. Shut down machines and potentially dangerous equipment such as boilers / autoclaves/ gas plant etc

iv. Meanwhile arrange for fire fighting, selecting by type the appropriate extinguishers and train staff in their use. The extinguishers should be serviced regularly.

v. Under the supervision of the safety officer, carry out rescue/evacuation of people from affected areas as follows:

- *DO NOT USE LIFTS*

- *Close doors and windows behind you as you leave the building*

- *When escaping through smoke filled area, keep close to the floor as there is most oxygen at that level.*

- *When trapped in a building, do not panic. Move to an outer room and try to attract attention from a window*

- *Do not attempt to jump from a building unless you are sure there is enough arrangement made to ensure your safe landing e.g. on a safety net or a soft piece of soil, etc.*

- *Should clothes catch fire do NOT RUN. Fall to the ground and roll.*

vi. Have a roll call to ascertain numbers/names of missing employees who may be trapped or affected and where last seen.

vii. Ensure that first aid is rendered and arrange for transportation of injured/affected persons to appropriate health facility / section under the supervision of relevant health staff.

viii. Cordon off affected area, to facilitate thorough investigation by the safety department, police service and other appropriate body.

ix. Results of all investigations should be used to prevent future occurrences of similar incidents.

x. Conduct mock exercises/fire drills and simulate other disaster management situations at least 2 times a year. This is to ensure that in the event of any disaster, all employees will be abreast with actions to take.

6 CONTROLS OVER PURCHASING

Within the public sector, purchasing will be required to be carried out under the existing MOH procedures based on the Procurement Act. Purchasing committees are however expected to ensure that due diligence has been undertaken and efforts made to comply with any precautions and disclosures necessary for the safety of staff and clients of the sector.
Where committees are uncertain of the specifications, purchasing committees are required to seek expert advice from the Occupational and Environmental Health Unit of the Service and take the appropriate steps required to ensure that suppliers are well informed of and comply with health and safety standards of the MOH.

7 MANAGEMENT OF CONTRACT WORK

Managers of health services are required to ensure that the health and safety standards of MOH are explained to contractors and that the contractors are held accountable for any safety breaches in their performance. Environmental management as well as work place safety plans should be required from contractors as part of their technical proposals before the award of contracts and their implementation should form a vital deliverable to be procured before payments are made. This may be integrated with the business plans submitted by the contractors. Where the gravity of environmental and safety risks so warrant, separate plans covering these should be developed and submitted by the contractors.

8 ALCOHOL AND DRUGS

It is recognised that the use of alcohol and other drugs can affect work performance and the safety of staff. Alcohol abuse (Acute intoxication or alcohol dependence) and drug abuse (taking a psychoactive drug or performance enhancing drug for a non-therapeutic effect) can cause job related injuries, increase absenteeism as well as reduced job performance and morale within the organisation.
The aim of this policy is to provide a safe, healthy and productive workplace for health workers. All individuals therefore have a responsibility to avoid alcohol or other drug (particularly illicit drugs) use to the extent that it impacts adversely on work performance or safety.

8.1 **Scope**

As a part of the occupational health and safety policy for health workers, this policy applies to all staff of the Ministry of Health (MoH), its departments and agencies as well as to contractors (and their employees) who may work on their premises. It further applies to health workers in quasi government, the private sector and health facilities operated by non – governmental agencies.

8.2 **Policy Objectives**

The objectives of this policy with regard to alcohol and drugs are to:

- maintain a safe and healthy work environment
- reduce the adverse effects of alcohol and abuse /misuse of other drugs to health personnel, their clients and visitors to their premises as well as costs to their institutions.
- address workplace factors that can contribute to harmful alcohol and other drug misuse /abuse
- integrate action on alcohol and other drug abuse /misuse with other occupational health and safety initiatives
- provide access to information on alcohol and other drug abuse and encourage those with problems to seek assistance.

8.3 **Employer Responsibility**

Individual supervisors will be responsible for the implementation of this policy and will address organisational factors that may contribute to alcohol and other drug misuse. To achieve these aims, managers of facilities / e*mployers should*

- provide suitable alcohol and other drug training to management, supervisors, employee representatives and other staff responsible for policy implementation
- provide suitable alcohol and other drug information and education to all employees
- ensure that alcohol or other drugs are not consumed during working hours or on work premises.

- assist and motivate employees with alcohol and/or other drug problems to access counseling and treatment services

In Ghana, possession and use of illicit drugs is a criminal offence. On the other hand, the rights of individuals to drink socially is acknowledged, but when work performance suffers or individuals are endangered as a result of its use, then action must be taken. In the interests of occupational health and safety, action will be taken in the following circumstances:

- when an individual is, through the consumption of alcohol or other drugs, in such a state as to endanger their own safety or the safety of any other person at work
- when an individual is found in possession of illicit drugs on the premises
- when work performance is adversely affected.
- assist and motivate employees with alcohol and/or other drug problems to access counselling and treatment services. Employees seeking help will be directed to appropriate institutions/organisations by their supervisors/managers
- ensure, by continuous monitoring, that work environment conditions which may contribute to alcohol consumption are adequately addressed

8.4 **Employee Responsibility**

Employees should not be adversely affected by alcohol or drug use during working hours and must at all times carry out their duties and responsibilities in a safe manner.

- Employees have a responsibility to be fit for duty and to meet established standards for job performance and conduct.
- Employees who have concerns about working with any other employee due to possible alcohol or other drug use should consult with their supervisor, manager, or occupational health and safety representative.

A worker is considered to be a danger to himself/herself or other workers when under the influence of alcohol if he/she: -

- speaks with a slur
- has motor coordination difficulties
- cannot pick things from the floor without difficulty
- staggers/stumbles whilst walking
- cannot maintain a balanced gait
- has red shot eyes
- smells of or has alcohol on the breath
- is noisy and rowdy
- uncharacteristically uninhibited in behaviour due to a lack of total awareness of his /her environment.

