

THE UNITED REPUBLIC OF TANZANIA



**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND
CHILDREN**

**NATIONAL GUIDELINES FOR WORKERS HEALTH AND SAFETY IN HEALTH CARE
FACILITIES AND EMERGENCY RESPONDERS**

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Foreword

Tanzania is aiming to achieve universal access to improved health services for its population. The combined efforts are recorded through the implementation of the Health Policy, Health Sector Strategic Plan IV, Sustainable Development Goals, the country five year development plan and the National Strategic Plan on workers health of 2017 – 2021. Despite these Government initiatives in improving health services, it is evident that health workers are on daily basis at risk of workplace hazards that pose a serious threat to their health and well being.

In the health sector, health workers have a two-fold risk of contracting infectious diseases, for example, during service provision and behavioural risk when in community, and a risk of being exposed to various hazards, for example occupational injuries, psychosocial and social. Taking into consideration, the country critical shortage of human resources for health, the current emerging and re-emerging of highly infectious diseases such as, viral hemorrhagic fevers, SARS, H1N1 Influenza and Ebola outbreak occurring in the region, pose a threat dramatically to health workforce and emergence responders. The importance of health service delivery for the population and their contribution to the country economy, production and the movement towards middle class economy necessitate the development of these guidelines.

These guidelines aim to institutionalize the necessary implementation procedures, practices and tools for promoting workplace improvement in health care facilities, prevention and control of hazards, screening, earlier detection, treatment, and continuum of care for work related illness, injuries and workers' benefits. These guidelines apply to all health workplaces and workers in the health system, both public and private. These guidelines are inline with the National Health Policy; Health Sector Strategic Plan IV; HIV policy (2001); Public Health Act, 2009, HIV and AIDS (Prevention and Control) Act, 2008; and WHO Global plan of Action on workers health, ILO recommendation on workers health and safety and Sustainable Development Goals.

It is my expectation that, these guidelines will be given a required attention and special emphasis for workers health including health for emergence responders and will be used by all implementers both private and public health facilities for the prevention and control of work hazards to promote health and safety of health workforce.


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Definitions of terms

Accident; An unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury.

Employee; Any person who is employed or works for an employer and who receives or entitled to receive any remuneration.

Ergonomics; The study of humans in relation to their work and working surroundings, this broad science involves the application of physiological as well as psychological principles to the design of buildings, machinery, vehicles, packaging and anything else with which people come into contact.

Hazard; An inherent property of a substance, agent, source of energy or situation having the potential of causing undesirable consequences

Incident; The occurrence of an event that interrupts the completion of an activity, It may be a minor event or result in a crisis such as an accident.

Non-clinical staff; Workers in the health facility who are not involved in the treatment or direct care of patients.

Occupational Accident; Accidents, regardless of their cause, sustained during working hours at or near the place of work or accidents sustained within reasonable periods before and after working hours in connection with transporting, cleaning, preparing, securing, conserving, storing and packing work tools or clothes; accident's sustained while on the direct way between the place of work and: The employee's principal or secondary residence; or The place where the employee usually takes his meals; or The place where he usually receives his remuneration.

Occupational Disease; Any disease or disorder that occurs as a result of work or working conditions.

Occupational health; is considered to be multidisciplinary activity aiming at: (1) protection and promotion of the health of workers by preventing and controlling occupational diseases and accidents and by eliminating occupational factors and conditions hazardous to health and safety at work development and promotion of healthy and safe work, work environments and work organizations; (2) enhancement of physical, mental and social well-being of workers and support for the development and maintenance of their working capacity, as well as professional and social development at work; and (3) enablement of workers to conduct socially and economically productive

lives and to contribute positively to sustainable development. ((WHO, Global Strategy on Occupational Health for All, 1996).

Risk; The probability that damage to life, health, and/or the environment will occur as a result of a given hazard

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 assessment.

Safety; The condition of being protected from or unlikely to cause danger, risk or injury

Safety culture; The ways in which safety is managed in the workplace, and often reflects "the attitudes, beliefs, perceptions and values that employees share in relation to safety.

Worker; A person who is engaged in a legal activity for income, whether or not under an employment contract

Post Exposure Prophylaxis (PEP) is the immediate provision of preventive measures and medication following an exposure to potentially infected blood or other body fluids in order to minimize the risk of acquiring infection.

Health facilities: According to these guideline health facilities means all workplaces and all workers in the health system, both public and private. (Include different levels of hospitals, specialised health service such diagnostic services, health centres, Dispensary, outreach services, health post, public health emergency responding and any other related health care services).

OHS focal person: is a designated person to carry out the role and responsibility on health and safety in the health facility for the wellbeing of health workers and is trained on basic occupational health and safety.

Abbreviation

BBPs	Blood Borne Pathogens
BSCs	Biological Safety Cabinets
CBOs	Community Based Organizations
CCHP	Council Comprehensive Health Plan
CHMT	Council Health Management Team
DED	District Executive Director
DHIS	District Health Information System
DPS	Directorate of Preventive Services
DQA	Directorate of Quality Assurance
EHS	Environmental Health Services
H1N1	Swine Influenza Flu
HBiG	Hepatitis B Immune globulin
HBsAg	Hepatitis B surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HCWM	Health Care Waste Management
HEPA	High Efficient Particulate Air Filter
HIV	Human Immunodeficiency Virus
HMT	Health Management Team
HRH	Human Resource for Health
ICP	Information Communication and Practice
ILO	International Labor Organization
IPC	Infectious Prevention and Control
LGA	Local Government Authority
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MSDS	Material Safety Data Sheet
MSDs	Musculo-Skeletal Disorders
NCDs	Non Communicable Diseases
NEMC	National Environmental Management Council
NGO	Non- Governmental Organization
NSMIS	National Sanitation Management Information System
NTPP	National Tuberculosis and Leprosy Programme
OHS	Occupational Health and Safety
PEP	Post Exposure Prophylaxis
PO-RALG	President's Office- Regional Administrative and Local Government
PPE	Personal Protective Equipment

QIT	Quality Improvement Team
RHMT	Regional Health Management Team
RS	Regional Secretariat
SARS	Severe Acute Respiratory Syndrome
SOPs	Standard Operative Procedures
TB	Tuberculosis
ToTs	Trainer of Trainees
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WHS	Workers Health and Safety
WIT	Work Improvement Team

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background information

Occupational Health and Safety (OHS) is an area concerned with protecting health, safety and welfare of people engaged in work or employment. The goals of occupational health and safety programs include fostering a healthy and safe work environment. A safe and healthy work environment promotes work productivity and is a key element of worker's dignity (ILO, 2010). Occupational Health and Safety is a multi-disciplinary subject targeting four basic aspects:-

- i. The protection and promotion of workers health by preventing and controlling occupational diseases and accidents;
- ii. The development and promotion of healthy and safe work, work environments and work organizations;
- iii. Enhancement of physical, mental and social well-being of workers; and
- iv. Enabling workers to conduct socially and economically productive lives and to contribute positively to sustainable development (WHO 2010).

1.2. Occupational health and safety (OHS) hazards in the Health facilities

Occupational hazard means any agent, situation or condition that may cause an occupational illness or injury. It may lead to serious immediate effects or long-term problems that affect all or only part of the body. Health workers may be exposed to a variety of workplace hazards in the course of performing their functions. The type and degree of exposure is dependent upon a variety of individual factors including people-related factors as well as environmental factors. Symptoms of occupational illness may not be recognized immediately, for instance detection of noise-induced hearing loss is often difficult until it is in advanced stage. Moreover some occupational diseases may take long to be apparent e.g. disorders related to musculoskeletal system. Careful evaluation of potential exposure to hazard should be done in all the tasks in the healthcare facilities to ensure that they have an effective hazard control in place. The following OHS hazards are found in health facilities:

1.2.1 Biological hazards

Biological hazards, also known as biohazards, refer to biological agents, such as microorganisms, fungi, parasites, plants, substances of biological origin that pose a threat to the health of workers. The routes of exposure to biological hazards can be:

- The Direct and indirect contact with patients and contaminates surfaces and

objects – for example cholera, staphylococcus, haemorrhagic fever viruses, scabies

- Airborne (droplets and bio aerosols) from coughing and sneezing containing viruses and bacteria, such as TB, influenza, MERS, measles
- Blood-borne (needlestick injury, blood splashes), such as HBV, HCV & HIV/AIDS, haemorrhagic fevers
- Transmitted through vectors (mosquito or tick) - such as malaria, Zika, yellow fever, dengue, encephalitis

1.2.2 Chemical hazards

Work processes in health facilities involve the use of many chemicals for various purposes. They may be present in any form like solid, liquid or gas. Examples of hazardous chemicals may include formaldehyde, used for preservation of specimens; glutaraldehyde used for equipment sterilization; anesthetics gases, cleaning agents, laboratory reagents and other numerous chemicals used in healthcare. Also some medicines e.g. cytotoxic drugs dispensed to patients can be detrimental to staff if not handled properly.

1.2.3 Ergonomic hazards

Health workers are potentially exposed to ergonomic hazards due to the nature of their work. These hazards occur when the type of work, body positions and working conditions put a strain on the body. Working conditions that magnify the risk include intensity, frequency and duration of activities. Health effects due to ergonomic hazards develop gradually and workers don't always immediately notice the strain on their body or the harm that these hazards pose.

Ergonomic risk factors are found in jobs requiring repetitive, forceful, or prolonged exertions of the hands; or carrying of heavy objects; frequent or heavy lifting, patient handling, pushing, pulling, and prolonged awkward postures. For example surgeons are exposed to long standing hours during an operation. Likewise hospital attendants as well as nursing professionals have tasks, which involve lifting of heavy objects (eg patient during bed making and transfer) awkward posture during patient care etc. Jobs or working conditions presenting multiple risk factors will have a higher probability of causing a musculoskeletal problem.

1.2.4 Physical hazards

Physical hazards in health facilities encompass extremes of temperatures, pressures, noise and vibration, illumination, ionizing radiation, such as x-rays and isotopes, non-ionizing radiation, such as lasers and electromagnetic fields. Physical agents can be

harmful to workers if not properly controlled. For example workers working in the radiology department are exposed to x-rays and other forms of radiations. Furthermore, vibration and cold may add risk to these work conditions, for instance, mortuary attendants stay in a cold environment for a long time. In addition, those working outdoors among community in tropical climate, face heat stress and its adverse effects on health.

1.2.5 Mechanical hazards

Mechanical hazards are hazards concerning the moving parts, sharp objects, and hot surfaces that pose risks of injuries to the health workers. Equipment used in health facilities if not correctly installed and sustained may cause injuries. Other risks include slips, trips and falls due to wet/slippery floors, poor housekeeping and chipped floors, as well as cuts and punctures from poor handling of needles and other sharps resulting in needle stick and sharps injuries.

1.2.6 Psychosocial hazards

Hazards related mainly to job stressors in workplace, work has psychosocial effects to staff in health facility and community.

Violence or aggression from patients, visitors, and members of the public, residents, staff and clients could take the form of physical, emotional and/or mental abuse. Most health care settings require some sort of shift work. Shift work can be very stressful to workers and their families. Additionally working alone, substance abuse as well as economic factors is other forms of psychological hazards.

Working with people who are seriously or even terminally ill day in and day out can be emotionally wearing. Shortage of human resource leads to extra workloads, which result in burnout. Conflicts with competing and changing roles in the family, as well as from work issues (work-life conflict), can cause tremendous stress.

1.2.7 Hazards for Emergency aid workers

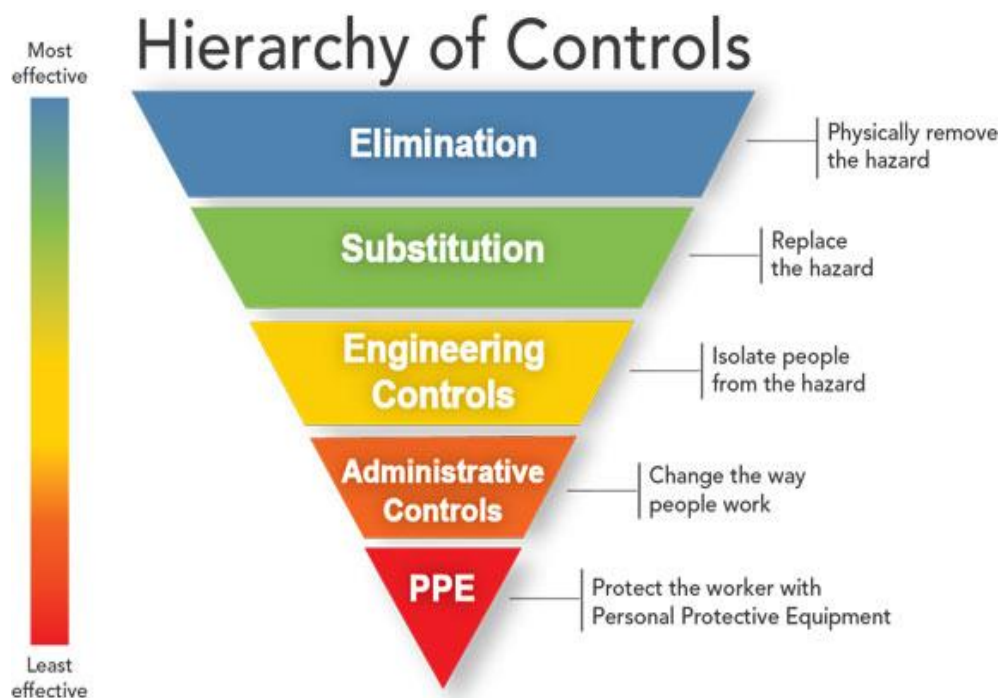
Emergency aid workers provide essential and lifesaving services in emergency response and humanitarian crises. They are at risk of injuries, poisonings and infections; attacks and violence, long working hours, traumatic stress events, fatigue and unfavourable climate conditions. Their health and safety requires specific measures for anticipating and recognizing occupational hazards and provision of adequate protection, such as personal protective equipment, safety instructions, security measures, housing and stress management

1.2.8 Home care workers OHS hazards and risks

Health workers providing care for patients at their homes are frequently exposed to a variety of potentially serious or even life-threatening hazards. These dangers include overexertion; ergonomic and psychosocial stress; verbal abuse and other forms of violence in the home or community; bloodborne pathogens; needlesticks; latex sensitivity; temperature extremes; unhygienic conditions, including lack of water. Long commutes from worksite to worksite also expose the home healthcare worker to weather and transportation-related risks.

1.3. Hierarchical of controls

The hierarchy of control is a list of control measures, in priority order, that can be used to eliminate or minimize exposure to the hazard. It is a systematic process to identify the most effective method of risk reduction. This concept should be promoted as a standard practice in the workplace. The employer should assess the risk and deal with it in feasible and effective control solutions. The following control solutions should be utilized based on the order of priority as follows: eliminate the risk; control the risk at source; minimize the risk by means that include the design of safe work systems; in so far as the risk remains, provide for the use of personal protective equipment. Where appropriate the above control measures may be used in conjunction.



Elimination

Eliminating the potential source of exposure ranks the highest in hierarchy of controls. Examples of controls in this category include taking steps to minimize visits to an infectious ward, thereby reducing/eliminating potential exposure of the workers to infectious agents. Others are postponing non-essential visits to health care facilities by patients with suspected or confirmed bird flu (H1N1) until they are no longer infectious.

Substitution

This form of control involves substituting a safer process or material for the hazardous process/material identified. For example, substituting a cleaning solution/detergent causing allergic reactions and nausea to a less toxic or non-allergic cleaning solution for the task.

Isolation

This control involves separating the hazards or hazardous work practice from employees in other work areas. This may involve sectioning of the area by erecting barriers or by relocating either the hazardous work practice or the other employees and their work practice. For example, installation of shielding material to separate between the source of x-rays and the health worker (radiographer) in the x-ray room.

Engineering Controls

This method of control involves designing and/or installing physical safety features to equipment. They are particularly effective because they reduce or eliminate exposure at the source and many can be implemented without placing primary responsibility of implementation on individual workers. For example, introducing a closed suctioning system for airway suction in intubated patients or introducing an automating washing system in the laundry instead of manual handling in washing to reduce chances of prick injuries.

Administrative Controls

Administrative controls and work practices are policies and practices which prevent or minimize exposure. They include limiting the exposure of personnel to elements that are only hazardous when they exceed a certain threshold. Other administrative controls and work practices include job rotations, promoting and providing vaccination to workers, screening for illnesses, grouping patients with similar exposures together.

