Advanced Infection Prevention and Control Training

Injection safety and safe injection practices: trainer’s guide

Outline of the module
The “Injection safety and safe injection practices” advanced training module is part of a broader infection prevention and control (IPC) training package targeting individuals and teams in IPC who work or intend to work as IPC focal points. Trainees are expected to possess at least basic experience and competence in IPC. They could include IPC professionals, IPC hospital teams, facility administrators, hospital epidemiologists, microbiologists and other relevant health care professionals, among others. The package complements a basic training package intended for all front-line health care workers.

Objectives of the module
The module aims to equip the IPC focal point to:
1. describe the reasons and factors behind unnecessary and unsafe injection practices;
2. explain the risks associated with unsafe injection practices and key epidemiological data of the infections caused by them;
3. list the key WHO recommendations for injection safety;
4. understand the mechanisms of safety-engineered syringes;
5. list the seven steps to safe injections;
6. explain how to collect, handle and dispose of needles and other sharps safely;
7. give details of needle-stick injuries and associated prevention strategies;
8. describe multimodal strategies to implement injection safety.

Overview
This module is to be delivered during a half-day training session. It comprises a blend of PowerPoint slides, audiovisual material and a student handbook. The training is divided into four sessions:

**Session 1**: the problem of unsafe injections (75 minutes: 45 minutes plenary, 30 minutes group work);

**Session 2**: IPC best practices and guidance for safe injections (60 minutes, including breaks);
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Session 3: needle-stick injury prevention (60 minutes: 30 minutes plenary, 30 minutes group work);
Session 4: injection safety implementation strategies (90 minutes: 30 minutes plenary, 60 minutes group work)

Materials needed
All materials should be collected and reviewed prior to starting the training:
• PowerPoint slide deck;
• trainer’s guide;
• student handbooks (these include handouts and group work instructions);
• WHO guideline on the use of safety-engineered syringes for intramuscular, intradermal and subcutaneous injections in health care settings;
• injection safety training and educational videos;
• laptop and data projector capable of playing video and audio;
• flip chart and pens;
• paper for students to use during group work.

Evaluation
The same pre- and post-training test (Annex 1) will be distributed to participants at the beginning and end of this module to help gauge their knowledge of injection safety. The pre-training test will develop a baseline, measuring existing knowledge, and identify knowledge gaps. The post-training test will assess the knowledge gained through the module.
Details of presentation slides, with guidance for the trainer

<table>
<thead>
<tr>
<th>Slide no.</th>
<th>Slide image</th>
<th>Notes and suggestions for trainer</th>
<th>Resources required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><img src="image" alt="Advanced Infection Prevention and Control (IPC) Training" /></td>
<td>Welcome participants and introduce yourself and the topic for this module. Ask if there are any questions before advancing to the next slide.</td>
<td>–</td>
</tr>
<tr>
<td>2</td>
<td><img src="image" alt="Module outline" /></td>
<td>Give a 1–2-minute overview of the whole workshop. State that this module will cover different aspects of injection safety, including the importance of a multimodal improvement strategy with practical examples – the module is divided into four sessions to make different aspects of injection safety clear. Read the slide. Emphasize that each session builds on the previous one.</td>
<td>–</td>
</tr>
<tr>
<td>3</td>
<td><img src="image" alt="Summary of the module" /></td>
<td>• Talk through the slide so that the student has a little more understanding of the content of each session. • Emphasize how each session links to build on the previous one.</td>
<td>–</td>
</tr>
</tbody>
</table>
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#### The symbols explained
- **Discussion**
  - You are encouraged to participate in discussion questions, where you can use your own experience and prior knowledge.
- **Group activity**
  - You are encouraged to participate in group activities to drill into key topics.
- **Essential content**
  - Essential content (not to be missed).
- **Key reference**
  - Key reference for consolidating learning.

#### Read
- The explanations of the symbols from the screen.

## 4

### Competencies
At the end of this module, the IPC focal point should be able to:
- Identify unsafe injection practices;
- Carry out an injection safety assessment using WHO guidelines;
- Take immediate measures to improve injection practices by pinpointing gaps;
- Develop short- and long-term plans to address all aspects of injection safety comprehensively, based on WHO guidelines;
- Educate injection prescribers and providers on WHO recommendations for injection safety.