8.5 **Intoxication at Work**

The following conditions will apply:

i. Employees will be made aware of the impact on work performance and the safety of themselves and other employees of consuming alcohol or other drugs.

ii. Where work performance is affected, it is appropriate for the facility manager / supervisor / employer to cause the removal of the individual from any position of risk.

iii. Any individual who is adversely affected by alcohol or another drug will not be allowed to work until they are deemed fit to safely and productively perform the job.

iv. If an employee affected by alcohol or another drug is sent home to recover, they will not be paid for the lost time.

v. Disciplinary action may be taken on return to work.: An individual found under the influence of alcohol during working hours will receive a written warning to stating that if it occurs again, appropriate disciplinary action will be taken by a disciplinary committee and penalties will range from interdiction with/ without salary to outright dismissal.

8.6 **Illicit Drugs**

In Ghana, the growing, possession and use of illicit drugs - irrespective of the quantity – is a criminal offense punishable by imprisonment.
The following conditions will apply:

i. Illicit drugs (e.g., cannabis, amphetamines and heroin) are not permitted on work premises or to be used during working hours under any circumstances.

ii. An individual found in possession of, selling, transferring, distributing or manufacturing any substances known or suspected to be illicit substances in the workplace, will be handed over to the law enforcement agencies. If found culpable, the individual will be dismissed.

8.7 **The Disciplinary Procedure**

Supervisors may become aware that an individual's work performance has deteriorated sufficiently to be of concern or that they have repeatedly placed themselves or others at risk of accident or injury. When a pattern of unsatisfactory work performance or situation of being on alcohol or drugs becomes clear the following measures will be adopted:

i. The details of the case will be documented and an interview arranged with the individual to advise them of the problem and offer help.
ii. If the problem continues, a second interview will be arranged to caution the individual, offer help and warn of disciplinary action.

These interviews will be held by a senior supervisor / manager in the presence of a witness of the affected staff member's choice.

iii. If a third interview is required, the employee will be given the option of obtaining help or facing the consequences (severe discipline in form of suspension, demotion or dismissal).This interview will be conducted by a disciplinary committee set up by the regional director of health services, or constituted by management in consultation with the local workers' union.

All information will be treated in strict confidence.

iv. Where an employee is taking prescribed drugs and is unable to perform the work required of one, the supervisor / management /employer in consultation with the employee may make adjustments to the work requirements if reasonably practical. If this is not possible and the situation is temporary, the employee should go home on sick leave. If it is not temporary, further consultation and consideration of appropriate duties will be required.

8.8 **Social Functions**

There may be certain occasions where alcohol is available at functions. On these occasions, the responsible serving of alcohol at social functions will apply. In addition, it is up to each individual to ensure that the consumption of alcohol is kept to relevant legal limits and that appropriate standards of behaviour are maintained.

The following guidelines are to assist in planning and hosting MoH */GHS and other health service organizations' functions* when alcoholic beverages are served.

i. A nominated person agreed upon by both management and employees will have responsibility for overseeing any function where alcohol is served. That person will be responsible for providing a brief about the policy to those attending the function, staff members, caterers and those responsible for logistics at hotels, conference centres etc.

ii. Alcohol is not essential to any function. The use of alcohol is a personal choice. No one should feel pressured to either drink or not drink, and must not be made to feel uneasy or embarrassed as a result of their choice.

iii. The *MoH* drug and alcohol policy shall be observed at all times (i.e., no return to work if under the influence of alcohol or other drugs).

iv. The respective supervisor / employer / management shall encourage those who intend to consume alcohol at functions to use public transport or refrain from driving themselves.

v. The person responsible for organising any event where alcoholic beverages are served is accountable for ensuring that alcohol is served in a manner, which limiting its potential to affect both health and safety by ensuring that an adequate variety and supply of non-alcoholic beverages shall always be visibly available. They should be presented in a manner that is as appealing as beverages containing alcohol.

vi. If anyone is aware that a guest has had too much to drink he/she should contact the nominated person responsible for overseeing the function. The nominated person should attempt to provide supervised transportation home for that person. If in doubt about a

guest’s condition that person will be discouraged from driving. If the nominated person is not available then individuals should attempt to provide supervised transportation.

9 FINANCING OF OCCUPATIONAL HEALTH SERVICES (OHS)

Medical surveillance and rendering of medical care for injuries and disease suffered by the worker should be at no cost to the worker. The cost should be borne by the employer through arrangements made in accordance with national conditions and practice. The MOH will ensure the availability of funds for OHS via a combination of funds from the following sources:

i) National Health Insurance Scheme to cover periodic medical examinations, medical care for ailments, rehabilitation and worker education.

ii) An endowment fund set up for the purpose which may involve contributions from both employer and employee. This will be drawn upon to complement other sources for accident and injury cover, sickness pay and death as a result of workplace and other hazards and to complement other sources for terminal illness rehabilitation.

iii) Group insurance for workers

iv) Workmen's Compensation Act: the above will complement the provision of this law.

The eventual configuration of funding sources may include all or some of the above as practicable.

10 MONITORING OF OCCUPATIONAL HEALTH AND SAFETY PROGRAMME

10.1 Health and Safety Audit and Performance Review

This is the final step in the health and safety management control cycle which effective organizations use to maintain and develop their ability to manage risks to the fullest possible extent. As a process, it aims to ensure that control measures are working and kept up to date. Auditing and performance review allow policy implementation to be assessed against four key indicators:

- Assessment of achievement of specific objectives;
- Assessment of compliance with health and safety performance standards;
- Identification of areas where standards are absent or inadequate; and
- Analysis of incident, accident, and ill health data.

Programme review and evaluation should measure outcomes such as the attainment of goals and objectives, and programme effectiveness and should also analyze trends. The outcomes can be evaluated by using employee interviews and testing, observation of work practices to determine whether employees understand the health and safety policies and procedures. Programme effectiveness may also be evaluated by observing both overall and departmental trends in occupational injuries and illnesses.

10.2 Specification for Performance Audits

Audits of the performance of the health, safety and environment programme of health institutions is mandatory. Regular audits will be performed internally (2 times a year as a minimum) and external audits shall be performed periodically, 2 years at the minimum. Such audit should cover:

- OSH policies/rules/regulations and their review
- Inventory of health and safety risks and on going monitoring of them
- Control measures for risks
- Results/Trends in health surveillance
- Trends in accident statistics
- Training of staff in health and safety
- Emergency response plans and procedures and their effectiveness

10.3 **Review of Policy and Objectives**

From time to time, in consultation with the health and safety representatives, this policy statement will be reviewed and revised as required. This should take place at least once in 3 years.