Personal Protective Equipment (PPEs)

PPEs ranks lowest in the hierarchy of controls. It is the last line of defense for workers against hazards related to infectious agents that cannot otherwise be eliminated or controlled. PPE must not be used on its own, but in conjunction with other recognized controls. Examples of PPEs include use of appropriate masks, eye protection, gloves, gowns and respiratory protection devices such as N95 respirators for aerosol generating procedures.

1.4. Situation analysis

The ILO estimate that every day 6,300 people die as a result of occupational accidents or work-related diseases resulting in over 2.3 million deaths per year (ILO 2010). This is on the background of over 337 million on-the-job accidents annually resulting from poor occupational health and safety practices (ILO 2001). However, the rate of related injuries is believed to be much higher (both reported and non-reported).

The healthcare industry, whose mission is the care of the sick, is itself a 'high-hazard' industry for the workers it employs. In both well-resourced settings and in low/middle income (LMI) countries illness and injury statistics are high. The work-related accident rate in the healthcare sector is 34% higher than the EU average. (<http://agency.osha.eu.int>). Safety management is a common phenomenon in industries but not in hospital settings especially in many developing countries (Subhani 2010). The general feeling is that hospitals and health institutions work environments are safe and are meant to be "healthy" as health is considered a core objective of such institutions. Studies have demonstrated that the state of OHS is an international problem and is bound to remain a top priority with complexity in its attainment. Occupational Health and Safety based management systems not only reduce accidents and injury rates but also improves the working conditions, retention of workers and performance in health care service delivery (Subhani 2010).

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 body fluids. 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 predisposing 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. Other patient and health care worker behaviours' also contribute to sharps injuries. Health care staffs are considered to be at a higher risk of needle stick injuries. For example 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 working period (Ghana OHS policy guideline 2010). There is limited data on needle stick injuries in Tanzania, but the magnitude of the problem is considered to be the same as in other African countries. Anecdotal evidence also suggest that a number of health workers have either contracted or died from complications of work-related blood-borne infections like HBV and HIV/AIDS.

To minimize the exposure risk to health care workers on the mentioned risks, ILO asked countries to design operational programs based on its recommendations to adopt and implement with regards to OHS (ILO 2010). The World Health Organization (WHO) also developed a ten-year (2008 to 2017) global plan of action on workers health.

1.5. Local perspective-Tanzania's context

Tanzania is among the African countries with the critical shortage of human resources for health (HRH). Therefore their retention is very critical for assurance of health services provision in the country. It is in this view that, health workers are important resources in delivering health care, which necessitate providing a safe and healthy working environment as far as, reasonably practicable. Health facilities in Tanzania attend various clients depending on the level of the facility itself. However the health care system does not have a mechanism to collect and analyse information on hospital injuries and illnesses suffered by its staff. Therefore, it is difficult to analyse the incidence of injuries or diseases among its staff.

Some of the studies in Tanzania reported that, prevalence of low back pain among nurses was high (Mwilila, MC, 2008), Psychosocial problems, were observed among Health Workers, 30% of Nurses, 45% clinical support workers and 88% of works complained that, employers don't care about their welfare (Leshabari *et al.*, 2008). Literatures from Bugando Medical Center in Mwanza on the seroprevalence among HCWs revealed a prevalence of 7% for Chronic Hepatitis B Virus Infection.

Hospital based studies revealed that Hepatitis 'B' Virus prevalence ranges from 5-11% to 16-50% in high risk hospital based patients, while Hepatitis 'C' Virus for general community is around 2% (Matee *et al.*, 2006). In additional needle stick injuries was high among HW 52.9% (Manyere *et. al.*, 2008). It is estimated that, infection following a needle-stick injury from infected sources is 0.3% for HIV, 3% for hepatitis C and 6-30% for hepatitis B (HPACI, 2006).

The risk of infection is high among many facilities, inadequate basic infrastructure for water, sanitation and hygiene, infection prevention and control and personnel safety, health and wellbeing initiatives. Besides, on call duty, high workload, 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.

1.6. Rationale

The current emerging highly infectious diseases such as, viral hemorrhagic fevers, SARS, and the H1N1 Influenza, occurring in the region, pose threat to health workforce. Further more in responses to the National health policy; health sector strategic plan IV 2015- 2020; HIV policy (2001); Public Health Act, HIV and AIDS (Prevention and Control) Act, 2008; WHO Global plan of Action on workers health, ILO conventions and recommendations on occupational safety and health, Sustainable Development Goals and the gaps identified in workers health profile report 2016, there is a strong need for guidance.

The Ministry of Health, Community Development, Gender, Elderly and Children has developed this guideline in order to guide in the prevention and control of hazards at the health facility level, improving working conditions and environments; workers safety including emergence situation, health monitoring, workers benefit including compensations for occupational diseases and injuries. The guideline also covers risk management, medical check-ups and training on workers health and safety for both public and private health facilities.

1.7. Scope and purpose

1.7.1 Scope

These guidelines apply to all health care workplaces and workers in the health system, both in public and private facilities.

For the purpose of these guidelines:

- The health system includes all the activities whose primary purpose is to promote, restore and/or maintain health together with the people, health facilities and resources, arranged together in accordance with established policies, to improve the health of the population they serve.
- Health workers are defined as all people engaged in actions whose primary intent is to enhance health, including health service providers as well as health

management and support workers who are employed by or work for an employer or under the direction or supervision of an employer in the health system, including interns, sub contracted staff and emergence responders

1.7.2 Broad objective:

To promote workers health and safety through improved work conditions, in the public and private Health care facilities.

1.7.3 Objectives

The objectives of this guideline are:

- a) To provide a framework for implementing healthy and safe work practices in the health facilities.
- b) To promote culture of health and safety among health workers.
- c) To provide guidance for minimum workers health and safety requirements for health facilities
- d) To provide guidance in training and capacity building on workers health and safety (WHS) in the health sector.

CHAPTER TWO:

2.0 Policy, regulatory and institutional framework

Tanzania policies and laws provide some directives towards workers health in various ways. The main law is the constitution of Tanzania that provides the right for every citizen to work and live (article 13-29). Other laws and policies have some provisions in the following ways:

- a. The National health policy, 2007, places the occupational health among the primary health care components and it gives responsibility to the managers for work places to offer health information and services to their employees;
- b. The Public Health Act, 2009 advocates and is geared towards ensuring welfare and health of workers are maintained at all times and in consultation with the Minister responsible for labour, make regulations regarding health standards for working environment, working equipment and health measures to be adhered at work places. It also provides implementations guidelines as well as through monitoring (Worker's health surveillance) and supervision;
- c. The Occupational Safety and Health Act, 2003, puts provisions for registration of workplaces, the safety, health and welfare of persons at work in factories and other places of work;
- d. The Environmental Management Act, 2004, makes provisions for safe, clean and health environment including at workplace;
- e. The Industrial & Consumer Chemical (Management & Control) Act, 2003, establishes provisions on safe manner for handling chemicals, including at the workplace;
- f. The Workers Compensation Act, 2008, creates provisions for rights to protection and compensation for occupational injuries and diseases including medical and rehabilitation benefits;
- g. The Employment and Labour Relations Act, 2004, makes provisions for occupational safety and health standards and the working environment secured by an appropriate system of inspection
- h. Atomic Energy Act No.7, 2002, makes provisions for protection of workers against radiations, through availing protective and medical check-ups.
- i. The HIV and AIDS (Prevention and Control) Act 2008; Section 12 (2) requires owners, managers or the in-charge of health care facilities to protect workers against occupational exposures by; providing services for post exposure prophylaxis, availability of personal protective equipment (PPEs) and appropriate handling and disposition of healthcare waste.

- j. National Workers Health Strategic Plan 2017: Key performance area 2 demands Scale up and establish Occupational health and safety programme for health workforce and emergency responders

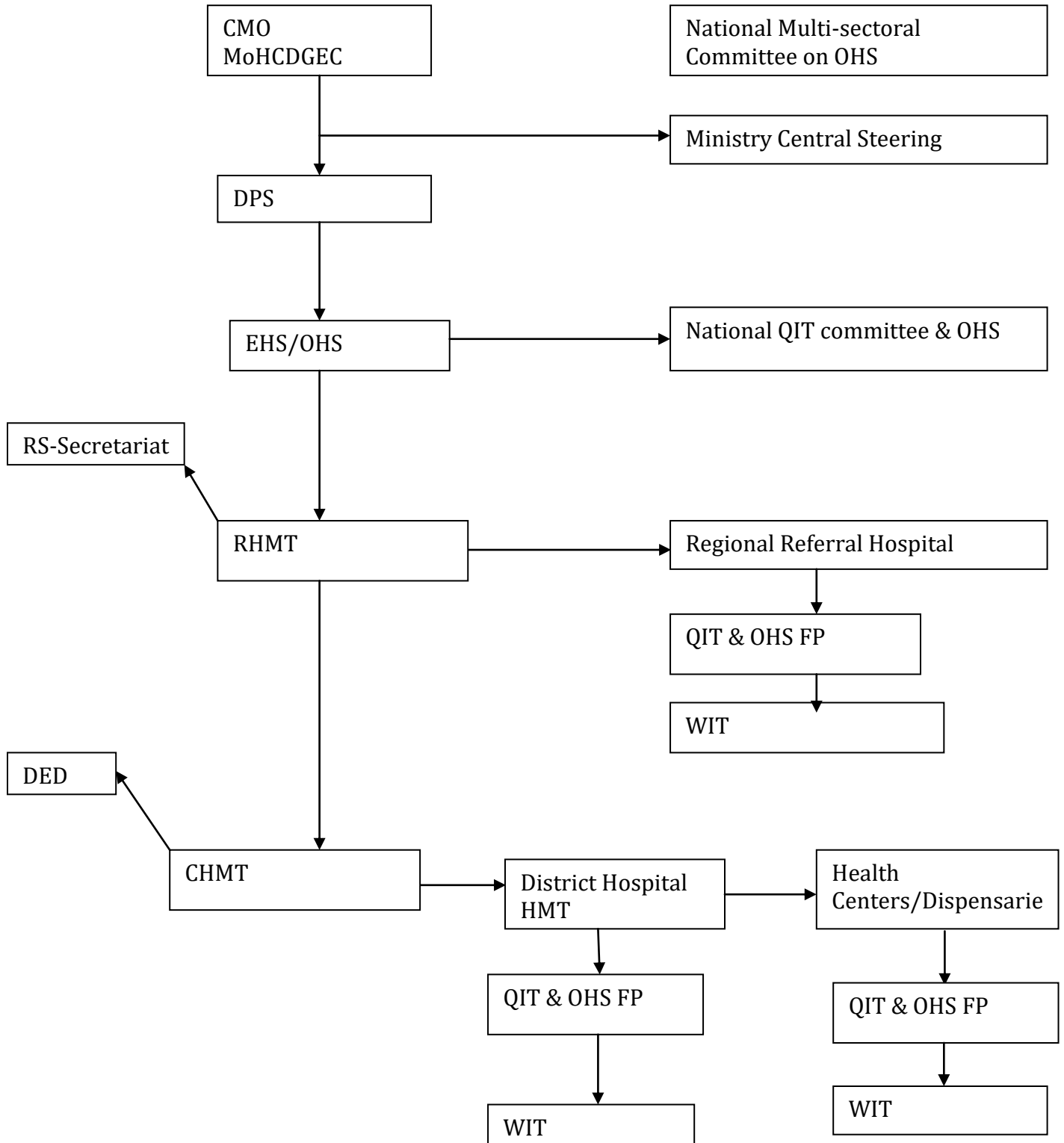
Tanzania has also ratified several ILO Conventions such as Convention on Safety in the Use of Chemicals at Work (C170), and agreed on resolution 60.1 of the World Health Assembly (WHO Global Plan of Action on Workers' Health 2008-2017 WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020) provide guidance for setting up the system and services for protecting occupational safety and health in the country.

For more policies, legislations, guidelines and strategies related to Occupational health and safety of workers see Annex 10

2.1 Workers health Organizational Structure

The workers health organizational Structure follows similar structure of the quality improvement in the health facility. The following elaborate on workers health and safety structure at National, Regional, Council and facility level of implementation.

Organizational Structure for OHS



Organization structure (adapted from DQA guideline, 2015)

2.2 Roles and responsibilities

To effectively deliver workers health and safety issues the roles and responsibilities of key actors need to be clearly comprehended. The following are the roles and responsibilities of key actors;

2.2.1 Ministry responsible for Health

The Ministry through Occupational Health Unit under the Directorate of Preventive health Services shall be responsible for managing workers health, safety and wellbeing in the health system, in particular to:

- Develop inspection procedures and operating standards/code of practices for OHS in the health facilities
- Review the national occupational health and safety strategic plan
- Establish inventory of work related incidents and maintenance of workers health and safety information in the health facilities
- Provide technical support to regions, districts and health facilities to ensure compliance on all OHS policies and guidelines.
- Conduct supportive supervision and monitoring of OHS services
- Liaise with other relevant sectors on the implementation of OHS guidelines and Coordinate activities of all partners and other stakeholders
- Mobilize and facilitate allocation of resources for OHS services
- Facilitate capacity building at national, regional and district levels on OHS standards
- Monitor and evaluate the implementation of workers health and safety guidelines
- Establish and facilitate OHS technical working group
- Liaise with health training, academic and research institutions to integrate occupational health and safety in their training curriculum as well as for operational research on OHS areas of relevance to Tanzania.
- Promote networking among research institutions and health facilities for carrying out practical research on OHS issues of concern to health workers and translation of research into practice, particularly with respect to combined exposures and applied intervention effectiveness research

2.2.2 Ministry responsible for labor

- Create enabling environment for the implementation of occupation health and safety policy both in public and private sector,
- Put in place regulatory and legal framework and facilitate resource mobilization for provision of effective occupation health and safety prevention services.

- Ensure timely and justice compensation system to all affected employees
- Coordination of various sectors in the implementation of OHS services
- Advocate for workers' rights

2.2.3 Ministry responsible for Local Government and Regional Administration

- Complement efforts of central Government and other stakeholders in the promotion of occupational health and safety in all workplace.
- Register all workplaces
- Monitor and manage OHS services at all levels both public and private.
- Provide safe work environment for health workforce
- Coordinate implementation of the national workers health and safety guidelines
- Link injured workers to ministry of labour for compensation
- Mobilize and facilitate allocation of resources for OHS services
- Facilitate capacity building at, regional, Council and health facility levels

2.1.1 National Multisectoral OHS Committee: (Members from Ministry responsible for Health, PO-RALG, Ministry of Labor, PO-PSM, WHO, ILO, Trade unions, Professional associations, employers associations, private health facility association)

- Steer up the implementation of OHS plans at all levels in the health sector
- Advise the Ministry responsible for health on issues related to the improvement and promotion of occupational health and safety.
- Facilitate information sharing, Coordination of national and international efforts on OHS and act as platform for occupational health and safety dialog.
- Mobilize and facilitate allocation of resources for protecting and improving workers' health and safety in the health sector

2.2.4 Research institutions

These includes; Universities, Teaching Hospitals, Private Occupational Health Institutions, MOH Health research institutions and other related health research and training Institutes

- Design and review OHS training programmes that meet demands for different health professionals,
- Review professional curriculum for incorporation of OHS
- Design specialization training in various aspects of OHS

- Carrying out research on various aspects of occupational health and safety and translation of research into practice, particularly with respect to combined exposures and applied intervention effectiveness research
- Provide specialized occupational therapy for affected health workers.

2.2.5 National occupational health and safety committee

National committee on occupational health and safety of health workers will be integrated into the Central steering committee for quality improvement. Together with quality improvement tasks they will also work on occupational health and safety for health workers to promote the implementation of this guidelines and to ensure coordination with the other relevant programmes.