#### Learning objectives
On completion of this module, the student should be able to:
- Describe the reasons and factors behind unnecessary and unsafe injection practices;
- Explain the risks associated with unsafe injection practices and key epidemiological data of the infections caused by them;
- List the key WHO recommendations for injection safety;
- Understand the mechanisms of safety-engineered syringes;
- List the seven steps to safe injections;
- Explain how to collect, handle and dispose of needles and other sharps safely;
- Give details of needle-stick injuries and associated prevention strategies;
- Describe multimodal strategies to implement injection safety.

#### Ice breaker
- At this point, ask the participants to introduce themselves to the person next to them and share with them one fact about why they are interested in IPC and injection safety.
- Allow a couple of minutes to exchange the information.
- Then allow 10 minutes for participants to tell the class what they have learned from each other: the name and fact about their partner.
### Session 1: The problem of unsafe injections

**Say:**

“The first session describes the problem of unsafe injections.”

### Click once and ask:

“**What is a safe injection?”**

Then **show** the definition of a safe injection to the participants and read it.

### State** that there are three drivers of unsafe injection practices.

They are:
- prescribers, who write the prescription for an injection (prescriber could be trained or untrained);
- providers, who give the injections to patients (provider could be trained or untrained);
- patients, who sometimes insist on receiving an injection even for conditions that can easily be treated with oral medications, such as seasonal flu or minor aches and pains.
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#### 10. How can an injection be unsafe?

If any of the steps to make an injection safe are not undertaken appropriately.

*In particular, if:*

- the injection is given in an environment that is not clean and hygienic;
- the needle or the syringe are used for more than one patient;
- the package is not sterile or new and sealed;
- the vial is used multiple times;
- the skin is not properly disinfected;
- the needle is not disposed of safely;
- an injection is unnecessary and may cause harm (e.g. antibiotics, which can cause resistance);
- the injection is given incorrectly, which can cause damage to the nerve and lead to paralysis of the area.

**Beyond the definition, ask:**

“What do you think makes an injection unsafe?”

Then **click** and show the most frequent causes:

- the injection is given in an environment that is not clean and hygienic;
- the needle or the syringe are reused for more than one patient;
- the package is not sterile or new and sealed;
- the vial is used multiple times;
- the skin is not properly disinfected;
- the needle is not disposed of safely;
- an injection is unnecessary and may cause harm (e.g. antibiotics, which can cause resistance);
- the injection is given incorrectly, which can cause damage to the nerve and lead to paralysis of the area.

#### 11. Why do patients prefer injections?

- Belief that injections are **stronger medication** (Pakistan)
- Belief that injections work faster (Romania)
- Belief that injection pain is a marker of efficacy (southern African countries)
- Belief that a drug is **more efficient** when entering the body directly (Cambodia, Thailand)
- Belief that injections represent a **more developed technology** (many countries, including high-income ones)

**Click once and ask:**

“Why do patients prefer injections?”

**Mention** that:

- studies from Pakistan have shown that patients believe injections are stronger medication;
- patients from Romania believe that injections work faster;
- studies from southern African countries have documented that patients believe that injection pain is a marker of efficacy;
- patients from South-East Asian countries like Thailand and Cambodia think that a drug is more efficient when it enters the body directly;

Refer to handout 1 in the student handbook for a summary of the Reeler et al. paper.
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<table>
<thead>
<tr>
<th>12</th>
<th>Motivation for overuse of injections among health care workers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Financial incentives (private health care providers can charge a higher fee if they administer injections)</td>
</tr>
<tr>
<td></td>
<td>• Belief in better efficacy of injected drugs</td>
</tr>
<tr>
<td></td>
<td>• Ability to observe therapy and compliance with treatment regimens directly</td>
</tr>
</tbody>
</table>