11 ADMINISTRATIVE ARRANGEMENTS

11.1 Ministry of Health (MOH)

The overall responsibility for ensuring the implementation of this policy rests with the Minister for Health. The policy will be implemented in all sub-sectors of the health sector, with the administrative structure being based on the currently existing arrangements within these various sub-sectors.

The health and safety policy will be implemented at all levels of the MOH i.e., Sub-district, District, Regional and National levels. The Policy Planning Monitoring and Evaluation Directorate (PPME) and the Human Resources Directorate (HRD) will be responsible for putting systems in place for resource mobilization for specific programme components, implementation, and monitoring as well as periodic evaluation of programmes. To facilitate programme implementation, the Occupational and Environmental Health Unit (OEHU) will lead in the formulation of technical guidelines and in monitoring and evaluation.

11.2 Teaching Hospitals, CHAG, Private Health Institutions, MOH Subvented Organizations

Responsibility for implementation rests with heads of these institutions (i.e. Chief Executives/ Directors of teaching hospitals, CHAG institutions, and Private Health facilities)

The unit within the Ministry of Health responsible for the private sector will in collaboration with the OEHU provide guidelines on an on-going basis to the sub-sector. Implementation reports shall be prepared and sent regularly from the institutions, to the private sector unit, yearly as a minimum. These will be reviewed in collaboration with the OEHU and appropriate advice given.

11.3 Ghana Health Service (GHS)

Within the GHS, the overall responsibility for the workplace programme lies with the Director-General. He /she is to ensure implementation at all levels of the public health system by ensuring that;

- appropriate administrative structures are in place
- roles are assigned to appropriate persons at various levels within the existing organizational structure
- resources are made available for implementation
- there is active monitoring from headquarters, regions and districts with supervisory visits being conducted at each level of the health care system.

11.3.1 National Level

At the national level, various divisions have important OHS components under their ambit. Important in this regard are the Human Resources Division, Institutional Care, Health Administration and Support Services as well as the Public Health Division of the GHS. OHS services shall be managed by the Human Resources Division of the GHS. With support from Institutional Care and Public Health Directorates, the Human Resource Directorate will lead in planning and be responsible for the implementation of programmes. Technical guidelines will be provided by the Occupational and Environmental Health Unit. Each department will however ensure that that the needs of their staff are adequately addressed.

Supervision and on-going monitoring will be jointly carried out by the Occupational and Environmental Health Unit in collaboration with individual programmes as appropriate. This unit will be responsible for providing technical expertise, monitoring and evaluation, as well as advocacy for the OHS function within the health sector. In view of the importance of OHS in safeguarding the scarce human resource and facilitating productivity as well as its broad scope and cross-cutting nature, this policy proposes for the medium term, the creation of an Occupational and Environmental Health Directorate **(**also covering issues of the general environment) under the GHS to be responsible not only for staff needs but also for facilitating the rendering of OHS services to clients/patients of the service.

11.3.2 Regional Level

The administration of OHS at the regional level will be handled by a Regional Co-ordinator /Focal Person for Occupational Health and Safety who shall be at the level of a deputy regional director. His/her role will be in formulating operational plans, supervision, monitoring and evaluation. He /she will co-ordinate activities at the regional and district levels. Returns from the districts (submitted by district focal persons) will be collated by him/her. The regional focal person for OHS will report to the RDHS.

At the facility (regional hospital) level, an Occupational Health and Safety unit will be established. This will be operated by at least three persons. One of these three, should be a senior health officer preferably a medical practitioner who shall head the unit. He/she will be assisted by a minimum of one nurse and a biostatistician. Until there are specialists and adequately trained staff (e.g. occupational health nurses and physicians, hygienists etc in adequate numbers) to man the unit full time, at least one day a week will be devoted to planning, monitoring and evaluation and other supervisory functions. The clinical care services and relevant preventive services will run daily. There should be institutional arrangements to remunerate the staff. The team will report through the medical superintendent to the RDHS with the Regional Focal Person facilitating these activities. The regional focal person will assist the OHS units where appropriate and facilitate the smooth running of their activities, including organizing in-service training programmes for health and safety committees and staff, conducting risk assessment, planning and execution of internal and external audits.

The ILO advocates the formation of Health and Safety Committees (HSC) by organizations to facilitate the inclusion of both management and employees in issues affecting Health and safety. In the health sector, a central HSC will be best placed at institutional level ie at health facility or RHMT/ DHMT level. Further, departments / units should also have their individual HSC from which representatives are nominated to serve on the central committee at (RHMT/DHMT). These representatives will serve as a mouth piece to promote safe work and working environments for their respective departments/unit.

11.3.3 District Level

The administration of OHS will be handled by a District Focal Person for OHS. S/he will be responsible for planning and execution of programmes at the district. Activities will include sensitization, organizing in-service training for staff, collection, analysis and use of occupational health data. The focal person will report to the District Director of Health Services (DDHS).

At the facility (District Hospital) level, the OHS function will be performed by the Occupational Health and Safety team made up of at least 2 members to be led by a senior public health officer. Until there are enough staff to man the unit full time, at least one day a week will be devoted to planning, monitoring and evaluation and supervisory functions. The clinical care services and relevant preventive services eg medical surveillance will run daily. The team will report to the DDHS via the district focal person who collates all reports from the sub-districts and the district health facilities. As at the Regional level, health and safety representatives should be nominated at departmental level within the health facilities to serve on a central Health and Safety Committee at their respective facilities. Each department / unit will in turn form its own HSC.

11.3.4 Sub-district Level

There will be a health and safety committee (HSC) chaired by the medical assistant in charge of the sub-district facility, who will have overall responsibility for the health and safety of worker within his/her jurisdiction. S/he will collect data which will be collated and analysed and then transmitted to the DDHS. On a day to day basis, the responsibility for monitoring of this data will be delegated to the OHS District Focal Person.