The national committee shall include additional representatives from:

- i. Occupational health unit
- ii. Representative from human resources management
- iii. Quality of care unit
- iv. Infection prevention and control
- v. Emergency preparedness and response
- vi. Two representatives of nationally recognized associations of workers in the health sector
- vii. Two representatives of nationally recognized associations of employers in the health sector

The committee shall meet at least quarterly. The minutes of the committee shall be made public as appropriate

2.2.6 Regional Secretariat

The Regional Secretariat through RHMT shall be responsible for managing workers health, safety and wellbeing in the health system, in particular to:

- Designate focal person for coordination of occupational health and safety services in the region.
- Mainstream Occupational Health and Safety at the regional hospital quality improvement team
- Establish regional hospital OHS committee (to oversee worker's rights, compensations and other related matters) as per Occupational Health and Safety Act, 2003
- Review and facilitate cases for rehabilitation and compensation for injured, diseases and death of health workers.
- Translate policies and guidelines for the implementation of OHS services in the region

- Conduct supportive Supervise, follow-up and evaluate on implementation of OHS activities in the Councils.
- Monitor compliance on design and building with regards to OHS requirements for new construction of health facilities in the Councils.
- Identify training needs for human resource development in occupational health and safety.
- Receive and analyze occupational health and safety reports and give feedback to the councils.
- Carryout operational research for appropriate OHS interventions.
- Prepare OHS reports and submit them to the relevant authorities at national level

2.2.7 Local government Authorities (LGAs)

The Local Government Authority through CHMT shall be responsible for managing workers health, safety and wellbeing in the health system, in particular to:

- Designate focal person for coordination of OHS services in the Council.
- Mainstream OHS at the health facility quality improvement teams.
- Establish District hospital health facility OHS committee (to oversee worker's rights, compensations and other related matters) as per OSH Act, 2003
- Conduct regular OHS assessment of all health facilities.
- Provide technical support to health facility to ensure compliance of OHS policies and guidelines.
- Review and facilitate cases for rehabilitation and compensation for injured, diseases and death of health workers.
- Collaborate with other departments and stakeholders for implementation of OHS related interventions .
- Scrutinize and monitor compliance on design and building with regards to OHS requirements for new construction of health facilities in the councils.
- Identify training needs for human resource development in occupational health and safety.
- Mobilize and allocate resources for implementation of OHS services.
- Develop annual plans for OHS services and incorporate in the CCHP.
- Keep and update records for OHS and submit them to the Regional Secretariat.

2.2.8 Health facility level

- Designate responsible person for occupational health and safety for the facility
- Establish health facility OHS committee as per Occupational Health and Safety Act, 2003

- The facility workers health and safety committee with members, OHS designated focal person, quality improvement team, Representatives from workers association and Labour officer
- Comply with the OHS guidelines and related SOPs and enforce corrective measures in case of non-compliance at the facility level.
- Plan for capacity building on OHS in the facility.
- Manage and notify OHS incidents and emergencies arising in health facility.
- Conduct OHS audits and risk assessments.
- Keep records of OHS and submit to the CHMT.
- Maintain facility infrastructure.
- Ensure security of health workers.
- Collaborate with community leaders to promote health and safety of health workers in the community.
- Identify training needs of OHS for healthcare providers in the health facility

2.2.9 Occupational health and safety focal person

Criteria to be designated as a OHS focal person.

1. Preferable Health officers
2. If health officer is not available, QIT member can be designated

NOTE: The designated OHS focal person shall undergo training on workplace improvement for health facility and the certificates will be issued.

Roles of OHS Focal Person;

- i. Work with quality improvement team to ensure health and safety of workers
- ii. Conduct quarterly assessment of the facility and workers health to assess compliance to the set health and safety measures; (use Annex 1)
- iii. Prepare and update Standard Operating Procedures (SOPs) for such issues linked to workers health and safety
- iv. Develop an Action plan to mitigate the identified OHS gaps with timelines and a responsible person for each gap to be closed,
- v. Follow up workers benefit after notification to the responsible authority
- vi. Maintain record of workers health and safety and prepare a quarterly report

NOTE: Scheduled Meetings

- Occupational health and safety committee meetings will be held annually basis with clear documented meeting minutes at all levels
- Other working improvement teams with representation of OHS focal person (QIT) will meets on qaterly basis

CHAPTER THREE:

3.0 Worker's Health and Safety

3.1 Minimum occupational health and safety (OHS) package for health facilities

Workers health and safety in health facilities requires comprehensive integration of OHS related components. These components include water, hygiene and sanitation, Health care waste management, infection prevention and control, patient safety, quality of care, emergency preparedness and human resource for health. The inclusion of these components promotes health and safety of workers, retention and improves working conditions.

The recommended minimum package for OHS support is based on the risk control known as the hierarchy of controls whose approach pays primary emphasis on controlling the hazard at the source. For high risk, steps should be taken immediately to minimize risk of injury. The minimum package may change as per specific risks identified.

The minimum OHS packages for health facilities include; Environmental consideration, Infection prevention and control, Personnel and Policy, and health facility design. The details are described below;

3.1.1 Environmental consideration

The health facility management team should ensure the facility has;

- **Access to sufficient and safe water**

Sufficient water-collection points and water-use facilities that supply sufficient water at all times that meet national drinking water standards should be available to allow convenient access to, and use of, water for drinking, food preparation, personal hygiene, medical activities, laundry and cleaning. There should be an alternative supply available with storage capacity for 3 to 5 days in case of water supply cutoff.

- **Waste disposal- wastewater, excreta and health care waste**

There should be adequate, accessible and appropriate toilets for patients, staff, caretakers and people with special needs. Wastewater produced should be treated and disposed-off safely to protect workers and the environment. Similar Health-care waste should be segregated, contained, transported, treated and disposed-off safely.

- **Cleanliness of the facility: working environment and surroundings:** Health care provision areas maintained clean
- **Laundry:** there should be sufficient laundry facilities and supplies in the health facility.
- **Food storage and preparation:** proper food preparation and storage minimize the risk of disease transmission. Including availability of staff canteens or team rooms; Pantry or safe eating-places near work areas.
- **Control of vector and vermin:** Building design, drainage, waste control, screens; self-closing doors, Insecticide treated beds nets, periodic spaying for vector control (every after six month).
- **Information, communication and workers health promotion:** periodic Staff training to reinforce practices on OHS. Frequent information sharing and updates on new innovations and technologies, equipment and safety measures at once annually.

3.1.2 Infection prevention and control (IPC)

The facility quality improvement team (QIT) and designated person for OHS should:

- Train/orient and monitor the implementation of IPC interventions.
- Reinforce the use of IPC guidelines
- Monitor and evaluate the use of IPC guidelines

3.1.3 Personnel and policy (Management / Administration)

To facilitate implementation of OHS services in the health facilities there should be;

- Designated competent person for OHS (OHS focal person)
- OHS Committee
- Existence of a program for vaccination and prophylaxis e.g Hepatitis B vaccination and Post-exposure prophylaxis and other work related vaccine preventable diseases
- Existence of a program for hazard prevention and control including;
 - Air borne diseases prevention e.g. Tuberculosis
 - Injection safety programs
 - Information communication practice (ICP)
 - Chemical hazards control
 - Physical hazards control such as noise, heat/cold, radiation
 - Safety hazards such as Slips, trips, falls
 - Stress/bullying/violence prevention
 - Radiation hazards control
 - Ergonomics hazards control

3.1.4 Facility design and layout

Buildings are designed, constructed and managed to provide a healthy and comfortable environment for patients, staff and caretakers.

The quality building for health facility should have the basic OHS requirement which includes:-

- **Waiting Space/ rooms:** should have adequate space to avoid overcrowding and areas to provide food and drinks while patients are waiting
- **Ventilation** - Each workstation should have circulation of fresh air with adequate ventilation.
- **Lighting** – Should be sufficient and suitable lighting whether natural or artificial in every part of the workstation.
- **Floors** – Should be washable, made of non-slippery materials with suitable floor gradient.
- **Sanitary convenience** – There should be a sufficient number of sanitary facilities with sufficient lighting for both sexes. Sanitary facilities should have hand washing areas with running water, soap/ detergent and changing rooms with cabinets for clothing not worn during working hours.
- **Fire Prevention** – All workrooms should be provided with appropriate firefighting appliances and adequate means of escape, in case of fire.
- **Provision of emergency exits** with signage and space(s) for workers assembly in case of emergency (Assembly area(s))
- **Layout** – should not allow cross contamination- refer to design layout of the facilities
- **Isolation** - Isolation is an establishment of mechanical or spatial barrier to prevent transmission of infectious agents to health workers. The isolation of specific areas e.g. laboratories, infectious wards etc should be according to recommended standards.
- **Equipment** - Placement of equipment should be considered during facility design and take consideration of any future expansion of the facility or other hazards eg earthquakes, floods.
- Accessible for people with physical disability
- Security; Including fencing, secured doors and windows

All facility designs and layout should be in compliance with the building standards and comply with public health requirements. During designing the OHS focal person should be involved to review the patient flow and appropriate allocation of special units within the facility master plan, e.g. theatre, mortuary, laundry, kitchen among others.

3.2 Risk management

Risk management is important in managing workplace hazards through identification, evaluation and determination of the means to reduce the risk to an acceptable level to protect health workers and/from the working environment. The process of risk management includes hazard identification, risk assessment, risk control and monitoring.

3.2.1 Hazard identification

Hazard identification should be done to find out the major hazard and its cause within the health facility departments. The following should be done to effectively identify the hazard;

- Conduct a walk-through survey to assess the workplace using a facility assessment checklist (annex 1).
- Carry out job hazard analysis in each department using hazard report form (annex 4).
- Review accident, incident and ill-health records present in the facility
- Ask the workers on the hazards they encounter
- Follow the manufacturers' instruction/ materials/ safety data sheets, and decide who might be harmed and how. Pay particular attention to new employees, persons with disabilities, inexperienced and lone health workers.
- Develop hazard / risk register and review it twice per year

Note: every health worker is responsible to identify and immediately report hazards in their working station.

3.2.2 Risk assessment

Risk assessment determines how safe a situation is and then making judgement of the acceptability of a risk. It provides an insight in the risk and allow to prioritise risks for taking mitigation actions. It should be done by the health facility quality improvement team comprising of the designated OHS focal person. It can also be done by RHMTs and CHMTs.

In order to effectively determine a risk, the assessment should be done;

- Before any new development
- Any time there is new or redeployed or transfer of staff or equipment or procedure,
- Any time there is an accident/ incident or near miss,
- At scheduled annual risk assessments jointly with labour representative
- During maintenance activities.
- During disposal of equipment

3.2.3 How to carry out a risk assessment

- Consider whether to carry out the assessment for the whole facility/ department/machinery or specific procedure
- Identify the hazards and those at risk.
- Evaluate and prioritize risks (if the risk is high, moderate or low)
- Decide on preventive action
- Taking action by developing mitigation plans and budget
- Use risk assessment guidance and matrix to make decision (annex 2).
- Documentation, monitoring and review

3.2.4 Risk control

Evaluation and actions should be taken to reduce or eliminate potential risks. However, findings from risk assessment that involves identifying potential risk factors found in the health facility shall be utilized in risk control. The following are hierarchy of control may be applied to mitigate the risks identified;

- Eliminate the hazard.
- Substitute the hazard.
- Isolations.
- Use engineering controls.
- Use administrative controls.
- Use personal protective equipment (PPE)

Identified risks can be managed with reference to specific functional areas in the health facility. The details of possible control measures in the functional areas are described in Table1.

TABLE 1: Minimum recommendation for risk mitigation per department/ functional area

Department/ section	Potential Hazard/ risk	Minimum Recommended Package for Risk Mitigation
<p>Central Stores/ General Storage Areas</p>	<p>Main risk include exposures due to poor store House Keeping of Hazardous chemicals spills and exposure e.g. laboratory reagents, Mercury, Glutaraldehyde etc., Burns/Cuts, Ergonomics, Slips/Trips/ Falls, and Latex Allergy</p>	<ol style="list-style-type: none"> 1. SOP on general OHS housekeeping issues in a health facility store/supplies storage areas. This should be scaled and tailored for each level. Approaches such as 5 - S or HealthWISE approach can be used 2. The SOP should include; General House Keeping, Chemical spills and exposure handling especially for laboratory reagents, Mercury Exposure, Glutaraldehyde, Burns/Cuts, Ergonomics, Hazardous Chemicals, Slips/Trips/Falls, and Latex Allergy. 3. Promote use of Material data safety sheet among workers for various chemical used in the health care facilities 4. Stores air-quality system and ventilation
<p>Clinical Services workstations, Theater, Wards and Intensive Care Units</p>	<p>Risk of exposure to Blood Borne Pathogens (BBP), eg HIV and HBV, Poor Clinical Ergonomics related complications, Slips/Trips/ Falls, Hazardous Chemicals, Equipment Hazards, air borne hazards eg. Tuberculosis, HBV, and HIV, Radiation Exposure and psychosocial hazards including Workplace Violence, workload, time and shifts</p>	<ol style="list-style-type: none"> 1. SOPs on general house keeping OHS Issues in all work station /clinical areas 2. SOP based on Universal Precautions for Blood Borne Pathogens (BBP), 3. SOP based on Clinical Ergonomics Slips/Trips/Falls, 4. SOP on Hazardous Chemicals and Equipment handling 5. Engineering control for air borne disease, Radiology/X-ray Room, Radiation Exposure, and Waste Management 6. Administration measure including:- <ul style="list-style-type: none"> ○ Control of Workplace Violence and other psychosocial hazards, ○ Personal protective gears, Immunization and PEP ○ Improve working environment, medical equipment and supplies ○ Training and orientations

<p>Casualty/ Emergency Department</p>	<p>Common OHS risks are Blood, Blood borne Pathogens, Hazardous Chemicals, air borne infections, Slips/Trips/Falls, Tuberculosis, Latex Allergy, Equipment Hazards, Workplace Violence, Workplace Stress, Antimicrobial resistance pathogens,</p> <p>Highly Infectious with epidemic potential such as Ebola, and other viral hemorrhagic fevers</p>	<ol style="list-style-type: none"> 1. Use universal precautions when dealing with blood and other potentially infectious materials 2. Promote the Engineering control as primary means to eliminate or minimize exposure to Blood borne Pathogens, air borne slips, trips and falls. 3. Health facility management ensure: - <ol style="list-style-type: none"> a. Health workers wear appropriate PPE, gloves, gowns, face masks, when anticipating blood or other potentially infectious materials b. Develop and display safety good practices posters in strategic site c. Health workers comply with HCWM guideline when handling waste d. Needle stick/sharps injuries recorded. e. Application of administration control to minimize the risk of violence and stress eg apply triage system, SOP showing directions, security, good organization duty rosters, breaks etc f. Each work area should have a sink foot, elbow, or automatically operated for hands wash and a readily available eye wash facility.
<p>Laboratory</p>	<p>Exposures related to Blood borne Pathogens, Tuberculosis, Exposure to hazardous chemicals, Needle stick/ Sharps Injuries, Allergy, Slips/ Trips/Falls and Ergonomics.</p>	<ol style="list-style-type: none"> 1. Adoption and mainstreaming Laboratory Bio-safety measures according to levels 2. Develop SOPs and train lab staff 3. Use universal precautions when dealing with blood and other potentially infectious materials 4. Restricted and controlled access should be practiced 5. Use labels and Signage at all applicable areas 6. Each work area should have a sink foot, elbow, or automatically operated for hands wash and a readily available eye wash facility 7. Health workers comply with HCWM guideline when handling waste

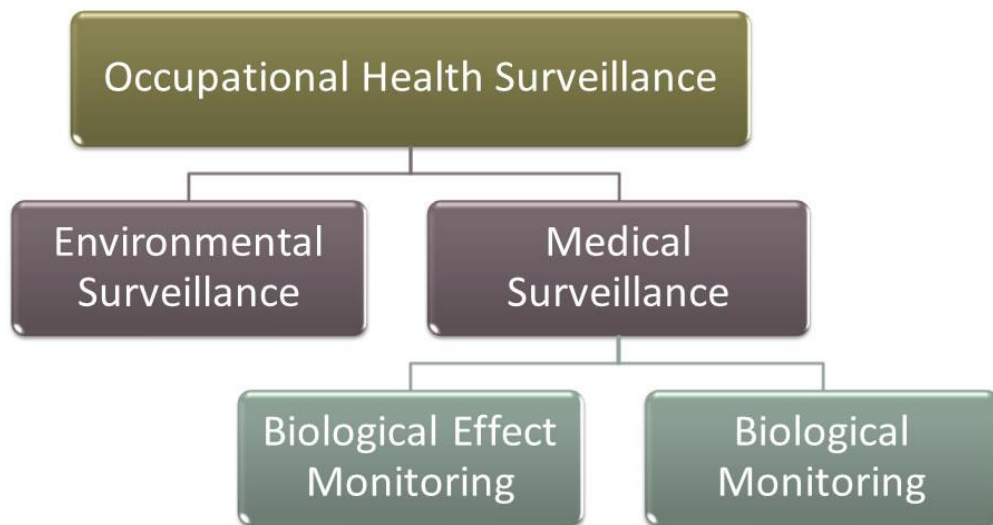
Pharmacy	<ul style="list-style-type: none"> • Signage and labeling. • Lack of safety label on hazardous drugs, • Poor handling practices of hazardous drugs, chemicals, reagents, • Exposure to hazardous Drugs, allergy, • Ergonomics and Violence 	<ol style="list-style-type: none"> 1. Design and develop SOP for handling storage and disposal 2. Training for workers, 3. Warning labels, 4. Access to Material Safety Data Sheets (MSDSs). 5. Personal protective equipment 6. Regularly assess potential hazards 7. Restricted and controlled access should be practiced 8. Health workers comply with HCWM guideline when handling waste.
Mortuary	<p>Exposure to infectious pathogens and chemicals such as Formaldehyde.</p> <p>Allergy, slips/trips/falls Ergonomics, Lack of basic equipment including PPE Inadequate knowledge among Staff on personal safety at work Lack of Morgues SOPs</p>	<ol style="list-style-type: none"> 1. QIT and OHS focal person should:- <ul style="list-style-type: none"> • Train/orient on use of universal precautions • Ensure Health workers comply with HCWM guideline when handling waste • Develop and display Safety Good Practices Posters and SOPs in strategic areas. • Ensure supply of PPE and Health workers wear appropriate PPE, • Provide equipment to be used at the morgue and train use of equipment 2. Promote the Engineering control as primary means to eliminate or minimize exposure to Blood borne Pathogens, air borne Slips/Trips/Falls, waste water.
House Keeping and Laundry Departments	<p>Inadequate knowledge to Staff on personal safety at work and provisions of the law, Inadequate supply of PPE and low utilization Lack of or outdated SOPs.</p>	<ol style="list-style-type: none"> 1. HF QIT and OHS focal person should:- <ol style="list-style-type: none"> a. Train/orient on use of universal precautions b. Ensure health workers comply with HCWM guideline when handling waste c. Display safety good practices posters in strategic site d. Ensure supply of PPE and Health workers wear appropriate PPE