**Refer to handouts 1 and 2 in the student handbook for further reading.**

<table>
<thead>
<tr>
<th>13</th>
<th>Why is injection equipment reused?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Lack of awareness or understanding of risks associated with unsafe injections</td>
</tr>
<tr>
<td></td>
<td>• Lack of injection equipment and supplies</td>
</tr>
<tr>
<td></td>
<td>• Saving money on syringes and needles</td>
</tr>
<tr>
<td></td>
<td>• Mostly related to private settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14</th>
<th>Risks associated with unsafe injection practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Bloodborne pathogen transmission</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B virus (HBV) infection</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis C virus (HCV) infection</td>
</tr>
<tr>
<td></td>
<td>• HIV</td>
</tr>
<tr>
<td></td>
<td>• Viral haemorrhagic fevers</td>
</tr>
<tr>
<td></td>
<td>• Abscesses</td>
</tr>
<tr>
<td></td>
<td>• Septic</td>
</tr>
<tr>
<td></td>
<td>• Aseptic</td>
</tr>
<tr>
<td></td>
<td>• Nerve damage</td>
</tr>
<tr>
<td></td>
<td>• With risk of paralysis</td>
</tr>
<tr>
<td></td>
<td>• Other less common diseases</td>
</tr>
<tr>
<td></td>
<td>• Such as malaria</td>
</tr>
</tbody>
</table>

**Explain in detail the risks associated with unsafe injection practices.**

**Mention** the motivating factors among health workers to overuse injections.

**Click once and ask:**

“What, in your opinion, are the reasons for reuse of injection equipment?”

Click again to show the reasons documented by studies.

- There is lack of awareness or understanding of risk associated with unsafe injections among prescribers and providers.
- In some public and private settings shortage of injection equipment has led to its reuse.
- Private practitioners want to save money on syringes and needles.

- For example, there is a risk of transmission of bloodborne infections such as hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV because of reuse of syringes and needles and contamination.
- Unsafe injections can also lead to abscesses.
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<table>
<thead>
<tr>
<th>15</th>
<th>Risk of HIV, HBV and HCV transmission in health care settings</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Risk of HIV, HBV and HCV transmission in health care settings" /></td>
<td></td>
</tr>
<tr>
<td><strong>30%</strong></td>
<td><strong>3%</strong></td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>HEPATITIS C</td>
</tr>
</tbody>
</table>

**State** that the estimated risk of transmission of hepatitis B from a syringe that has been used on an infected patient or source is 30%; for hepatitis C it is 3%; and for HIV it is 0.3%. While the estimated risk of HIV transmission is low, its severity cannot be undermined.

**State** that these factors are also related to the bore of the needle and viral load among patients.

**Refer to handout 3 in the student handbook for further reading.**

<table>
<thead>
<tr>
<th>16</th>
<th>How long can HBV, HCV and HIV survive outside the human body?</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="How long can HBV, HCV and HIV survive outside the human body?" /></td>
<td></td>
</tr>
</tbody>
</table>

- HBV can survive for seven days outside the human body and can cause infection if it enters the body of a person who is not infected.
- HCV can survive for up to three weeks on environmental surfaces at room temperature.
- HIV can survive in dried blood at room temperature for up to three days.

**Click once and ask:**

“Do you know how long some dangerous viruses such as HBV, HCV and HIV can survive outside the human environment?”

**Click again and show** that:

- HBV can survive for a week outside the human body and cause infections if it enters the body of a person who is not infected;
- HCV can survive up to three weeks on environmental surfaces at room temperatures
- HIV can survive in dried blood at room temperature for up to three days.
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#### 17

**State** that the animated video developed for patients and health workers describes the problem of unsafe injections, risks associated with reuse of injection equipment and WHO’s recommendation on resolving the problem of injection safety.

**Play** the video from the link provided.

[Animated video for patients](https://www.youtube.com/watch?v=3QmvhlG5olw&feature=youtu.be)

### 18

**State** that it is estimated that over 16 billion injections are provided every year, of which 90–95% are therapeutic or medical injections. The remaining injections include immunizations and other injection types.

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**State** that the global burden of disease study in 2000 estimated that over 70% of these injections were unnecessary and caused 21 million cases of hepatitis B, two million cases of hepatitis C and 260 000 HIV infections.

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**State** that a 2010 study estimated that as many as 33 800 people were infected with HIV, up to 1.7 million with HBV and up to 315 000 with HCV. It was based on population surveys and various sources of information, including injection safety assessments and published studies on injection practices.

Refer to handout 4 in the student handbook for a summary of the Pépin et al paper.
Mention that, of all WHO regions:

- in the Eastern Mediterranean Region 14% of injections still involve reuse and there is a high number of unsafe injections per capita (0.567) – three and a half times the worldwide average (up to 15 times higher than in the poorest regions of the world);

- the South-East Asia Region remains an area of concern, with an average of 7% reuse in some countries.