Annex 1 Hazards in Health Care Work Environment

Health Care Work is associated with numerous hazards both in the clinical care setting as well as in administration of various support services. The hazards are varied and may be classified according to the following major categories:

- **Biological Hazards:**

Examples of these are infections of varying aetiologies e.g. those caused by micro-organisms such as Viruses (HIV, Hepatitis B, C and D) bacteria like mycobacterium tuberculosis and typhoid, parasites e.g. intestinal helminths, and fungal causes.
Other biological hazards include rodents and insects.
The effects of common biological hazards are infections, parasitic infestations, and insect stings etc.

- **Physical Hazards:**

They include extremes of temperature, (cold/heat), poor lighting affecting vision, poor ventilation, radiation, faulty electrical wiring and other faults with the risk of electric shocks, noise, vibrations and explosions from pressurized containers. These hazards if not adequately controlled predispose staff to a deterioration of vision, radiation-induced malignancies, noise-induced hearing loss and injuries.

- **Mechanical Hazards:**

These include situations resulting in slips, trips and falls such as wet floors, slippery finish to floors, poor handling of needles and other sharps resulting in needle stick and sharps injuries.

- **Ergonomic Hazards:**

These include manual lifting and other patient handling procedures, poor work posture, repetitive or monotonous work and standing for prolonged periods. These predispose workers to musculoskeletal injuries often affecting the back.

- **Chemical Hazards:**

It includes cleaning detergents, reagents (used in laboratory and other areas) anaesthetic gases, and drugs. These have the potential for causing contact dermatitis, allergies, colds and other ailments like asthma.

- **Psychosocial Hazards:**

Some important hazards in this category include stress, excessive workload, verbal and physical harassment, work organization lapses such as poor work arrangements and procedures, and poor interpersonal relationships. There is often interplay between these hazards and lifestyle such as wrong diets, poor timing of meals, and lack of physical activity. The long-term effects of some of these hazards include psychological disorders including drug abuse, alcoholism leading to neurosis and psychotic illness. Obesity combined with some of these factors cause an upsurge in the degenerative diseases like hypertension and heart disease.

ANNEX 2 Steps in Risk Assessment

5 Steps to assess the risk in your workplace

Table 1 illustrates 5 steps to be taken in assessing risk in the workplace. It is necessary to seek the professional advice of Occupational Safety and Health practitioners in carrying out the assessment whenever in doubt and in situations where job design may have to be modified.

Table 1: Steps in Assessing Risks in the Workplace.

Step	Action
I:	Look for the hazards
II:	Decide who might be harmed and how
III:	Evaluate the risks and decide whether the existing precautions are adequate or whether more should be done
IV:	Apply control measures
V:	Record your findings
VI:	Review your assessment and revise it if necessary

Step I: Look for the Hazards:

If you are doing the assessment yourself, walk around your workplace and look afresh at what could reasonably be expected to cause harm. Ignore the trivial and concentrate on significant hazards which could result in serious harm or affect several people. Obtain the input of your employees or their representatives. They may have noticed things which are not immediately obvious. Manufacturers' instructions or data sheets can also help you identify hazards and put risks in their true perspective. So can accident and ill-health records. A summary of common hazards in the health workplace environment are provided in Annex 1 Please refer to this and other relevant policies and guidelines such as the MOH Workplace HIV/AIDS Policy and Health Care Waste Management Policy and Technical Guidelines for more information.

Step II: Decide who might be harmed, and how

In deciding who might be harmed the following categories of persons should be considered in addition to all workers:

- Young workers, trainees, new and expectant mothers, etc, who may be at particular risk
- Cleaners, visitors, contractors, maintenance workers, etc who may not be in the workplace all the time
- Members of the public, or people you share your workplace with, if there is a chance they could be hurt by your activities.

Step III: Evaluate the risks

The goal of this step is to decide whether the existing precautions are adequate or more should be done. Consider how likely it is that each hazard could cause harm. This will determine whether or not you need to do more to reduce the risk. Even after all precautions have been taken, some risks usually remain. What you have to decide for each significant hazard is whether this remaining risk is high, medium or low. Because the law also says that you must do what is reasonably practicable to keep your workplace safe, your real aim is to make all risks 'as small as possible' by adding to your precautions as necessary. If you find that something needs to be done, draw up an 'action list' and give priority to any remaining risks which are high and/or those which could affect most people. Appropriate control measures should be instituted commensurate with the level of risk.

Step IV: Apply Control Measures

In taking action, ask yourself:

a) Can I get rid of the hazard altogether?

b) If not, how can I control the risks so that harm is unlikely?

Apply the principles below in the order in which they are listed, if possible:

- Try a less risky option
- Prevent / limit access to the hazard (e.g. to isolation ward, radiation exposed areas, by guarding of beds with side rails etc)
- Organize work to reduce exposure to the hazard
- Issue and ensure the use of personal protective equipment
- Provide welfare facilities (e.g. washing facilities for removal of contamination and first aid)

Caution – It is important to ensure that the control recommended / instituted does not pose another hazard

Step V: Record your findings

It is important and useful to keep a written record of what you have done i.e. you must record the significant findings of your assessment. This means writing down the significant hazards and conclusions e.g., blood spillages on floor, or 'side rails (guarding) absent from side of bed' 'electrical installations: insulation and earthing checked and found sound'. You must also tell your employees about your findings.

Risk assessments must be suitable and sufficient, not perfect! You need to be able to show that, you:

- conducted a proper check
- enquired about who might be affected
- dealt with all the obvious significant hazards, taking into account the number of people who could be involved; and that
- the precautions are reasonable, and
- the remaining risk is low.

Keep the written record for future reference or use; it can help you if an inspector asks what precautions you have taken, or if you become involved in any action for civil liability. It can also remind you to keep an eye on particular hazards and precautions. And it helps to show that you have done what the law requires.

Step VI: Conduct periodic review

Periodically review your assessment so that you can take care of any factors that might have changed. This will enable you to ensure that the precautions you had taken remain relevant.

All subsequent reviews should follow steps I to IV stated above and should be duly recorded for the stated reasons.

ANNEX 3 Vaccination for Blood – Borne Pathogens

The common blood –borne pathogens for which some vaccinations are available are the blood-borne viruses: Hepatitis B and HIV.