<p>Kitchen</p>	<p>General House Keeping OHS Issues, Kitchen Ergonomics, Kitchen Equipment Safety, Fire Safety, Hazardous Chemicals, Machine Guarding, Food borne Disease, Slips/Trips/ Falls and Electrical Safety. Can also expose other staff, self and patients to food poisoning or food borne diseases</p>	<ol style="list-style-type: none"> 1. The designing of kitchen should comply with food premises requirement under Tanzania food, drug and cosmetic (hygiene Reg). 2006. 2. SOP for General House Keeping OHS Issues in a facility, Kitchen Ergonomics, Kitchen Equipment Safety, Fire Safety, Hazardous Chemicals, Machine Guarding, Food borne Disease, Slips/Trips/Falls and Electrical Safety. 3. Provide necessary PPE like gloves and heat resistant gloves for the kitchen staff 4. Kitchen air-quality system to include ventilators or smock extractor 5. Food handlers should undergo medical checkup regularly 6. Additional safety measures for the kitchen should include; Tasks assessment to identify potential work site hazards, regular medical checkup, appropriate Personal Protective Equipment (PPE). <p>Ensure that cold rooms and walk-in freezers are fitted with a panic bar or other means of exit on the inside of freezers to prevent trapping workers inside.</p> <ol style="list-style-type: none"> a) Ensure that electrical equipment are free from recognized hazards and that Electrical Safety Guidelines is followed. <ol style="list-style-type: none"> 6. Food handlers should ensure Good work practices by: <ol style="list-style-type: none"> a) Store and use knives and other sharp utensils safely b) Knives, saws, and cleavers should be kept in a designated storage area when not in use. The blades should not be stored with the cutting edge exposed. c) Knife holders should be installed on worktables to prevent
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		<p>worker injury.</p> <ul style="list-style-type: none">d) Knives and other sharp objects should not be put into sinks between periods of use.e) Newly purchased knives should be equipped with blade guards and knuckle guards that protect the hand from slipping onto the blade.f) The wheels of food carts should be large, low rolling, low resistance wheels that can roll easily over mixed flooring as well as gaps between steps, stairs and hallways.g) Use appropriate PPE and training to avoid steam burns when working with hot equipment or substances.h) Hold the cover to deflect steam from the face when uncovering a container of steaming materials.
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3.3 Occupational health Surveillance

The concept of occupational health surveillance, also known as “**workplace surveillance**” is new to the field of occupational health and is frequently confused with medical screening. **Medical screening** refers to the early detection and treatment of diseases associated with particular occupations while **occupational health surveillance** refers to the removal of the causative factors. It provides the information on where, how and why workers get sick or hurt on the job. This information is used to improve workers health and safety through appropriate prevention activities.



3.3.1. Environmental Surveillance

Environmental surveillance in health is based on the recognition of the relation between risks and their adverse health effects from exposure to environmental factors, that are present in work environment i.e. environment in and around working areas. The workplace hazards e.g. physical, chemical, biological hazards need to be monitored so as to create and maintain a safe and healthy work environment for the workers. The minimum hazards that would require monitoring include Illumination and sound levels.

It is a set of actions that provide knowledge and the detection of any change in the determinant and conditioning of factors of the environment that interfere with human health, with the objective of recommending and adopting measures and prevention and control of risks. Inadequate disposal of biohazards, contamination of soil or water sources and adverse working conditions pose health risks from adverse environmental conditions. Examples include intoxication by chemical products at workplace or diseases transmitted by vectors (refer to the environmental health considerations component at a minimum OHS requirement and annex 1).

3.3.2. Medical surveillance

Medical surveillance includes any procedure undertaken to assess, review or monitor an individual's health in order to identify or detect any significant change from normality. Medical surveillance has been stipulated in the Public Health Act of 2009 section 169(2)(a), whereby a routine examination for workers is mandatory. Systematic health assessment of employees exposed or potentially exposed to occupational hazards at the workplace is important to monitor the adverse health effects and determine the effectiveness of exposure prevention interventions. Thus surveillance program shall include the analysis of both health workers and surveillance data obtained over time.

A planned program for medical surveillance should involve periodic examination, which may include, clinical examinations, biological monitoring, biological effect monitoring and medical tests of persons employed by a medical practitioner or occupational medical practitioner.

3.3.3 The purpose of medical surveillance

Medical surveillance shall

- Assess the health status of the employee's pre-placement, during and after employment.
- Determine health status of the employee before transfer to another work area.
- Determine the job post of a health worker within an organization.
- Ensure that those who have had occupational medical conditions or exposures are attended early enough to prevent any complication.
- Provide information that help determining and justifying workers compensation.
- Provide data for epidemiological studies related to workers health and safety
- Monitor health workers exposed to occupational hazards for early detection of adverse health effects.

3.3.4 Components of medical surveillance

The health management team should ensure that all workers undergoes medical checkup according to the components of Medical Surveillance Programme:

- **Pre-employment and pre-placement medical examination.**
This examination shall 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 should define the initial health status. Furthermore, subsequent examinations will be used to evaluate the evident health effects of the work environment and other working conditions. Pre-

placement medical examination is required before transfer or placing a worker on a hazardous work.

- **Periodic medical examination:**

This will consist of examinations conducted periodically to identify vulnerable groups among the health workers, which can be of immense value to prevention. The frequency and types of examinations will be determined for each vulnerable group based on several factors such as the nature of work, ages and gender of the group members.

- **Return to work/ post sickness absence examination.**

This will 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

- **Exit medical examination.**

This type of medical examination provides data on employees at the point of exit from a particular occupation or workplace. This helps to judge if the injury/diseases is work related or not.

3.3.5 General guide for medical examination

The Health facility management team should ensure that:-

- Workers' physical abilities fit the specific requirements of the job and he/she remains fit throughout his/her working life.
- Record keeping, reporting and certification; follow professional ethics on confidentiality and respect for human rights.
- Medical information will not be accessible to unauthorized parties, without the written consent of the individual concerned.
- The health care facilities should request that an employee undertakes a medical assessment based solely on impaired ability to perform the required job.
- All costs associated with the medical assessments will be borne by the employer.
- Inventories of employees are kept up-to-date

NOTE: For medical examination use annex 11

3.4 Prevention and control of priorities Occupational diseases for health workers

3.4.1 Vaccination of Health workers

Health workers are at risk for exposure to infectious diseases when taking care of the patients or handling of materials that could spread infections. To minimize the risk, appropriate vaccines should be administered to protect themselves, patients and their family members.

Public and private health facility should vaccinate health workers against Hepatitis B and tetanus. Due to the risks of contracting infectious diseases from the work environment, all health workers and emergence responders should be aware and provided with appropriate vaccinations.

The most important diseases to be vaccinated against include Hepatitis B, Tetanus and other vaccine preventable diseases. For health workers who have not been vaccinated in childhood (e.g. by virtue of their country of origin), vaccination against Influenza, Measles, Mumps & Rubella, Varicella, Diphtheria, Pertussis, Meningococcal, Tuberculosis and Poliomyelitis will be required. The programme should have arrangements for record keeping and recall for boosters. Health workers will be vaccinated during pre-employment and as required for the working environment. Workers at high risk of diseases e.g. cholera, such as those working in cholera treatment units, isolation wards etc. would receive cholera vaccination.

The following procedures will be considered:

- Health workers should be made aware of vaccination requirements including mode of administration, schedule and potential adverse effects of vaccination and type of vaccine to be administered.
- Determine if the employee had received the primary vaccinations.
- Provide vaccine as a precaution against contracting a disease.
- Administer the prerequisite vaccinations depending on workplace requirement.
- Document all Employee who have decline the vaccination
- Health facility vaccination area/ units should equipped with human and materials resources including vaccine for health workers
- Document the vaccination history of a health workers
- Report and update vaccination coverage among workers through national Sanitation Information System (NS MIS).

3.4.2 Management of occupational exposures to blood borne pathogens

Managing occupational exposures at the workplace is important to prevent and protect the health workers from being exposed to occupational hazards. Exposure is determined by the amount of a work place agent that has reached an individual worker (external dose) or has been absorbed into the individual worker (absorbed dose). The potential exposures include exposure to blood, body fluids. The main purpose for management of occupational exposure is;

- To identify the type of exposure.
- To determine the population exposure level (low, medium, high).
- To determine the population exposed (Number and sex).
- To plan on the post exposure practices of reducing/ eliminating exposures.
- To put in preventive and control measures to avoid/ minimize future exposures.
- Training workers at risk.

Occupational exposures to blood-borne pathogens (BBP) pose a serious workplace threat to health workers. Contaminated sharps may pose a risk to blood borne pathogens when a health worker is performing procedures or attending patients. Occupational exposures include contact of the eyes, mouth, other mucous membranes, or broken skin and parenteral contact with blood or other potentially infectious materials. The most common blood borne pathogens that commonly involved in workplace transmission are Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV). The risk of acquiring these exposures can only be reduced by proper management through provision of post exposure prophylaxis and vaccine

Post exposure management is the care, support and provision of ARV medication to a person exposed to BBPs and includes counseling, education, psychosocial support, testing and prophylaxis.

3.4.3 Primary prevention of occupational exposure to blood borne pathogens

Due to high proportion of hospital patients who are infected with blood borne pathogens, the health worker should carry out their duties by adhering to universal precautionary; (referee IPC, HCWM and WASH guidelines)

Note: key issues

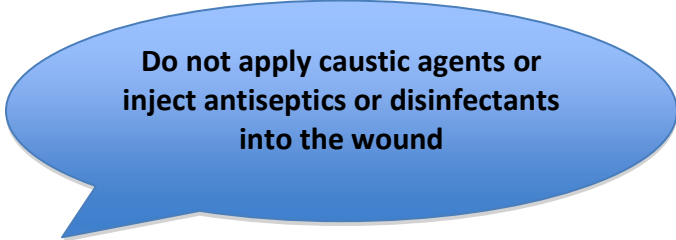
- Hand hygiene
- Use appropriate PPE
- Ensuring safe working environment;

Steps for occupational exposure management to BBPs

Step 1 : Treat Exposure site

Immediately after exposure,

- Wash the exposed site with soap and running water as soon as possible
- Flush the exposed mucus membrane with normal saline/water.
- Rinse gently the exposed eyes while open with normal saline/water.
- Remove the contaminated clothes and shower if necessary.



Do not apply caustic agents or inject antiseptics or disinfectants into the wound

Step 2: Exposure Report and Documentation

When an occupational exposure occurs, it should be immediately reported, circumstances of the exposure and PEP management should be recorded in the exposed health workers confidential medical report. The following information should be included in the medical report.

- Date and time of exposure
- Details of the procedure being performed and the use of protective equipment at the time of exposure
- Details of the incident: where and how the exposure occurred, exposure site, if related to sharp device, the type and brand of device
- The type, severity and amount of fluid or material to which the health worker was exposed
- Detail of the exposed health worker
- Medical documentation that provides details about counseling, post exposure management and follow up.

Step 3: Evaluate the exposure (Exposed health worker)

Health worker exposed to BBPs should be evaluated as soon as possible within 72 hours of exposure. Beyond that time PEP will not be useful. The exposure should be evaluated for potential to transmit the pathogens such as HBV, HCV and HIV based on the exposed site on the body, the route and severity of exposure. Exposure to blood, semen, fluids (cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic) and vaginal secretions pose a significant risk for blood borne pathogens and thus further evaluation is required. In addition, counseling and testing for HIV, HBV and HCV should be done. In case of refusal to test, PEP should not be given.

Step 4: Evaluate the exposure source (Source patient)

Evaluation of the source patient should be performed when the exposed health worker agree to take PEP. The following should be considered:

- ***If the source patient is known;*** test the patient for blood borne pathogens after obtaining consent. The exposed health worker should not be involved in obtaining consent from the source person.
- ***If the source patient is unknown;*** consider the following;
 - Evaluate the exposure as high risk for infection.
 - Do not test discarded needles or syringes for viral contamination.

3.4.4 Management of occupational exposure to HBV

Steps for managing an exposure to HBV should include;

1. Assessment of the risk of exposure to HBV
2. Determination of HBV status of the source and the exposed patient
3. Collection of specimen from the source person for HBsAg to determine if there is active HBV virus
4. If testing is not possible, base on clinical history (jaundice, hepatitis of any viral strain, and previous immunization status)
5. Administer Hepatitis B immune globulin (HBIG) (5 ml by intramuscular injection) as soon as possible but within 7 days of exposure
6. Administer first dose of HBV vaccine, which must be repeated according to the standard course.
7. If the first dose of HBV is not available, repeat HBIG one month from the first dose
8. In occupational settings, efficacy is increased by combining with HBV vaccine.

In healthcare settings, immunization against HBV must be routinely provided to health workers who perform tasks involving contacts with potentially infectious blood or other body fluids. After counselling and collecting blood from the health care workers (HCW) for baseline serological test for HBV, the following should be considered;

- If the health worker is already fully immunized, no further treatment is required;
- If the exposed health worker is partially immunized, then the immunization course should be continued and immunity should be checked 3 months after completion of the course;
- If the exposed health worker is not immunized, a course of vaccination should be offered, and immunity should be checked 3 months after completion of the course;

Pre-exposure vaccination (immunization) for HBV

The recommended standard course for immunization includes;

- First initial dose - start
- Second dose – one month after the first dose
- Third dose – 6 months after the first dose

Note:

- There is no need to vaccinate someone who is already infected with HBV
- Pre-vaccination serologic screening for previous infection with HBV virus is not necessary because it is not cost-effective
- Antibodies to HBV must be measured 2-6 months after the last dose.

Post-exposure immunization of HBV

HBV vaccines do not provide any protection from infection if given after an exposure. However, Hepatitis B Immune globulin (HBIG) should be given soon or within 7 days after exposure for non-immune individuals to HBV to offer protection.

Post-exposure Management of HBV

.If the source patient is HBsAg-positive or if the status cannot be obtained, the exposed health worker should receive one dose of HBIG and the first dose of the HepB vaccine. These can be administered simultaneously (but at different injection sites). The health worker should then complete the HepB vaccine series.

Assessment of sero status for HBV

If a health worker was previously vaccinated (and is immunized i.e. HBV surface antibody [anti-HBs] >10 mIU/mL) and accidentally exposed to a source patient who is HBV positive, no post-exposure management is required. If health worker was vaccinated but unknown if he/she responded to the vaccine, he/she should be tested for anti-HBs. If testing for anti-HBs is not possible he/she should be managed as someone who has not received HepB vaccination. In case the health worker was not previously vaccinated then he/she should start three doses of vaccination.

3.4.5 Management of occupational exposure to HCV

There is no vaccine against HCV. Antiviral agents against HBV and HCV exist. The exposed health worker shall receive appropriate counselling, testing and follow up. However, following exposure to blood or other body fluids the source person should be tested for HCV. If the results are positive, the exposed person must also be tested for anti-HCV and Alanine Aminotransferase (ALT) at baseline and at four to six months.