1.1 Hepatitis B (and C)

Transmission of Hepatitis B Virus (HBV) (and Hepatitis C Virus (HCV)) in the workplace occurs in the following ways:

- Accidental exposure to blood (AEB): Any contact with blood or body fluids as a result or injury with a needle that is contaminated with blood or blood products (needlestick injury) or any other sharp instruments, or via mucous membrane (eye, mouth), or contact via damaged skin (eczema, wounds).
- Percutaneous exposure (PE): exposure to blood or body fluids through non-intact skin.
- Blood splash: Skin visibly contaminated with blood or body fluids.
- Exposure of intact normal skin to a large volume of blood.
- Human bites.

Preventing transmission of HBV in the workplace implies complying with standard precautions and having in place procedures for pre and post exposure prophylaxis for Hepatitis B for which vaccination is available. Indications for hepatitis B vaccination include pre-exposure and post-exposure cases.

1.2 Procedure for Pre-exposure Prophylaxis for Hepatitis B

Pre-exposure prophylaxis is advised for health workers exposed to blood and blood products.

Immunization regime: The vaccination is indicated at 0, 1 and 6 months.

Site of administration: Intramuscularly in the deltoid region or the anterolateral aspect of the thigh and not in the gluteal region as it may reduce the efficacy of the vaccine.

Dosage: **Engerix B** 20 micg or
Recombivax-HB 20 micg
Heppacine-B (plasma derived): 1 ml

They are each administered at the stated 0, 1 month and 6 month intervals.

Where testing facilities are available, testing should be done for Hepatitis ‘B surface antigen and Hepatitis B antibody prior to initiating administration of the vaccine.

If the antibody titer level is low or negative, Hepatitis B immunization can proceed.

1.3 Procedure for Post-Hepatitis B Exposure Prophylaxis

Health personnel exposed to blood or body fluids by needle stick, cuts or bites should do the following:

- Wash the area thoroughly with soap and water.
- The worker should be tested for Hepatitis ‘B surface antigen and Hepatitis B antibody.

- If the antibody titer level is low or negative give booster does of Hepatitis B immunization.
- For unvaccinated persons (unlikely to have had previous exposure to HBV) sustaining exposure to HBV, HBIG should be administered for immediate action.
- Repeat tests after 1 month and then 6 months after the first test.
- If the titer is still low, repeat the Hepatitis B immunization after a 3rd dose should not be assigned to high risk areas (e.g. area where blood specimens are handled, fevers units, obstetric and gynaecological units. etc)

1.4 Treatment for HBV Infection

Treatment for HBV is available and several methods exist A few are listed here for easy reference.

- Tab Lamivudine 150 mg twice daily or 300 mg daily
- Tab Tenofovir 300 mg daily
- Interferon alfa 5 MU daily or 10 MU 3 times a week

CAUTION: Treatment for Hepatitis is complicated and must be initiated by a physician specialist. Treatment must be monitored by laboratory investigations.

1.5 Post-Exposure Prophylaxis for HIV

Preventing transmission of HIV in the workplace means complying with standard precautions, and providing post exposure prophylaxis after high-risk exposure to HIV.

In the event of possible exposure to HIV the following steps should be taken immediately:

- The wound site must be cleaned with soap and water or in case of mucous membranes, flushed with water.
- If therapy is necessary, it should be initiated promptly, preferably, 1-2 hours post exposure
- Report the incident immediately to the supervisor.

Post exposure prophylaxis reduces the likelihood of HIV infection after high-risk exposure. PEP may either prevent the establishment of infection or prevent new infection while allowing clearance of already infected cells PEP is particularly effective within 1-2 hours of exposure and not more than 72 hours after exposure.

Assessment of exposure to risk:

Exposure to HIV can be classified into three stages.

Very low risk is the splash of body fluid on intact skin.

Low risk exposures are:

- Exposure to small volume of blood or body fluid from asymptomatic HIV positive patient with low viral load.
- An injury with a soiled needle

- Any superficial injury or mucocutaneous exposure.

High-risk exposure is:

- Exposure to large volume of blood or potentially infectious fluid.
- Exposure to blood or blood contaminated fluid from a patient with a high viral titer (i.e. In the AIDS phase or early seroconversion phase of HIV)
- Injury with soiled hollow bore needle.

Prophylaxis in event of exposure

In the event of possible exposure to HIV the following actions should be taken

Very low risk - wash exposed/wound area immediately with soap and water. In the case of mucous membranes, exposed area should be flushed with water. Eyes should be flushed with water or saline.

Low risk - give Lamivudine 150mg 12 hourly x 28 days and Zidovudine 200mg (Combivir) 8 hourly x 28 days.

High risk
- give
- Lamivudine 150mg 12 hourly x 28 days
- Zidovudine 200mg 8 hourly x 28 days
- Lopinavir 400mg/100mg 12hrly x 28 days

Recommended laboratory investigations after HIV exposure

Baseline tests:
- Full blood count
- Liver and renal function tests.
- HIV serology and Polymerase Chain Reaction (PCR)

Two weeks:
- Full blood count
- Liver and renal function tests.

Six weeks - HIV serology

Three months - HIV serology

Six months - HIV serology

All exposed persons should receive counselling from trained counsellors throughout the period and thereafter if necessary. (For more details refer to guidelines for antiretroviral therapy in Ghana, June 2008)

ANNEX 4 Health and Safety Committee

To facilitate consultation and stimulate awareness in employee health and safety the formation of health and safety committee at the facility level is recommended.

Health and safety committee is made up of worker and employer (management) representatives working together to identify and resolve health and safety problems in the work place. To be successful, the committee must operate in an atmosphere of cooperation and be effective in promoting and monitoring a sound occupational health and safety program. While the employer and its representative (management of health facility /institution) is responsible for the overall health and safety program, the committee is responsible for identifying and recommending solutions to problems. The individual worker has a responsibility to refer problems to the supervisor or employer. However if the problem is not corrected a committee member should be contacted.