3.4.6 Management of occupational exposure to HIV

Like HBV and HCV, HIV is also a threat to health workers. The transmission of HIV among health workers can be as a result of occupational and non-occupational exposure and thus management should base on the nature of the exposure. The management of the occupational exposure to HIV has been well documented in the Tanzania National Guidelines for HIV and AIDS prevention 2009. The following are management steps recommended to be taken when a health worker has been exposed;

- Wash the exposed site contacted with blood or bodily fluids with soap and water and in case of mucous membranes flush with water.
- Report the circumstances of exposure to the authorized person at health facility.
- Post exposure management procedure should be recorded in the exposed person's confidential form for easy follow up and care. Refer Step 2(exposure report and documentation) for Information to be recorded.
- Assess the risk of the occupational exposure by considering the type, severity of the exposure and the status of the source person. Use the following criteria to assess the risk of the exposure based on mode of exposure;

BBP	Mode of exposure	Risk of infection/exposure (%)
HIV	Percutaneous	0.3
HIV	Mucous membrane	0.03 - 0.09
HBV	Percutaneous	10 – 30
HCV	Percutaneous	0 -10

Source; CDC 2001

- Evaluate the exposed health worker less than 24 hours. A starter pack should be initiated within 2 hours after exposure and before testing the exposed person. The exposed health worker should be counseled and tested for HIV at baseline in order to establish infection status at the time of exposure.
- Evaluate the source person for HIV status as described in Step 4.
- Assess and manage exposed person based on the status of source person and exposed health worker as shown in the table below;

Source person	Health worker	Healthcare worker management
HIV positive	HIV negative	PEP for 28 days then monitoring for 6 months
HIV positive	HIV positive	Stop PEP and Refer to CTC
Refuses to be tested - assume positive	HIV negative	PEP for 28 days then monitoring for 6 months
HIV negative	HIV negative	No PEP

Source: CDC Guidelines (2001)

- Initiate the recommended drugs for HIV PEP

3.4.7 Management of Occupational exposure to TB

Transmission of tuberculosis (TB) is a risk in healthcare environment. TB is a contagious and potentially life-threatening infectious disease caused by a bacterium called *Mycobacterium tuberculosis*. The TB bacteria are spread from person to person through the air droplets generated during coughing, sneezing. People with active TB have symptoms and can spread the disease. The risk of developing active TB disease is greatest in the first few years after infection, but some risk remains throughout life. TB is preventable and, in most cases, treatable. Occupational health and safety hierarchical control practices help to reduce the risk of TB transmission in a health facility.

TB Infection-Control Measures

The TB infection-control program for health workers should be based on the following hierarchy of control measures:

1. Engineering control
2. Administrative controls
3. Protective equipment

Engineering control

This is the first and most important level of control and is implemented at the design of the health facility. The following should be considered during the construction of a facility:-

- Ventilation to allow air in and out (through or cross ventilation)
- Laminar flow in selected areas e.g. laboratories,
- Installation of high particulate air filters (HEPA) in selected areas
- Install biological safety cabinets in the laboratories
- Provision of airborne infection isolation rooms (such as TB ward)
- Provide and promote use of PPEs as described below
- Controlling the source of infection by using local exhaust ventilation (e.g., hoods, tents, or booths) and diluting and removing contaminated air by using general ventilation.

Administrative Controls

Administrative controls are used to reduce the risk or exposure to persons with infectious TB. The health facility management should ensure the following activities:

- Educate and train health workers on airborne hazards, effects as well as safe work practice
- Provide proper triage system and crowd management in all waiting areas
- Conducting a TB risk assessment of the health facility;
- Implementing effective work practices for managing patients who may have TB disease; (such as workstation arrangement flow)

- Services for counseling health care workers in case of Occupational TB infection
- Testing and evaluating workers who are at risk for exposure to TB disease;
- Using posters and signs to remind health workers proper cough etiquette (covering mouth when coughing) and respiratory hygiene;
- Workers with HIV or with high risk of acquiring TB should be placed to work in workstation with low risk
- Consider rotation in work shift to reduce constant exposures to same groups of workers

Protective equipment Controls

The third level of control is the use of respiratory-protection control. It consists of the use of personal protective equipment in situations that pose a high risk of exposure to TB disease.

Use of respiratory protection equipment can further reduce risk for exposure of health care workers to infectious droplet nuclei that have been expelled into the air from a patient with infectious TB disease. The health workers should adhere to the following measures:-_

- Fit tested particulate respirator N95 or higher
- Appropriate eye protection such safety goggles or face shield depending on the risk
- Use impervious aprons
- Use appropriate gloves
- Training health workers on respiratory use

NOTE: for the TB treatment refer to the treatment guide and Manual of the National Tuberculosis and Leprosy Programme

3.5 Reporting and documentation

The OHS focal person and the Quality Improvement Team (QIT) will work as safety and health committee at health facility. The team shall report and maintain records of OHS events in the facility to facilitate prevention, care and bring to the attention of the immediate supervisor.

3.5.1 Accident and Incident reporting

Each health facility OHS focal person shall record, investigate and analyze incidents occurring in the workplace by using the accident report and investigation form (Annex 3)

Any accidents at work that involve an employee being unable to carry out his/her duties for three or more consecutive days or requiring treatment from a medical practitioner, are reportable to the health facility management and must be notified using accident report and investigation form. The reporting and investigation shall be done by OHS focal person immediately. The results of incident investigation shall be documented and maintained. Incident and accident reports shall be compiled on a monthly basis by using monthly report on occupational health & safety (Annex 6)

3.5.2 Dangerous occurrences

They are incidents with a high potential to cause death or serious injury, but which happen relatively infrequently. The worker shall report to OHS representative any dangerous occurrences within the work area by using the dangerous occurrence/near miss report form (Annex 7). Such occurrences shall be investigated and action taken. Dangerous occurrences usually include incidents involving:

- Lifting equipment
- Pressure systems
- Overhead electric lines
- Electrical incidents causing explosion or fire
- Explosions,
- Biological agents
- Spillage
- Radiation generators and radiography
- Breathing apparatus
- Collapse of equipment/structure

3.5.5 Internal Reporting Procedure

It is the responsibility of each health facility in-charge to ensure that appropriate investigation procedures take place in the event of an accident, near miss or dangerous occurrence arising in their area.

- Health facility in-charge must also ensure that the appropriate forms are completely filled
- Maintain register of all incidents
- Reported incidents are tabled and discussed at QIT and health and safety committee
- And all incidents are discussed in each health facility management meeting.

3.5.6 External Reporting Procedure

All accident and incident reports shall be well secured and made available when needed. External communication of reports will be done in accordance to existing legislations as follow:-

- OHS focal person in every healthcare facility must keep adequate occupational accident, disease and death records.
- These records should be kept in the form of a register. The importance of these records is to keep the information that can be used to identify, assess and control the hazards, as well as implement appropriate training where necessary.
- Health facility –in charge should also submit occupational accidents, diseases and death notification forms to the responsible authorities.

3.6 Compliance to OHS guidelines

3.8.1 Compliance

Occupational Health and Safety compliance at the basic level means complying with national regulations and occupational health and safety guidelines. Complying with OHS guidelines protects the employees, reduces workers compensation claims, improves the health facility image, and maintains employee safety and morale. Complying with OHS guidelines is just as baseline, however, additional Health and safety procedures and management systems can help to reduce workplace injuries and illnesses even further.

To ensure compliance to the health and safety guidelines in health care facilities, the following need to be observed by health facility management;

- i. Each facility should designate the OHS Focal person
- ii. The Quality service improvement team and OHS Focal person should conduct quarterly inspection of the facility and workers to assess compliance to the set health and safety measures; Annex 1
- iii. Each facility should have in place the Standard Operating Procedures (SOPs) for such issues linked to workers health and safety,
- iv. The facility should develop an Action plan to mitigate the identified OHS gaps with timelines and a responsible person for each gap to be closed,
- v. Quarterly supportive supervision should be conducted to healthcare facilities by RHMT and CHMT level using the standard tool to assess adherence to health and safety standards,
- vi. The facility should provide and conduct refresher course for the OHS.
- vii. QIT and OHS focal person to prepare a quarterly OHS facility report and be shared to other levels.

3.8.2 Tools of Compliance

The following tools should be used to ensure compliance at facility level.

Tools

- Assessment checklist
- Health facility Action Plan on OHS recommendation
- OHS Reporting form

Other working tools include:-

- Risk assessment guide
- Accident reporting and investigation forms
- Hazards report forms
- List of occupational diseases (WCF 2008)
- OHS Monthly reporting forms

3.8.3 Disciplinary action:

The fact that health workers sometimes face the occupational exposures as a result of mere negligence of precautions and non-compliance to SOPs set forth, the disciplinary actions are recommended as per professional ethical code, Public Service Management Standing Orders and employment and labor relations for the public and private respectively.

3.8.4 Compensation

The objective of these guidelines is to ensure workers are protected from OHS exposures. The health sector recognizes this and workers should be compensated accordingly for all work related exposures and injuries as follows.

Procedure for reporting accident

- i. Staff must report all accidents to the immediate supervisor verbally or through any other means of communication within 24 hours,
- ii. Supervisor should fill in and submit an accident notification form (annex 8) to the employer within 24 hours from the date of information.
- iii. The employer acknowledge receipt of the notification and submits to the Director General of WCF within 7 days after receipt of notification.
- iv. Supervisor should maintain register of all incidents
- v. Reported incidents are tabled and discussed by QIT / OHS committee
- vi. All incidents are discussed in each health facility management meeting
- vii. Report all registered occupational injuries to the Ministry responsible for Health in quarterly bases through NSMIS.
- viii. The QIT and OHS focal person in a council should coordinate accident and exposure investigation and ensure the relevant personnel are involved and a report is compiled.
- ix. Technical support and advice can be sought from the RHMT/CHMT.

Procedure for reporting of occupational Diseases

- i. Staff must report all suspected occupational disease (annex 5) to the immediate supervisor in writing within 7 days or Medical practitioner attending client report the suspected occupational diseases to the employer.
- ii. Supervisor should fill in and submit a diseases notification form (annex 8) to the employer within 7 days from the date of information.
- iii. The employer acknowledges receipt of the notification and submits to the Director General of WCF within 7 days after receipt of notification.
- iv. Supervisor should Maintain register of all suspected occupational disease
- v. Supervisor reported suspected occupational disease are tabled and discussed at QIT / health and safety committee
- vi. All suspected occupational disease are discussed in each health facility management meeting
- vii. Report all suspected occupational disease from register to the Ministry responsible for health in quarterly bases through NS MIS
- viii. The QI and OHS focal person in a council should coordinate suspected occupational disease and exposure investigation and ensure the relevant personnel are involved and a report is compiled. Technical support and advice can be sought from the RHMT/CHMT.

Procedure of reporting occupational Death

- i. Supervisors or any other person on behalf of employee to report death due to occupational disease or accidents (annex 8) to the employer or Medical practitioner attending the client report the death to the employer.
- ii. The employer acknowledges receipt of the notification of death and submits to the Director General of Workers Compensation Fund
- iii. The notification of death to employer or director general should be made within 12 months from the date of occurrence of such death.

After notification of either accident, disease or death the procedure for workers compensation will be in accordance to WCF assessment and verification.

3.7 Occupational Health and Safety supplies management

OHS Supplies are substances, equipment or materials that are used as a protective measure to individuals exposed to specific hazardous agent. The supplies include vaccines, drugs, personal protective equipment (PPE) and other safety equipment/ devices/ commodities.

The health facility in-charge shall ensure adequate availability of:-

- Basic OHS supplies (Annex 9) at all work station in the health facility.
- Plan the required amount of supplies equipment or materials annually
- Determine the annual budget for OHS supplies, and
- Fire safety equipment, use of signage, first aid kit and coordinate trainings on safety maintenance of equipment,

3.6.1 Facility maintenance

Engineering controls are methods that are built into the design of a facility, equipment or process to minimize the hazard.

The following should be observed in the health facility maintenance:-

- a) Ensure adequate budget for procurement of recommended supplies (annex 9).
- b) Prepare preventive maintenance schedule for different areas, equipment, structures for implementation and must include following.
 - Main walkways within and around facility to prevent slip, trip and falls.
 - Lifts
 - Stairways.
 - Ambulance vehicles
 - Transportation equipment e.g. trolleys, wheel chairs, waste handling trolleys, food transportation trolleys, etc.
 - Fire detection and fire fighting equipment
 - Electrical equipment, wiring and generator units.
 - Utilities e.g. boilers, compressors,
 - Building structural assessment on periodic basis
- c) The health facility QIT and OHS focal person shall ensure regular maintenance of equipment and facilities, as per engineering controls basing on risk.

3.6.2 Personal Protective Equipment

Personal protective equipment refers to protective barriers/ devices or clothing that are worn by a worker in order to prevent any part of his or her body and that of the clients from coming into contact with a hazard (s) present at the place of work.

All employees who are engaged in any process or activity that involves a risk of bodily injury or danger to health should be provided with suitable and appropriate protective clothing and/or equipment. The health facility shall plan; select, and budget for PPE's according to the annual risk assessment report for specific work areas.

General guidelines for appropriate use of PPE:




- Assess the risk of the exposure to a hazard.
- Read instructions clearly for use of PPE




- Select appropriate PPE.
- Use the right PPE for the right purpose.
- Fit the PPE to the person.
- Avoid any contact between contaminated PPE/clothing and people ie. Outside the work area
- Single use PPE should not be re-used
- Discard the PPE appropriately.
- Do not share PPEs.
- PPE should never be carried home or outside working area
- Re-usable PPE should be cleaned within work area.

3.6.3 Types and recommended uses of PPE

The type and recommended PPE should be specified for the work area and type of contaminant emanating from the activities, processes and procedures. The PPE must be correctly and effectively used

Table 2: Types of PPE in the healthcare setting and their use.

Type	Use	Materials /Use /Specification	How to don (put on) specific PPE	Image
Gown/ aprons	<ul style="list-style-type: none"> Prevents skin contact with infectious agents 	<ul style="list-style-type: none"> Natural or manmade Reusable or disposable Resistance to fluid penetration 	<ul style="list-style-type: none"> Select appropriate type and size Don(put on) as per instructions given Secure the PPE appropriately 	
Mask	<ul style="list-style-type: none"> Prevent air and droplet infections from client or provider 	Should fully cover nose and mouth	<ul style="list-style-type: none"> Place over nose, mouth and chin Fit flexible nose piece over nose bridge Secure on head with ties or elastic Adjust to fit 	
Respirators	<ul style="list-style-type: none"> Provides protection from dust air, gaseous droplets and fumes 	<ul style="list-style-type: none"> Particulate respirators Half- or full-face elastomeric respirators Powered air – purifying respirators (PAPR) 	<ul style="list-style-type: none"> Select a fit tested respirator Place over nose, mouth and chin Fit flexible nose piece over nose bridge Secure on head with elastic Adjust to fit Perform a fit check : Inhale – respirator should collapse., Exhale – check for leakage around face 	

Goggles	<ul style="list-style-type: none"> • Barrier of infectious materials to eyes 	<ul style="list-style-type: none"> • Should fit – snugly over and around eyes • Personal glasses are not a substitute for goggles • Antifog feature – improves clarity 	<ul style="list-style-type: none"> • Position goggles over eyes and secure to the head using the ear pieces or headband • Position face shield over – face and secure on brow with headband, Adjust to fit comfortably 	
Gloves	<ul style="list-style-type: none"> • Barrier of infectious materials to hands 	<p>Vinyl, latex, nitrile – Sterile or non-sterile</p>	<ul style="list-style-type: none"> • Wear gloves last • Select correct type and size • Insert hands into gloves • Extend gloves over isolation gown cuffs 	
Radiation shield aprons	<p>Protects client and provider from unnecessary radiation exposure</p>	<p>Lead materials</p>	<ul style="list-style-type: none"> • Select appropriate type and size • Don as per instructions given • Secure the PPE appropriately 	

Note: Safe use of gloves

- a) Keep gloved hands away from face
- b) Avoid touching or adjusting after put on PPE
- c) Remove gloves if they become torn; perform hand hygiene before donning (putting on) new gloves
- d) Limit surfaces and items touched

Biological Safety Cabinets (BSCs)

Name	Use
Class I BSC	Provides operator protection but no product protection. The exhaust air from the cabinet is filtered by a high-efficiency particulate air (HEPA) filter.
Class II BSCs	Class II biosafety cabinet will provide personnel, environment and product protection Types of Class II Cabinets: Class II, type A: this does not have to be vented, which makes it suitable for use in laboratory rooms which cannot be ducted Class II, type B1 Biosafety Cabinet: this cabinet must be vented, with 30% of the air exhausted from the cabinet while 70% is recirculated back into the room. Class II, type B2 Biosafety Cabinet: The cabinet must be totally exhausted, with 100% of air exhausted through a dedicated duct. Class II, type B3 Biosafety Cabinet: this must be vented. 70% of the air is exhausted from the cabinet while 30% is recirculated.
Class III BSC	Class III Biosafety Cabinet provides maximum protection of the environment and user when working with highly infectious microbiological agents. Both supply and exhaust air are HEPA filtered. Used mainly with highly pathogenic agents that usually do not have prophylaxis
Cytotoxic drug safety cabinets	Provides a barrier to the operator and environment
Laminar Flow or Clean Bench cabinets	Provide product protection only (must not be used where operator protection is required)
Pharmaceutical isolators	Provide protection to operator, product and work environment
Fume cupboards	Provide protection to operator only

3.6.5 Fire Extinguishers

Different types of fire extinguishers are designed to fight different sources of fire. Every health facility shall develop SOP on fire safety, which shall include ensuring availability and regular update of portable fire equipment and fire drills.

3.6.6 Safety showers/ eye /face wash units

Where applicable health HF shall ensure provision of facilities for emergency body shower, eye/face wash. Also develop instructions for body shower and eye/face wash

3.6.7 Spill kits

Where applicable facility shall have spill kits for chemical, biological and radiological spills. Every facility shall develop instructions for handling chemical, biological and radiological spills according to material safety data sheet.

Patient handling equipment

Availability of hoists, patient lifting aid or machines, stretchers, wheelchairs, special sheets for patient handling, for the areas with risk of violence such as psychiatric wards panic button should be available.

3.6.8 First Aid Kit

Every health facility provides standard first aid kit for staff and ensures adequate numbers of trained first aiders. The first Aid kit shall be in accordance to risk assessment of the facility. The minimum contents of first aid kit include:-

1. Sterile cotton balls.
2. Sterile pieces of gauze.
3. Bandages of various sizes including crepe.
4. Bandages and elastic bandages.
5. Arms ling or triangular bandages.
6. Safety pins.
7. Pair of scissors.
8. Gloves.
9. Splint of various sizes.
10. Tourniquets.
11. Maillol pain killers (Paracetamol or Aspirin).
12. Antiseptics (spirit weak iodine).
13. Blanket.
14. Note book for record keeping.
15. Stretcher.
16. Bottle of clean safety water for eye wash in absence of tape water

3.6.9 Safety signage and labels

- a) Every HF shall develop and display directional signage and labels at strategic areas.
- b) According to risk assessment findings, every HF should develop and display safety signs for biological, chemical, physical and radiological hazards
- c) Every facility shall display fire safety signs and labels and display them according to the facility fire risk assessment results
- d) Train health workers on safety signage and labels at workplace

3.8 Training on Occupational health and safety

Occupational Health and Safety is important for the wellbeing of health workforce for enhancing performance, retention and improving working conditions in health care provision. Training on occupational health and safety, will be emphasized to ensure that staffs adhere to the appropriate practices to minimize adverse OHS impacts.

Health Facility management team should ensure that all training needs have been identified in relation to hazards in the workplace and their mitigation measures, including integrated occupational health and safety trainings in the facility's/institution's plan for in-service training. Health facilities Managements are required to provide trainings in health and safety as part of their responsibility, such training should be provided periodically at all levels to ensure that the management and employees are able to fulfil their roles and responsibilities. Furthermore evaluation should be carried out as part of the regular review of the facility's health and safety programme. The following are the areas for various level of training:-

3.7.1 Introduction program for new employees/ short-term staff

- i. Every new staff shall be taken through the IPC guideline.
- ii. Governing procedures for the workers benefits e.g. WCF, circular No. 2 for Public services on workers living with HIV, The HIV and AIDS Act 2008.
- iii. Minimum standards for OHS at health care facilities (HCWM, WASH, IPC, workplace personnel and policy)
- iv. Basic Risk assessment and hazards identification and their mitigation
- v. Medical Checks (pre-employment, periodic and exit medical examination)
- vi. Exposure / incidence reporting and Documentation
- vii. Staff should be taken through a safety orientation of the facility (e.g. safety signs, evacuation, fire equipment,)
- viii. First aid measures
- ix. Orient health workforce on PPE selection Use and disposal
- x. Periodic refresher training on employee induction program
- xi. The orientation form should be signed by the employees and the supervisor

3.7.2 Induction program for out-sourced contractor

- i. Contractors and short-term staff shall undergo OHS induction training depending on the contract and the type of job.
- ii. Supply with necessary guidelines and SOPs related to contractual work including safety precautions for hazardous works.
- iii. Contractors should undergo safety training as part of contractual requirement.
- iv. Contractor should ensure the safety standards are adhered according to SOPs
- v. The designated OHS focal person should ensure facility orientation for the contractor as well as monitor contractors operations for safety. This may include use of Safety and operations Permits e.g. welding, work at heights for repairs, construction and painting, excavation work etc.

3.7.3 Internal facility training (existing staff)

- i. Identify professionals by cadres in a health facility
- ii. Identify OHS training requirements for each cadre of the health workers by carrying out a job hazard analysis
- iii. Prepare a risk register for all identified hazards according to cadres.
- iv. Develop training program based on the hazards identified on the risk register.
- v. Develop a yearly OHS training Plan.
- vi. All work improvement team (WIT) and OH focal person members should conduct Supportive supervision, training and mentoring on OHS in their department
- vii. Health facility QIT Monitor and evaluate annually OHS training program.

At the end of the training program, health workers should be able to:

- i. Identify occupational injuries and illnesses that may affect their health
- ii. Understand how to identify and report the OHS related injuries and illnesses
- iii. Understand the actions or procedures to take to reduce exposure to OHS related illnesses and injuries
- iv. Understand mitigations at the work place to reduce exposure
- v. Undertake a risk assessment and identify OHS hazards at the work place.
- vi. Be able to read and interpret MSDS at the work place
- vii. Developing OHS trainers' capacity within National, region, district and healthcare facilities (TOTs)

Apart from the above training clinicians shall be provided with a tailor made course on basic occupational health and safety for early detection, diagnosis and treatment

- i. Improve on ability for identification and management of occupational diseases and injuries at the work place.

- ii. Offer advice on prevention, management and design rehabilitation plans that recognize the employment needs of all health workers concerned

Note: Health facility focal person shall provide orientation /tailor made training on minimum requirement for occupational health and safety in health care facilities workforce and emergence responders

- i. Environmental health considerations (WASH, HCWM,)
- ii. Infection prevention and control (IPC)
- iii. Personnel and workplace policy (Compensation, Administrative issue)

3.7.4 TOTs training

To ensure that training in OHS is maintained in all health facilities, there should be adequately trained trainers in Occupational Health and Safety.

The TOT training manual will include the following:

- i. The contents of public health Act 2009, Occupational Health and Safety Act. 2003, and Workers Compensation Act, 2008
- ii. Aspects of National OHS guidelines for the health facilities
- iii. Understanding of National Health Policy and strategic plans
- iv. OHS hazards and risk assessment (facility based) and the mitigation plan.
- v. Early Occupational diseases detection/suspect, diagnosis, treatment for clinician
- vi. HealthWISE approach (improving work conditions, performance and workplace safety)

3.9 Ergonomics

Musculoskeletal disorders (MSDs) are among the common work-related health problem in health care facilities affecting most of workers. MSDs are among reasons for concern not only because of the health effects on the individual worker, but also because of the economic impact on health care systems as well as the social costs to countries. MSDs may also lead to higher compensation cost.

In order to achieve the prevention of MSDs and ensure sustainability the following measures are targeted.

Elimination measures include:-

- Avoid the risk (e.g. manual handling of loads/patients) by use lifting aids
- Improve the layout of the workplace to avoid workers performing tasks requiring high force or awkward/static postures, by appropriate design of the work place.
- If the risk of injury/strain cannot be avoided it needs to **be reduced**,
- Physical strain situation can be held within acceptable limits
- Avoid the MSDs risks at source and consider how far the risk must be reduced;
 - Adapt the work to the individual — especially the design of workplaces (e.g. ergonomic working height, adjustable worktops, standing aids) and the choice of work equipment;
 - Adapt to technical innovations for devices and mechanical aids such as electrically powered adjustable beds, lifts, stretchers, trolleys and vacuum lifting devices or mechanical handling equipment in storing or in the operating theatre must be provided.
 - For patient handling, small devices (handling aids) to reduce or increase friction (e.g. transfer boards, transfer belts, glide boards, sliding mats) are essential, as well as powered sit-to-stand or standing aids and hoists, preferably ceiling-mounted lifts.

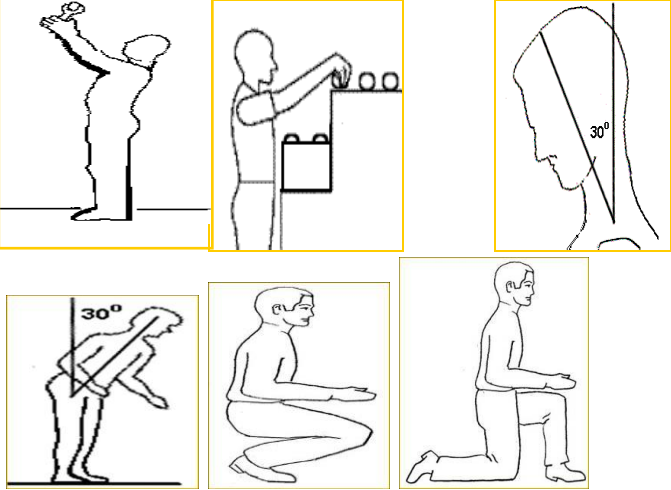
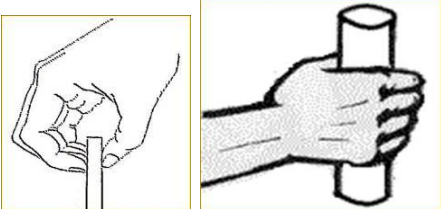

Administration measures:

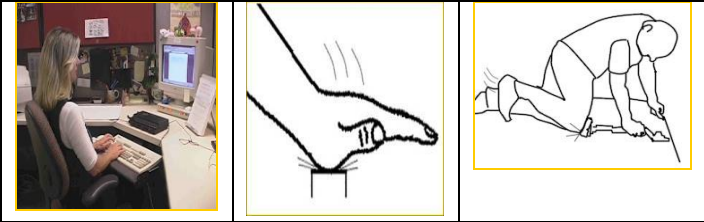


Should be considered if not possible to eliminate or reduce MSDs risks. It requires reduction of physical demands of the job by decreasing the levels of force, repetition and awkward postures; this often necessitates the use of handling devices or adjustable beds and tables and the choice of ergonomic working methods. Staff should be trained on how to deal with an emergency in case of malfunctioning equipment. Adequate maintenance programmes should be ensured.

Measures for the administration include:

- Provide sufficient staff for the work to be done.
- Make sure there is a balance between mechanical load and the individual loadbearing capacity of the musculoskeletal system of the workers.
- Consider reduction of time pressures.
- Implement a systematic training concept for manual handling activities
- Consider job rotation to reallocate tasks between workers to reduce prolonged standing or bending and twisting in the operating theatre.
- Implement a reasonable shift rotation system, rotate forward and allow enough days off work.
- Provide a certain variety in the work to be done.
- Introduce breaks between works.

Table 3: Avoid the following risk factors for ergonomic hazards;

S/No	Risk factors (avoided)	Ergonomic solution	Pictorial Demonstrations of caution zone
1	Awkward postures	Avoid being in the following work position for more than 2 hours total per day: Hands above head, elbow above shoulder, back bent forward more than 30 degrees, squatting, and kneeling	
2	High hand force	<ul style="list-style-type: none"> • Avoid pinching 1 or more kg of weight for more than 2hrs/day • Avoid gripping 5 or more kg of weight more than 2 hrr/day 	
3	Highly repetitive motion	Avoid to repeat the same motion of neck, shoulders, elbows, wrists and hands every few seconds for more than 2 hrs per day	

4	Repeated impacts	<ul style="list-style-type: none"> ● Avoid intensive keying for more than 4 hours per day ● Avoid repeated impacts using hands or knees as a hammer more than 10 times per hour and more than 2hrs per day 	
5	Heavy, frequent or awkward lifting	<p>Avoid lifting objects more than;</p> <ul style="list-style-type: none"> ● 35 kg once/day ● 20 kg more than ten times/day ● 5 kg more than twice/minute for more than 2 hrs per day ● 12 kg above shoulders, below knees, or at arm's length for more than 25 times/day 	
6	Moderate to high hand-arm vibration	<ul style="list-style-type: none"> ● Avoid moderate level hand-arm vibration for more than 2hrs/day ● Avoid high level hand-arm vibration for more than 30 mins/day 	

CHAPTER FOUR

4.0 Monitoring and evaluation

Monitoring in occupational health and safety implies to health and Safety audit and performance review to various activities in the health care system. 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 of the health and safety at the health care facility allows assessment of the implementation in four key indicators:

- Achievement of specific objectives;
- 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.

The review and evaluation process aim at measuring the outcomes such as the attainment of goals and objectives, also at seeing the effectiveness of the implementation at the facilities and 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 principles and procedures. The evaluation can also monitor the effectiveness by evaluating and observing both overall and departmental trends in occupational injuries and illnesses.

Monitoring of the performance of the health, safety and environment programme of health facility is mandatory. Internal monitoring should be done twice in a year and external monitoring should be performed at least after every two years. The monitoring process should cover:

- The health and safety policies/rules/regulations of the facility
- Inventory of health and safety risks
- Control measures for risks at the facility
- Results or trends in health surveillance
- Trends in accident statistics
- Training of staff in health and safety
- Emergency response plans and procedures and their effectiveness
- Financial/resources for OHS

Meanwhile, for effectiveness of the evaluation / performance of health, safety and environment programmes, the roles and responsibilities of each level must be indicated within the framework (refer to chapter 2 of the document).

Indicators for facility level (on annual basis)

- Number of reported incidents with blood exposure (blood splashes, needlesticks and sharps injuries)
- Number of reported incidents with violence (physical, verbal, sexual harassment)
- Number of cases with sickness absence due to low back pain) and days lost
- Number of reported work accidents
- Number of reported cases with suspected occupational diseases
- Number of cases with PEP (HIV and HBV)
- Existence of facility health and safety committee
- Number of preventive medical examinations of health workers
- Number of meetings of the health and safety committee
- Existence of facility focal point for occupational health and safety
- Number of walkthrough surveys (risk assessments carried out)
- Funds spent on occupational health and safety (human resources, training, safety equipment, PPE, information materials etc.)
- Number of health facility inspections covering occupational health and safety
- Number of training courses on occupational health and safety for health facilities (focal points and committee members)
- Number of health workers trained in occupational health and safety

Indicators at national level

- Proportion of health facilities with health and safety committees
- Proportion of health facilities with OHS focal points
- Proportion of health facilities covered with OHS inspection
- Incidence of incidents with blood exposure (blood splashes, needle sticks and sharps injuries) – number of reported cases per 1000 health workers
- Incidence of incidents with violence (physical, verbal, sexual harassment) – number of reported cases per 1000 health workers
- Incidence of sickness absence due to low back pain – number of cases of sickness absence due to low back pain per 1000 health workers
- Incidence of work accidents – number of reported work accidents per 1000
- Incidence of occupational diseases – number of registered occupational diseases per 1000 health workers
- Total number of health workers trained in occupational health and safety
- Number of meetings of the national steering committee for occupational health and safety
- Proportion of health workforce covered with preventive medical examinations
- Total number of cases of PEP (HIV and HBV)

ANNEXES

1. HEALTH FACILITY ASSESSMENT CHECKLIST

Name of the facility		Type (Public/Private)	
Region		Level*	
District		Total No. of staff M/F	
Inspector's name(s)		Average No. of daily patients	
Date of inspection		Total beds	
		Total No. in patient	
Contacts inspector and facility in charge			
Carders *			

*Level; Dispensary, Health centre District hospital, Regional hospital, Referral hospital, specialised hospital

Management

Sn	Area for inspection	Yes	No	NA	Comment
1	Is there a designated OHS focal person?				
2	Is the OHS focal person member of HMT?				
3	Are there written OHS related SoPs?				
4	Are there OHS guidelines?				
5	Are key OHS signage displayed in work areas?				
6	Are the periodic medical examination conducted?				
7	Is there a register to record incidents and accidents?				
8	Is there an effective system for correcting identified hazards?				