Functions of the Health and Safety Committee:

The functions of the committee include:

- Helping develop and distribute polices, practices and procedures that promote health and safety
- To act as problem solving group and help with the identification, assessment and control of hazards in the workplace.
- Help resolve health and safety issues in the workplace
- Assist in planning of action including the setting of priorities for controlling hazards
- Review management of injured workers and their rehabilitation programs.
- Assist in the employment of workers with disabilities
- Investigate work refusals and serious accidents

Selection of Health and Safety committee members

The committee should be made up of equal/equitable representatives of management and workers or sector representations. Since the committee itself does not have the authority to act on its own recommendations it vital that management representatives have sufficient authority to act upon any matters agreed upon at a meeting. The chairperson should be the CEO or management representative who has the authority to implement decisions of the committee, while the secretary should preferably be a workers' representative.

Worker representatives must be chosen by and represent all workers. They should be chosen to effectively represent all workers on all shifts and departments.

Size of the committee

The following factors will be considered when deciding the size of the committee:

- Degree of hazard in the work place,
- Number of employees,
- Number of departments
- Number of places of employment,

- Number of union or worker groups,
- Number of shifts. There is a need to represent different shifts.

The committee needs to be able to handle the needs of the organization and diversity of work. As a general guide, the committee should be large enough so that the health and safety concerns of the entire workplace is represented for example a health facility with doctors, nurses, laboratory workers, pharmacy workers, drivers, security and kitchen staff should have each of these areas represented on the committee.

When is a Health and Safety committee necessary?

Health and Safety committee is strongly recommended for any health facility with 20 or more employees. The head of the health facility / institution shall be responsible for establishing a health and safety committee when the above condition is met. This means causing the members to be chosen and setting aside a time and place for meetings.

Mode of Operation

There are only a few rules on how the H&S committee should operate. Thus the committee is free to decide its own procedures. These rules include:

- The committee must meet at least once every three months
- It must be co-chaired by two members, one of them representing workers and the other management
- Members are entitled to at least one hour of paid preparation time before each meeting or more if the committee decides, depending on the issues under consideration.
- Members are also paid for time spent at meetings and for carrying out certain other committee duties. In other words, work of the committee should be regarded as part of their routine tasks.
- The committee must keep a record of minutes of the meetings These minutes should be made available upon request by authorized inspector

ANNEX 5 Medical Surveillance Format

MINISTRY OF HEALTH / GHANA HEALTH SERVICE

MEDICAL EXAMINATION FORM

HEALTH INSTITUTION……

1. HEALTH QUESTIONNAIRE

REASON FOR ASSESSMENT: Pre-placement [ ] Routine/Periodic [ ]
Special [ ] Transfers [ ] Follow Up [ ]

Details of Post Applied for (where applicable)

……

…….

JOB TITLE

……

FULL NAME (Surname First)……

MR / MRS / MISS / TITLE: ……

SEX: Male [ ] Female [ ] AGE ……

Date of Birth

…….

Home Address

…….

Telephone Number ……

Next of Kin / Contact Person in case of emergency

…….

Address ……

……

Telephone Number……

OCCUPATIONAL HISTORY FORM

(To be filled at Pre-placement & for Departmental Transfers)
Please fill in the table below, listing all the jobs at which you have worked for more than six months. Start with your present job and go back to the first. Use additional paper if necessary.

Client / Patient's Name…….

Workplace (Employer's name and address)	Dates Worked From	Dates Worked To	Describe Job Duties	Known Health Hazards in workplace (dusts, solvents, etc)	Protective equipment used?	Were you ever off work for a health problem or injury? Explain

MEDICAL HISTORY FORM

PLEASE ANSWER 'YES' OR 'NO' TO ALL OF THE FOLLOWING QUESTIONS AND IF YES' GIVE DETAILS IN THE SPACE PROVIDED.

		YES	NO	DETAILS
1	Are you receiving treatment of any kind at the moment?			
2	Are you waiting for any treatment or investigation?			
3	Have you been seen or examined by a doctor in the last 6 months?			
4	Do you have any defect of sight?			
5	If yes is this corrected with glasses?			
6	Do you have any defect of hearing?			
7	If yes is this corrected with a hearing			

	aid?			
8	Do you have any physical limitation which may affect your ability to work?			
9	Have you ever had any kind of back problem leading to time off work?			
10	Have you ever had any kind of problems with your joints including pain, swelling or restricted movements?			
11	Do you have any difficulty in standing, bending, lifting or other movements?			
12	Have you ever had any skin problem?			
13	Have you ever been diagnosed with diabetes or had problems of the thyroid and prostate?			
14	Do you suffer from asthma, bronchitis or other chest problems?			
15	Have you ever suffered from Tuberculosis (TB)?			
16	Have you ever had a cough for more than 3 weeks in the last 12 months?			
17	Have you ever coughed up blood?			
18	Have you had any unexplained loss of weight or fever in the last 12 months?			
19	Is your weight steady?			
20	Have you experienced tingling sensations or numbness in your fingers?			
21	Do you have any urinary problems?			
22	Has any member of your family suffered from TB?			
23	Have you ever suffered from dizzy spells, blackouts, fits or epilepsy?			
24	Have you ever suffered from any form of mental, psychological or emotional illness?			
25	Have you ever sought help for mental, psychological or emotional problems?			
26	Have you ever had a drug or alcohol problem?			
27	Do you have any allergies?			
28	Have you ever had hepatitis or jaundice?			
29	Have you ever received treatment for or been diagnosed with any gastric or bowel (intestinal) problem?			
30	Have you ever had heart, circulation or blood pressure problems?			
31	Do you have any problem that affects your ability to drive?			
32	Do you have any other health problem?			

33	Do you smoke? If so how many sticks of cigarette do you smoke per week?			
34	Do you drink alcohol? If so how much per week?			
35	Have you been having medical check ups? If so, when did you have the last one?			
36	For women - have you had a breast examination? When was the most recent?			
37	Have you ever had a pap-smear examination? If yes, when was the most recent one?			
38	For men – have you had a PSA test done? If yes, when was the most recent one?			

If you responded yes to any of the above, please provide additional details (if any)
……
……

Past immunizations:
Please indicate past immunizations administered with dates.

Hepatitis A Yes ( ) No ( ) Date(s)…….

Hepatitis B Yes ( ) No ( ) Date(s)…….

Yellow Fever Yes ( ) No ( ) Date(s)…….