Training

Sn	Area for inspection	Yes	No	NA	Comment
1	Is there induction-training program on OHS for all health workers?				
2	Is the documentation of trained health workers done? <i>(if yes, check the document)</i>				
3	Is there regular on job training for all health workers on OHS provided?				
4	Is training provided specific to the individual workplace?				
5	Are training materials on OHS provided to the trainees?				

Work Environment

Sn	Area for inspection	Yes	No	NA	Comment
Indoor environment					
1	Do the general ventilation provisions appear sufficient?				
2	Is lighting adequate?				
3	Are stairs clean, not slippery and grab rails in good conditions?				
4	Are floors clean, in good conditions and not slippery?				
5	Are windows in good condition and fly screened?				
6	Is exposure to noise prevented?				
7	Are workers protected from extreme temperature risk?				
8	Are surfaces in workplace free from dust?				
9	Are workers protected from radiations?				
10	Is there regular maintenance of anaesthesia machine?				
Outdoor environment					
1	Is there beautification of the surrounding environment? (Observe)				
2	Is there vectors control and pets program after every six month? (Observe a proof of fumigation)				
3	Is the environment clean (observe for presence of rubbish and tall grasses)				
4	Is there stagnant water (observe)?				

Water supply

Sn	Area for inspection	Yes	No	NA	Comment
1	Is the facility supplied with water?				
2	Is the water piped or from deep well?				
3	Is the water clean and safe water?				
4	Is there adequate water storage facility?				
5	Do all departments supplied with water?				
6	Is there hand washing facilities?				
7	Is there provision for drinking water?				

Emergency, Health and Safety

Sn	Area for inspection	Yes	No	NA	Comment
1	Are emergency exits visible?				
2	Are emergency exits free from obstruction?Observe				
3	Is emergency evacuation plan displayed?				
4	Are fire extinguishers presents?				
5	Are fire extinguishers regularly inspected and serviced?				
6	Are safety boxes for sharps available?				
7	Are safety retractable needles available and used?				
8	Is there appropriate PPE?				
9	Do health workers regularly trained on PPE use?				
10	Do infection prevention control protocols adhered to?				
11	Are appropriate manual handling (eg. Lifting, pulling) controls in place?				
12	Is there appropriate mechanical handling or aid equipment?				

Signage and Instruction

Sn	Area for inspection	Yes	No	NA	Comment
1	Are chemicals labeled properly?				
2	Are restricted areas identified?				
3	Are evacuation routes identified?				
4	Are isolation signs available?				
5	Are wet floor signs present?				
6	Are instructions for PPE use present?				
7	Are biohazard areas identified?				
8	Are radiation areas labeled?				
9	Are there hand hygiene posters?				

Waste management

Sn	Area for inspection	Yes	No	NA	Comment
1	Are there appropriately color coded /labeled waste bins for health care waste?				
2	Are waste equipment and facilities clean and maintained?				
3	Are there guidelines for health care waste				

	management?				
4	Is there incinerator for hazardous waste disposal?				
5	Do safety boxes in use and not overfilled?				
6	Do health workers trained on how to manage spills?				

Psychosocial and violence management

Sn	Area for inspection	Yes	No	NA	Comment
1	Are there measures in place for reporting workplace violence?				
2	Are there procedures for handling aggressive patients?				
3	Do staff put on identification badges?				
4	Are contact numbers for security displayed?				
5	Are entrances, exits, parking areas and walkways well secure?				

Ergonomic management

Item	Factors to evaluate	Yes	No	NA
Chair	Seat height is adjustable to accommodate operator's height when he/she is seated			
	Supported back rest chair is provided			
	Seat allow user to sit upright			
Desk	Have appropriate height with round edge			
Monitor	When head is erect, the top of screen is in line with eyes. i.e. Screen is adjustable to allow inline with eyes when head is looking at screen			
Work and rest rates	Work and rest rates are ensured (Allow work diversification)			
	Different tasks are alternated while working, for example taking 10-minute breaks per hour (or 5 minutes per half hour), get up and walk around etc			
Conducive working environment	Reduced noise level (generators)			
	Frequent supply of fresh air			
	Lighting (adjustable to reduce glare (i.e. high contrast)			
	Favourable temperature			
	Appropriate work space and reach distance (bed to bed)			
Safe lifting	Availability of proper patient lifting techniques			
Bed	Adjustable patient/operation bed			

2. RISK ASSESSMENT GUIDANCE

Region:	
District:	
Level of the facility	
Name of facility:	
Department:	
Name of person doing assessment:	
Date of assessment:	
Activity or Procedure being assessed:	
Known or expected hazards associated with the activity or procedure:	
Who is at risk?	
Prioritize the risk	Low (), Moderate (), High ()
The risk of injury and its severity likely to arise from these hazards	
Action to be taken in an emergency	
Measure to be taken to reduce the level of risk	
Signature of Assessor	

Risk Assessment Matrix

Date	Identified Risk	Current control processes in place	Frequency (F)	Severity (S)	Detectability (D)	Criticality (FxSxD)	Is this risk acceptable	Recommended additional control processes needed to reduce the risk to acceptable levels.

Frequency (F) Rating Examples			
Common Terms	Rating	Example (ISO 14971)	Practical Example
Frequent	5	$\geq 1/1,000$	More than 1x/week
Probable	4	$< 1/1,000$ and $\geq 1/10,000$	Once every few months
Occasional	3	$< 1/10,000$ and $\geq 1/100,000$	Once a year
Remote	2	$< 1/100,000$ and $\geq 1/1,000,000$	Once every few years
Improbable	1	$< 1/1,000,000$ and $\geq 1/10,000,000$	Unlikely to happen
Severity (S) Examples			
Common Terms	Rating	Possible Description (ISO14971)	
Catastrophic	5	Results in patient death	
Critical	4	Results in permanent injury of life-threatening injury	
Serious	3	Results in injury or impairment requiring professional medical intervention	
Minor	2	Results in temporary injury or impairment not requiring professional medical intervention	
Negligible	1	Inconvenience or temporary discomfort	
Detectability (D) Examples			
Common Terms	Rating	Examples	
Low	5	Control is ineffective	
	4	Control less likely to detect the failure	
	3	Control may or may not detect the failure	
	2	Control almost always detects the failure	
High	1	Control can detect the failure	

Criticality =	Frequency X Severity X Detectability
Criticality	Results
Low	<10
Mid	10-20
High	>20

Risk Acceptability Matrix

	Severity of Harm				
Probability of Harm	Negligible	Minor	Serious	Critical	Catastrophic
Frequent	Unacceptable	Unacceptable	Unacceptable	Unacceptable	Unacceptable
Probable	Acceptable	Unacceptable	Unacceptable	Unacceptable	Unacceptable
Occasional	Acceptable	Acceptable	Unacceptable	Unacceptable	Unacceptable
Remote	Acceptable	Acceptable	Acceptable	Unacceptable	Unacceptable
Improbable	Acceptable	Acceptable	Acceptable	Acceptable	Unacceptable

3. ACCIDENT REPORTING AND INVESTIGATION FORM

INCIDENTS AND OCCUPATIONAL DISEASE NOTIFICATION		THIS FORM IS MADE UNDER SECTION 101 OF THE ACT No. 5 of 2003; IT SHALL BE FILLED IN BY AN EMPLOYER OR OTHER RESPONSIBLE PERSON AND SUBMITTED TO THE CHIEF INSPECTOR WITHIN SEVEN DAYS
<p>A- Particulars of the Workplace (Maelezo ya Eneo la kazi)</p> <p>1. Name of the workplace (Jina la eneo la kazi): <input style="width: 100%;" type="text"/></p> <p>2. Postal address (Anuani ya Posta): <input style="width: 100%;" type="text"/></p> <p>3. Location of the workplace (Mahali lilipo eneo la kazi): <input style="width: 100%;" type="text"/></p> <p>4. Telephone No. (Simu): <input style="width: 100%;" type="text"/></p>	<p><input type="checkbox"/> Biological factors (Vijidudu vya magonjwa)</p> <p><input type="checkbox"/> Contact with electricity/ electrical discharge (Shoti ya umeme)</p> <p><input type="checkbox"/> Drowned or asphyxiated (Kuzama au kukosa hewa)</p> <p><input type="checkbox"/> Injured by an animal (Kujeruhiwa na mnyama)</p> <p><input type="checkbox"/> Exposed to an explosion (Mlipuko)</p> <p>Other kind of incident, please mention (Ingine, tafadhali taja): <input style="width: 100%;" type="text"/></p>	<p><input type="checkbox"/> Nerves or spinal cord (Neva au ugwe mgongo)</p> <p><input type="checkbox"/> Mental disorder (Matatizo ya akili)</p> <p>Any other, please specify (Ingine, tafadhali taja): <input style="width: 100%;" type="text"/></p>
<p>B- Particulars of the Affected Person (Maelezo Binafsi ya Majeruhi/Mgonjwa/Marehemu)</p> <p>5. Name of the person involved in the incident (Jina la mhusika): <input style="width: 100%;" type="text"/></p> <p>6. Title (Cheo): <input style="width: 100%;" type="text"/></p> <p>7. Date of birth (Tarehe ya kuzaliwa): <input style="width: 100%;" type="text"/> Sex: M/F (Jinsia: Me/Ke): <input style="width: 50px;" type="text"/></p> <p>8. Period of employment (Kipindi cha utumishi): Months (Miezi): <input style="width: 100%;" type="text"/></p> <p>9. Date/time of incident (Tarehe/muda wa tukio): <input style="width: 100%;" type="text"/></p> <p>10. Location where the incident happened (Jina la sehemu ya tukio): <input style="width: 100%;" type="text"/></p> <p>11. The affected person is [tick v] (Mhusika ni [weka v]):</p> <p><input type="checkbox"/> An employee (Mwajiriwa)</p> <p><input type="checkbox"/> An employer (Mwajiri)</p> <p><input type="checkbox"/> Self employed (Mtu aliyejijiriri)</p> <p><input type="checkbox"/> Other (Ingine): <input style="width: 100%;" type="text"/></p>	<p>D- Nature of Injury or Disease (Aina ya Jeraha au Ugonjwa)</p> <p>13. [tick v] ([weka v])</p> <p><input type="checkbox"/> Fatal (Kifo)</p> <p><input type="checkbox"/> Fracture of spine (Kuvunjika uti wa mgongo)</p> <p><input type="checkbox"/> Puncture wound (Kuchomwa na kitu chenye ncha)</p> <p><input type="checkbox"/> Other fracture (Jeraha linginelo)</p> <p><input type="checkbox"/> Poisoning or toxic effects (Sumu)</p> <p><input type="checkbox"/> Dislocation (Kuteguka)</p> <p><input type="checkbox"/> Multiple injuries (Majeraha)</p> <p><input type="checkbox"/> Sprain or strain (Maumivu ya kifundo au msuli)</p> <p><input type="checkbox"/> Damage to artificial aid (Kuvunjika kiungo bandia)</p> <p><input type="checkbox"/> Head injury (Jeraha la kichwa)</p> <p><input type="checkbox"/> Disease, nervous system (Athari kwenye mfumo wa fahamu)</p> <p><input type="checkbox"/> Internal injury of trunk (Maumivu ya kiwiliwili)</p> <p><input type="checkbox"/> Disease, musculoskeletal system (Kulemaa viungo)</p> <p><input type="checkbox"/> Amputation (Kukatika kiungo)</p> <p><input type="checkbox"/> Disease, skin (Ugonjwa wa ngozi)</p> <p><input type="checkbox"/> Disease, eye (Ugonjwa wa macho)</p> <p><input type="checkbox"/> Open wound (Kidonda)</p> <p><input type="checkbox"/> Disease, digestive system (Athari kwenye mfumo wa chakula)</p> <p><input type="checkbox"/> Superficial injury (Jeraha dogo)</p> <p><input type="checkbox"/> Disease, infectious or parasitic (Maambukizi ya vimelea)</p> <p><input type="checkbox"/> Bruising or crushing (Kuchubuka au kukandamizwa)</p> <p><input type="checkbox"/> Disease, respiratory system (Athari kwenye mfumo wa kupumua)</p> <p><input type="checkbox"/> Foreign body (Kuingiwa na kitu au kihatarishi mwilini)</p> <p><input type="checkbox"/> Burns (Kuungua)</p> <p><input type="checkbox"/> Tumour (malignant or benign) (Uvimbe)</p>	<p>E- Description of the Incident (Maelezo ya Tukio)</p> <p>14. Describe briefly, or you may attach separate sheet(s) (Fafanua kwa kifupi, au ambatanisha karatasi ya maelezo): <input style="width: 100%; height: 100px;" type="text"/></p>
		<p>F- Treatment of the Affected Person (Matibabu)</p> <p>15. Type of treatment provided (Matibabu yaliyotolewa):</p> <p><input type="checkbox"/> None (Hakuna) <input type="checkbox"/> First Aid (Huduma ya kwanza)</p> <p><input type="checkbox"/> Sent to Doctor (Kutibiwa) <input type="checkbox"/> Hospitalized (Kulazwa)</p>
		<p>G- Notification to Chief Inspector (Taarifa kwa Mkaguzi Mkuu)</p> <p>16. Name and position of the person reporting the event (Jina na cheo cha anayetoa taarifa ya tukio): <input style="width: 100%;" type="text"/></p> <p>Signature (Saini): <input style="width: 100%;" type="text"/></p> <p>Date (Tarehe): <input style="width: 100%;" type="text"/></p>

Source OSHA regulations

4. HAZARD REPORT FORM

<p>Name of the assessor</p> <p>Date:</p>
<p><i>Name of the facility</i></p> <p>Level of facility</p> <p><i>Location/ workstation:</i></p>
<p><i>Description of the hazard: (Include area and task involved, any equipment, tools, people involved. Use sketches if necessary)</i></p>
<p><i>Suggested corrective action: (List any suggestions you may have for reducing or eliminating the hazard.)</i></p>
<p><i>Submit to Health Facility In-charge</i></p> <p><i>Signature:.....</i></p>
<p><i>Supervisor's remarks (Action taken):</i></p> <p style="text-align: right;"><i>Date:</i></p> <p>.....</p> <p style="text-align: right;"><i>Health facility In-charge:</i></p> <p>.....</p>
<p><i>Corrective action taken:</i></p> <p style="text-align: right;"><i>Date:</i></p> <p>.....</p> <p style="text-align: right;"><i>Health Facility In-charge signature:</i></p> <p>.....</p>

5. LIST OF OCCUPATIONAL DISEASES AS IN THE WCF ACT, 2008

1.1. Diseases caused by chemical agents

- 1.1.1. Diseases caused by beryllium or its compounds
- 1.1.2. Diseases caused by cadmium or its compounds
- 1.1.3. Diseases caused by phosphorus or its compounds
- 1.1.4. Diseases caused by chromium or its compounds
- 1.1.5. Diseases caused by manganese or its compounds
- 1.1.6. Diseases caused by arsenic or its compounds
- 1.1.7. Diseases caused by mercury or its compounds
- 1.1.8. Diseases caused by lead or its compounds
- 1.1.9. Diseases caused by fluorine or its compounds
- 1.1.10. Diseases caused by carbon disulfide
- 1.1.11. Diseases caused by halogen derivatives of aliphatic or aromatic hydrocarbons
- 1.1.12. Diseases caused by benzene or its homologues
- 1.1.13. Diseases caused by nitro- and amino-derivatives of benzene or its homologues
- 1.1.14. Diseases caused by nitroglycerine or other nitric acid esters
- 1.1.15. Diseases caused by alcohols, glycols or ketones
- 1.1.16. Diseases caused by asphyxiants like carbon monoxide, hydrogen sulfide, hydrogen cyanide or its derivatives
- 1.1.17. Diseases caused by acrylonitrile
- 1.1.18. Diseases caused by oxides of nitrogen
- 1.1.19. Diseases caused by vanadium or its compounds
- 1.1.20. Diseases caused by antimony or its compounds
- 1.1.21. Diseases caused by hexane
- 1.1.22. Diseases caused by mineral acids
- 1.1.23. Diseases caused by pharmaceutical agents
- 1.1.24. Diseases caused by nickel or its compounds
- 1.1.25. Diseases caused by thallium or its compounds
- 1.1.26. Diseases caused by osmium or its compounds
- 1.1.27. Diseases caused by selenium or its compounds
- 1.1.28. Diseases caused by copper or its compounds
- 1.1.29. Diseases caused by platinum or its compounds
- 1.1.30. Diseases caused by tin or its compounds
- 1.1.31. Diseases caused by zinc or its compounds
- 1.1.32. Diseases caused by phosgene
- 1.1.33. Diseases caused by corneal irritants like benzoquinone
- 1.1.34. Diseases caused by ammonia
- 1.1.35. Diseases caused by isocyanates
- 1.1.36. Diseases caused by pesticides
- 1.1.37. Diseases caused by sulphur oxides