Tetanus Yes ( ) No ( ) Date(s)…….

……...

Declaration:
I declare that all of the above statements and information are true to the best of my knowledge.

Signed …… Date
……

II. CLINICAL EXAMINATION

General:

Body Mass Index (BMI)
(Weight in kilograms/height in m^2)…….

BP……

	Yes	No	Comments
Overall appearance healthy?	( )	( )	…….
Consistent with age?	( )	( )	…….
Females – is breast examination normal?	( )	( )	…….
Satisfactory teeth and gums?	( )	( )	…….
Any deformities?	( )	( )	…….
Enlarged lymph nodes?	( )	( )	…….
Enlarged thyroid gland?	( )	( )	…….
Any other significant findings?	( )	( )	…….

……

Cardiovascular System

Is pulse regular and steady?	( )	( )	…….
Is blood pressure normal for age?	( )	( )	…….
Are the heart sounds normal?	( )	( )	…….
Are there any varicose veins?	( )	( )	…….
Is there clinical evidence of oedema?	( )	( )	…….
Any other significant findings?	( )	( )	…….

……

Respiratory System

Is chest appearance normal?	( )	( )	…….
Are breath sounds normal?	( )	( )	…….
Is percussion normal?	( )	( )	…….
Any added sounds on auscultation?	( )	( )	…….

……

Gastrointestinal system:

Is tongue of normal appearance?	( )	( )	…….
Is abdomen soft?	( )	( )	…….

Are there any abnormal signs on abdominal examination?	( )	( )	…….
Are there any signs of hernia	( )	( )	…….
Are there any other significant findings?	( )	( )	…….

……

Skeletal System:

Is physique satisfactory?	( )	( )	…….
Is examination of the back normal?	( )	( )	…….
Is there any restriction of straight leg raising?	( )	( )	…….
Is there any restriction of neck movements?	( )	( )	…….
Is there any abnormality of the limbs? Any other significant findings?	( )	( )	…….

……

Nervous System:

Are reflexes normal?	( )	( )	…….
Do pupils react normally to light?	( )	( )	…….
Are the fundi normal?	( )	( )	…….
Are the cranial nerves intact?	( )	( )	…….
Are there any tremors?	( )	( )	…….
Any other significant findings?	( )	( )	…….

……..

Skin:

Is the appearance of the skin normal?	( )	( )	…….
Are there any skin lesions?	( )	( )	…….
Any other abnormal findings?	( )	( )	…….

……

Mental state?

Does the psyche seem normal?	( )	( )	…….
Is there any undue agitation?	( )	( )	…….
Is the patient co-operative?	( )	( )	…….
Any other abnormal findings?	( )	( )	…….

……

ECG: ( ) ( ) …….

Results satisfactory ( ) ( ) …….

Refer..…….

……

Special tests (based on work area and exposures)

Lung Function Test: (for work in dusty areas)

Peak flow Yes ( ) No ( ) ……. Litres/min

Spirometry Yes ( ) No ( ) FEVI/FVC…….

Normal ( ) Obstructive ( ) Restrictive ( ) Combined ( )

Vision:

Vision Screened Yes ( ) No ( ) Results……

Intra-ocular pressure Yes ( ) No ( ) Results……

Referral to optician/opthal Yes ( ) No ( ) Results……

……..

Audiometry: (noisy work areas)

Comments

Audiometry done Yes ( ) No ( ) ……

Hearing loss Right ear Yes ( ) No ( ) ……

Left ear Yes ( ) No ( ) ……

……

Current Immunizations:

Please indicate current immunizations administered with dates.

Hepatitis A Yes ( ) No ( ) Date(s)…….

Hepatitis B Yes ( ) No ( ) Date(s)…….

Yellow Fever Yes ( ) No ( ) Date(s)…….

Tetanus Yes ( ) No ( ) Date(s)…….

Other Date(s)……

……

III. RESULTS OF LABORATORY INVESTIGATIONS

Name :	Sex: F ( ) M ( ) Age:
Institution/Establishment:	Clinician:
Reason for Exam: Pre-employ ( ) Periodic ( ) Exit ( )	Sample Date:

TEST	RESULTS	REFERENCE RANGE
Haemoglobin*	g/dl	(m) 13.-18 (f) 11.6
Total WBC Count*	$x10^9$ /mm	2.5 -8.5
(ESR)	m/hr	(m) 3-5, (f) 4-7
Sickling (one –off)	Pos. ( ) Neg. ( )	Negative
G6PD (one –off)		Normal
Urine R/E		Neg. for protein, glucose, ketones, leucocytes and blood. PH – 4.8 – 8, Deposit
Stool R/E		Negative
Stool Occult Blood*		Negative
Glucose (FBS) (RBS)*	mmol/l	3.6 -6.4
Uric Acid	mmol/l	120 -420
Gamma GT	U/L	3 – 50
Total Serum Protein	g/l	60 – 86
Albumin	g/l	36- 52
Total Cholesterol	mmol/l	3.1 – 6.5
HDL – Cholesterol*	mmol/l	1.06 – 1.94
LDL – Cholesterol *	mmol/l	<3.88
PSA*		
Pap Smear*		
Stool C/S (for catering staff)		

Date…… **Signature……**

Technologist/Technician

*Highly essential.

IV. OVERALL ASSESSMENT:

……

FIT ( ) UNFIT ( ) ADVISED TO SEE SPECIALIST ( )

Comments

……..

……

Name of Doctor……..Date…….....

……

LIST OF HEALTH EDUCATION INFORMATION AND LEAFLETS GIVEN:

……

……

……

Given by……..Signature……

<u>Administration of Tests:</u>

Pre-placement: All investigations and Chest x-ray. Special tests if previous job(s) or current job placement warrant it. Pap smear and PSA if above 40 years

Periodic:
i. Staff under 40 years: As for preplacement (excluding CXR). All tests as above at 2-3 year intervals.

ii. Staff over 40 years: All tests as above (excluding chest x-ray) including pap smear and mammography for women and PSA for men

iii. **Catering Staff:** As for periodic exams and in addition, Stool R/E, Stool C/S and Urine R/E two times a year

iv. **Drivers:** As for periodic examinations and in addition, Eye screening at least once yearly.

ANNEX 6 Accident Reporting and Investigation Form

MINISTRY OF HEALTH/GHANA HEALTH SERVICE

ACCIDENT REPORTING AND INVESTIGATION FORM

1. Name of facility…….
2. Address ……
3. Tel No (s)……
4. Physical location…….
5. Name of Head of Facility……
6. Name of injured person ……
7. Sex: ☐ Male ☐ Female Age……. Occupation……
8. Length of service……..
9. Date of accident / incident…… Time……
10. Work being done by injured person at time of accident (e.g. lifting patient, dressing bed etc) ……..……

……..

11. Full details of how the accident or dangerous occurrence happened. State circumstances and describe what injured worker was doing at time of accident as well as any actions leading to accident. (e.g. if a fall, state height of fall).
    ……

    ……

    ……

    ……

    ……
12. If injury was due to machinery state name and machinery part causing injury

    ……
13. Was machinery in motion by the use of mechanical power at time of accident ?

    ☐ YES ☐ NO

14. Consequences of the accident

Type of injury		Part of body injured	
☐ Contusion, bruise	☐ Asphyxiation	☐ Head except eyes	☐ Hand
☐ Concussion & internal injuries	☐ Poisoning	☐ Eyes	☐ Finger
☐ Open wound	☐ Heat injury	☐ Neck	☐ Hip joint, thigh, knee cap
☐ Amputation	☐ Chemical burns	☐ Back, spine	☐ Knee joint, lower leg
☐ Open fracture	☐ Radiation effect	☐ Chest	☐ Foot
☐ Closed fracture	☐ Electric shock	☐ Abdomen	☐ Toes
☐ Dislocation	☐ Other …….	☐ Shoulder, upper arm, elbow	☐ Large parts of the body
☐ Sprain, torn ligaments	……	Lower arm, wrist	☐ Other injury

15a. Nature and extent of injury (e.g. fracture of leg, laceration of arm, scalded foot, Scratch on hand followed by sepsis)……

b. Whether fatal or non-fatal……

☐ If not fatal was injured person disabled for more than three days from earning full wages at the work at which he was employed? YES ☐ NO ☐

c. If Yes, indicate :

☐ Absence less than one day;

☐ Absence 1-3 days; ☐ Absence 4-14 days; ☐ Absence expected to exceed 14 days; ☐ Permanent disability

16. What was the nature of the work environment at time of accident (e.g. wet floor, hot work environment, noisy environment preventing hearing of safety signal, etc)

……

……

17. State information from injured person (Use additional paper where necessary)

……

……

……

……

18. What information was given by witnesses interviewed (Use additional paper where necessary)

Witness 1……

……

……

……

……

Witness 2……

……

……

……

……

Witness 3……

……

……

……

……

19. ACCIDENT CAUSES

(i) What is/were the immediate cause(s) of accident ….…….

……

……

……....

(ii) What is/were the underlying (remote) cause(s) of accident?

……

……

……

……

Signature of Investigator /

Chairman of Investigating Committee

……..20…

ANNEX 7 Reporting Requirements for Occupational Health and Safety Services

MINISTRY OF HEALTH , GHANA HEALTH SERVICE
MONTHLY RETURNS ON OCCUPATIONAL HEALTH & SAFETY SERVICES

Health Facility/ Service Centre ……

Reporting period (Month/Year)…….Staff Strength……

Sex: Males…… Females……

1. INCIDENTS AND ACCIDENTS

Number of incidents/ accidents reported……...

Total number of injuries reported……..

Sex of injured persons: Males…. Females……..

SEVERITY OF INJURY

	NATURE OF INJURY (STATE NO. ACCORDING TO SEVERITY)			
BODY PART INJURED/ AFFECTED	MILD	MODERATE	SEVERE	FATAL?
Head				
Eyes				
Neck				
Back/ spine				
Chest				
Abdomen				
Shoulder, upper arm, elbow				
Lower arm, wrist				

Hand				
Finger				
Hip joint, thigh, knee cap				
Knee joint, lower leg				
Foot				
Toes				
Large parts of the body (trunk, abdomen)				
Other injury				

Absence from work as a result of injury:

Number of cases resulting in absence from work:
a. Less than 1 day….. b. 1-3 days absence……
c. 4 – 14 days absence…… d. absence expected to exceed 14 days……. e. permanent disability …….

2. CONDITIONS OF ILL-HEALTH

No. of reports of ill-health……

No. of work-related reports……

Sex : Male…… Female……

Provide classification of ill-health below:

WORK RELATED CONDITIONS	NUMBER OF CASES
Musculo-Skeletal disorders	
Eye disorders	
Irritant or allergic dermatitis	
Blood-borne virus infection	
Chronic chest disorder	
Noise induced hearing loss	
Occupational asthma	
Occupational cancer	
Work related (parasitic) infestation	
Stress related illness (psychosomatic illness , depression, etc.)	

Sickness absence due to ill-health:

Number of cases resulting in absence from work:
a. Less than 1 day….. b. 1-3 days absence……
c. 4 – 14 days absence…… d. absence expected to exceed 14 days……. e. permanent disability …….
f. No resulting in deaths…….

3. MEDICAL SURVEILLANCE

Total No. of staff screened:…….. Males …….. Females……

Type of examinations: Pre-placement…….. Periodic…….

Post-sickness- absence…… Other special……. …. Exit…….

4. IMMUNIZATIONS

Indicate immunizations administered to staff during reporting period

Immunization for	No of recipients
Hepatitis B (Pre-exposure)	
Hepatitis B (Post-exposure)	
HIV (Post-exposure)	
Tetanus	
Yellow fever	
Other	

5. RISK ASSESSMENT

Number of risk assessments undertaken……

List areas assessed
(i)
(ii)
(iii)
(iv)
(v)

Action taken on recommendations made? Yes ☐ No ☐

If yes, indicate extent of actions taken:
Action taken on (i) all recommendations ☐
(ii) ½ to ¾ of recommendations ☐
(iii) Less than ½ of recommendations ☐

Copy to be forwarded by 2nd week of ensuing month through the RDHS to the Occupational and Environmental Health Unit, Ghana Health Service.
Email: ochealth@ghana.com