- 1.1.38. Diseases caused by organic solvents
- 1.1.39. Diseases caused by latex or latex-containing products
- 1.1.40. Diseases caused by chlorine
- 1.1.41. Diseases caused by other chemical agents at work not mentioned in the preceding items where a direct link is established scientifically, or determined by methods appropriate to national conditions and practice, between the exposure to these chemical agents arising from work activities and the disease(s) contracted by the worker

1.2. Diseases caused by physical agents

- 1.2.1. Hearing impairment caused by noise
- 1.2.2. Diseases caused by vibration (disorders of muscles, tendons, bones, joints, peripheral blood vessels or peripheral nerves)
- 1.2.3. Diseases caused by compressed or decompressed air
- 1.2.4. Diseases caused by ionizing radiations
- 1.2.5. Diseases caused by optical (ultraviolet, visible light, infrared) radiations including laser
- 1.2.6. Diseases caused by exposure to extreme temperatures

1.3. Biological agents and infectious or parasitic diseases

- 1.3.1. Brucellosis
- 1.3.2. Hepatitis viruses
- 1.3.3. Human immunodeficiency virus (HIV)
- 1.3.4. Tetanus
- 1.3.5. Tuberculosis

- 1.3.6. Toxic or inflammatory syndromes associated with bacterial or fungal contaminants

1.3.7. Anthrax

1.3.8. Leptospirosis

2. Occupational diseases by target organ systems

2.1. Respiratory diseases

- 2.1.1. Pneumoconioses caused by fibrogenic mineral dust (silicosis, anthraco-silicosis, asbestosis)
- 2.1.2. Silicotuberculosis
- 2.1.3. Pneumoconioses caused by non-fibrogenic mineral dust
- 2.1.4. Siderosis
- 2.1.5. Bronchopulmonary diseases caused by hard-metal dust
- 2.1.6. Bronchopulmonary diseases caused by dust of cotton (byssinosis), flax, hemp, sisal or sugar cane (bagassosis)
- 2.1.7. Asthma caused by recognized sensitizing agents or irritants inherent to the work process
- 2.1.8. Extrinsic allergic alveolitis caused by the inhalation of organic dusts or microbially contaminated aerosols, arising from work activities
- 2.1.9. Chronic obstructive pulmonary diseases caused by inhalation of coal dust, dust from stone quarries, wood dust, dust from cereals and agricultural work, dust in animal stables, dust from textiles, and paper dust, arising from work activities
- 2.1.10. Diseases of the lung caused by aluminium

2.1.11. Upper airways disorders caused by recognized sensitizing agents or irritants inherent to the work process

2.2. Skin diseases

2.2.1. Allergic contact dermatoses and contact urticaria caused by other recognized allergy provoking agents arising from work activities not included in other items

2.2.2. Irritant contact dermatoses caused by other recognized irritant agents arising from work activities not included in other items

2.2.3. Vitiligo caused by other recognized agents arising from work activities not included in other items

2.3. Musculoskeletal disorders

2.3.1. Radial styloid tenosynovitis due to repetitive movements, forceful exertions and extreme postures of the wrist

2.3.2. Chronic tenosynovitis of hand and wrist due to repetitive movements, forceful exertions and extreme postures of the wrist

2.3.3. Olecranon bursitis due to prolonged pressure of the elbow region

2.3.4. Prepatellar bursitis due to prolonged stay in kneeling position

2.3.5. Epicondylitis due to repetitive forceful work

2.3.6. Meniscus lesions following extended periods of work in a kneeling or squatting position

2.3.7. Carpal tunnel syndrome due to extended periods of repetitive forceful work, work involving vibration, extreme postures of the wrist, or a combination of the three

2.4. Mental and behavioural disorders

2.4.1. Post-traumatic stress disorder

3. Occupational cancer

3.1. Cancer caused by the following agents

3.1.1. Asbestos

3.1.2. Benzidine and its salts

3.1.3. Bis-chloromethyl ether (BCME)

3.1.4. Chromium VI compounds

3.1.5. Coal tars, coal tar pitches or soots

3.1.6. Beta-naphthylamine

3.1.7. Vinyl chloride

3.1.8. Benzene

3.1.9. Toxic nitro- and amino-derivatives of benzene or its homologues

3.1.10. Ionizing radiations

3.1.11. Tar, pitch, bitumen, mineral oil, anthracene, or the compounds, products or residues of these substances

3.1.12. Coke oven emissions

3.1.13. Nickel compounds

3.1.14. Wood dust

3.1.15. Arsenic and its compounds

3.1.16. Beryllium and its compounds

3.1.17. Cadmium and its compounds

3.1.18. Erionite

3.1.19. Ethylene oxide

3.1.20. Hepatitis B virus (HBV) and hepatitis C virus (HCV)

4. Other diseases

4.1. Miners' n

6. MONTHLY REPORT ON OCCUPATIONAL HEALTH & SAFETY

Name of the facility		Type (Public/Private)	
Region		Level*	
District		Total No. of staff M/F	
Inspector's name(s)		Average No. of daily patients	
Date of inspection		Total beds	
		Total No. in patient	
Reported by			

1. ACCIDENTS AND INJURIES

Number of accidents reported.....

Total number of injuries reported.....

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

SEVERITY OF INJURY

Severity of injuries fatal..... Non fatal.....

BODY PART INJURED/ AFFECTED	NON FATAL		
	MILD	MODERATE	SEVERE
Head			
Eyes			
Neck			
Back/ spine			
Chest			
Abdomen			
Shoulder, upper arm, elbow			
Lower arm, wrist			
Hand			
Finger			
Hip joint, thigh, knee cap			
Knee joint, leg			
Foot			
Toes			
Other injury			

Absence from work as a result of injury:

Number of cases resulting in absence from work:

- a). a). 1-3 days absence.....
- b). 4 – 5 days absence..... d). Absence exceed 14 days.....
- c). Permanent total disability e) Number resulting in Death.....

2. CONDITIONS OF ILL-HEALTH

No. of sick sheet issued.....

Sex : Male..... Female.....

Sickness absence due to ill-health:

Number of cases resulting in absence from work:

- a). 1-3 days absence.....
- b). 4 – 5 days absence..... d). Absence exceed 14 days.....
- c). Permanent total disability e) Number resulting in Death

MEDICAL SURVEILLANCE

Total No. of staff under take medical examination: Males
Females.....

Type of examinations:

Pre-placement..... Periodic..... Post-sickness-absence..... Other
special.....Exit.....

3. 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	
Other	

7. DANGEROUS OCCURRENCE/NEAR MISS REPORT FORM

Date:	Time:
Name of person(s) involved:	
Where did the incident take place	
What activity was being undertaken at the time of the incident?	
Name, Address & Contact details of any witnesses to the incident:	
Name:	
Mobile phone No:	
Description of Dangerous occurrence/Near Miss:	
Steps taken to prevent a reoccurrence of this type of this incident:	
Signature of person completing report:	Date:
Name:	Job
Title:	
Signature of health facility in-charge:	Date:
Name:	

8. NOTIFICATION FORM FOR OCCUPATIONAL ACCIDENTS, DISEASES OR DEATHS

(Made under regulations 15, 16 and 17)

(To be completed by an employee, employer or any person on behalf of an employee in triplicate. The form shall be filled in case of serious conditions which needs employer's attention)

A. TYPE OF NOTIFICATION (mark (✓) appropriately)

Occupational accident		Occupational disease		Death	
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B. EMPLOYER'S PARTICULARS

Name of employer.....
 WCF Reg. NoContact
 address.....Street/Village.....
 District.....Region.....Country.....
 TelFax.....Cell phone.....
 E-mail.....

C. EMPLOYEE'S PARTICULARS

Name of employee

 Employee's Code No.National ID
Employee's ID
 Job title
Section/Department.....
 Date of birth.....Sex..... Marital
 Status.....No. of Children.....
 District..... Region
Nationality.....
 Street/VillagePlot No..... Block
 No.....
 Tel.....Fax..... Cell
 phone.....
 E-mail..... Next of
 kin.....

D. PARTICULARS OF OCCUPATIONAL ACCIDENT

Date of accident.....Time of accident.....Place of accident..... Date of reporting occurrence of an accident to the employer.....

Activity/Duty performed at the time of accident

.....
.....
.....

Describe in brief how accident occurred

.....
.....
.....
.....

Witness (s):-

1. Name.....Cell Phone
2. Name.....Cell Phone
3. Name.....Cell Phone

Supervisor's name

.....Section/Department.....

E. PARTICULARS OF OCCUPATIONAL DISEASE

Date of diagnosis.....Occupational disease diagnosed Date of reporting disease to employer.....

Name of the health facility where the diagnosis was established..... Name and address of medical practitioner who diagnosed the disease.....

.....
.....

F. PARTICULARS OF DEATH (mark (√) appropriately)

Name of employee's representative.....

Contact and physical address of employee's representative

.....

Date of death..... Place of death

Cause of death - occupational accident () or occupational disease ()

Date of reporting to the employer

Medical practitioner (name and contact address)

.....
.....
.....
.....

DECLARATION

I,, declare that what I have stated herein above is true to the best of my knowledge and if it is proved that there is forgery or fraud in relation to the information provided, legal action should be taken against me.

Name.....

Signature.....

..

Date.....

..

Employer's acknowledgement of receipt of notification

Date of receipt of notification by employer	Notified by (Name and designation)	Received by (Name, designation, signature and official stamp)

I,, declare that the information provided herein above is true to the best of my knowledge.

9. OCCUPATIONAL HEALTH AND SAFETY SUPPLIES FOR HEALTH FACILITIES

01	Sterile surgical gloves
02	Clean examination gloves
03	Elbow-length gloves for manual removal of placenta (gauntlet gloves)
04	Utility gloves
05	Plastic apron
06	Area-specific attire
07	Protective eyewear
08	Face masks covering mouth and nose
09	Caps
10	Gumboots
11	Lead aprons
12	Lead hand gloves
13	Ganado lead covers
14	Surgical attire
15	N95 masks for airborne isolation ward, or kept in case of emergency
16	Alcohol hand rub
17	Ethyl or isopropyl alcohol (60–90%)
18	Cetrimide and chlorhexidine gluconate (2–4%), e.g., Savlon, OR chlorhexidine gluconate (2–4%), e.g., Hibiclens, Hibiscrub, Hibitane, OR iodine preparations (0.5–3%), e.g., Lugol's, OR iodophors (usually not diluted), e.g., Betadine, OR other MHCDGEC-approved antiseptics.
19	Liquid detergents
20	Chlorine solution, powder or tablets (precepts)
21	Glutaraldehyde 2–4%
22	Standard colour-coded waste bins (yellow, red, blue/black)
23	Colour-coded bin liners (yellow, red, blue/black)
24	Sharp containers
25	Waterproof bags
26	Drapes
27	Laundry hamper
28	First aid kits
30	Spill kit

10. POLICIES, LEGISLATIONS, GUIDELINES AND STRATEGIES RELATED TO OHS

SN	Document	Provisions
	National Occupational Health and Safety Policy 2010	Provides for workers' participation through their health and safety committees at workplaces, OHS awareness creation among workers and employers. Prevention and control of hazards at workplaces

		and adaptation of work processes and environment to workers so as to increase their productivity
The Tanzania Quality Improvement Framework in Health Care 2011 - 2016	<p>Principles – Provider focus</p> <p>For the health workers to execute their responsibilities they need support from administrators. The support include getting clear job description, receiving clear and immediate feedback on performance, equipment and supplies, good work environment, recognition, motivation, etc. Possible needs and expectations from internal clients are;</p> <ul style="list-style-type: none"> • Clean and well organized working place • Better remuneration and benefits • Good teamwork • Clear job description with appropriate work load • Proper equipment and medical supply for provision of appropriate services • Staff recognition, appraisal and communication • Family friendly measures • Appropriate supportive supervision 	
Strategic plan II for the prevention and control of HIV, TB and Hepatitis B infections for health workers at the workplace (2013 -2017)	Focus on increasing access to prevention, treatment, care and support for HIV, TB and HBV services to all health and social welfare workers and their families	
National IPC Standards for Hospitals in Tanzania, 2012	Encourage all staff involved in the delivery of health and social care to accept responsibility for their role in preventing and controlling infection.	
National Policy on HIV/AIDS, 2001	<ul style="list-style-type: none"> • Protection of Healthcare Workers and Traditional Birth attendants • Empower health workers and traditional birth attendants to avoid the risk of infection and to ensure that institutions that provide health care services provide the necessary protective gear to the workers in accordance with the principles of universal safety precautions against infectious diseases and substances. 	

	Comprehensive Council Health Planning Guidelines, Fourth Edition, 2011	<p>Priority area 6: Environmental Health and Sanitation</p> <ul style="list-style-type: none"> • Provides for occupational health and safety as one of the key planning intervention areas in Council health sector planning
	Health Sector Strategic Plan IV July 2015 – June 2020	<ul style="list-style-type: none"> • Advocates Workplace health programmes to promote healthy lifestyles • Provides for periodic health screening in workplaces to pick occupational health related problems early enough for definitive intervention.
	National guidelines for the management of HIV and AIDS, 2012 (Revised May 2015)	Provides for prevention of occupational exposure of HIV/AIDS to health care workers through Post Exposure Prophylaxis (PEP)
	Manual of the National Tuberculosis and Leprosy Program in Tanzania (year)	<p>Provides for Tuberculosis infection control in health care institutions and congregate setting</p> <ul style="list-style-type: none"> • Measure to reduce TB transmission includes administrative, environmental and personal protective measures. Administrative measures should include early recognition, diagnosis and treatment of TB especially infectious cases. Environmental protection includes maximizing natural ventilation and using ultraviolet radiation (if applicable). • The NTLP will continue to collaborate with institutions like prison, army, police and occupational health services where this is likely to improve the accessibility and quality of TB care and control.
	The Environmental Management Act No. 20 (2004):	The Act sets out the mandates of various actors to undertake enforcement, compliance, review and monitoring of environmental impact assessment, to facilitate public participation in environmental decision-making and to exercise general supervision and coordination matters relating to the environment. Institutionally, it provides for the continuation of the National Environmental Management Council (NEMC), which is mandated to oversee environmental management issues and review programs to decide whether they need to undertake

		Environmental Impact Assessments (EIAs) and prepare Environmental Impact Statements (EISs).
	Water Utilization (Control and Regulation) Act, (No. 42) 1974:	This Act, and its amendments, is the principal legislation dealing with the protection of water resources and control of water extraction for different uses. The extraction of water for different users is controlled through a "water right permit". The projects need to undertake the procedures for acquiring and managing water rights, discharges to open environment and maintenance of water quality, which are provided by this act.
	Energy and Water Utilities Regulatory Authority (EWURA), 2001:	The general functions of EWURA are to regulate the provision of water supply and sanitation services by a water authority or other person including the establishment of standards relating to equipment and tariffs chargeable for the provisions of water supply and sanitation services.
	Energy and Water Utilities Regulatory Authority (EWURA), 2001:	The general functions of EWURA are to regulate the provision of water supply and sanitation services by a water authority or other person including the establishment of standards relating to equipment and tariffs chargeable for the provisions of water supply and sanitation services.
	Water Supply and Sanitation Act No 12 (2009):	The Act provides the legal framework for water supply and sanitation. It outlines the responsibilities of government authorities involved in the water sector, establishes Water Supply and Sanitation Authorities as commercial entities
	The Employment and Labour Relations Act	Sets out provisions for fundamental rights and protections, which include forced labor, child labor, discrimination, and freedom of association. It also sets out employment standards, wage parameters, working hours, and dispute regulations, among others.
	The Local Government Act,	its amendments, the village, district and urban authorities are responsible for planning, financing

	1982 (revised in 2002)	and implementing development programs within their areas of jurisdiction. Each authority has to suppress crimes, maintain peace, good order and protect the public and private property. LGAs are also capable of holding and purchasing, or acquiring and disposing of any movable or immovable properties.
	Gender Policies:	There are a number of policies positively impacting gender. Important among them include the following: (i) Gender Policy, (ii) Affirmative Action Policy, (iii) Sexual Offenses Act (1998), and (iv) Action Plan against Gender Based Violence (since 2010).
	Rights of the Child;	Rights to Reproduction and Access to good quality Reproductive Healthcare: Tanzania is a signatory to the Universal Declaration of Human Rights and specifically to the Convention on the Rights of the Child and has submitted the 3 reports in 2013.