**Examples from low- and middle-income countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Reference</th>
<th>Findings</th>
</tr>
</thead>
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<tr>
<td>Cameroon</td>
<td>Assian GB, Agass IB, Bousse MC, Zamp COP, Ramé M, Samb C.</td>
<td>The study compared survey data against records of medical injections and found that 14% of patients were given injections with reused equipment due to shortages. The study also identified unsafe practices among health workers.</td>
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<td>Hassanlou SI, Tawadros AI, El-Sayed MM, El-Dessoupy HI, Elsayed AM, El-Sayed AM.</td>
<td>The study assessed medical injections in the Eastern Mediterranean Region and found that 14% of patients were given injections with reused equipment due to shortages. The study also identified unsafe practices among health workers.</td>
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<td>Lass AL, Ng SS, Togou M, Faye J-A, Zogbou M, Sissoko S, et al.</td>
<td>The study assessed medical injections in the Eastern Mediterranean Region and found that 14% of patients were given injections with reused equipment due to shortages. The study also identified unsafe practices among health workers.</td>
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A study published in 2014 used national data from the Kenya AIDS Survey 2012 and found that, among

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Mention some of the recent epidemiological studies from low- and middle-income countries, which have attributed unsafe injections to disease transmission or identified the reasons for unsafe injections.

- A study from Cameroon published in 2011 found that 44% of injections were given with reused injection equipment, mostly due to shortage of supply. In many parts of the world shortage of supply has been documented as a reason for reuse of needles in syringes. Many of you may be aware that, in the public sector, the process of emergency procurement is very complicated.

- A case control study from Egypt published in 2012 investigated risk factors for hepatitis C and found that cases had an extremely high odds ratio of receiving an injection with a reused syringe – especially those who had HCV and had received injections in the last six months. Other risk factors included receiving intravenous fluids in a hospital or outpatient department, having a minor surgical procedure or being injection drug users.

- A study published in 2014 used national data from the Kenya AIDS Survey 2012 and found that, among
men aged between 16 and 64 years, those who had received higher number of injections in the past 12 months had a higher chance of being HIV positive.

- A study from India investigated a hepatitis B outbreak in the State of Gujarat in 2009. It found that 40% of positive cases had history of receiving injections in the last six months from private practitioners.

- An outbreak of HIV in a rural community in Cambodia was reported in 2016. Of 242 cases, 22% were children aged less than 14 years. Investigation revealed that HIV-positive cases were five times more likely to have received an intramuscular or intravenous injection in the last six months and four times more likely to have received an intravenous infusion.

**Examples from high-income countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Source</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Korea</td>
<td>Long S, Kim HS, Seo E, Park JH, Youn SC</td>
<td>In a retrospective case control study in 2012, investigators found that 15% of the patients and 35% of the needlesticks were in one vial. This resulted in an outbreak of hepatitis B in South Korea.</td>
</tr>
<tr>
<td>United States of America</td>
<td>Taylor L, Greeley R, Dinitz-Sklar J, Mazur N, Swanson J, Wolick J</td>
<td>In a outbreak of hepatitis C in 2001, an investigation revealed that 40% of positive cases had history of receiving injections in the last six months from private practitioners.</td>
</tr>
</tbody>
</table>

**mention** that the problem of unsafe injections is not limited to low- and middle-income countries. High-income countries are also affected.

- In New Jersey, United States of America, an experienced nurse at an immunization clinic used multidose vials and syringes multiple times on 67 people who came for flu immunizations. She changed the needle every time but only wiped the syringe with alcohol. There was a lengthy investigation and follow-up.

- A retrospective case control study from South Korea investigated an outbreak of joint infections at a single clinic. There were 61 cases and 64 controls. Cases were more likely to have been exposed to unsafe preparation of injections and unhygienic cleaning of injection sites.

- In 2001 an outbreak of hepatitis C in a surgery care clinic was investigated in Western France. The investigation
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Discussion

1. What are the reasons for unnecessary and unsafe injections in your health care setting?

2. Can you give an example of when you observed breaks in injection safety?

3. What did you do when it happened?

Ask:

“What are the reasons for unnecessary and unsafe injections in your health care setting?”

“Can anyone give an example of when you observed breaks in injection safety?”

“What did you do when it happened?”

Allow 10 minutes for this discussion (2–3 minutes per question).

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Health care risk factors among women and personal behaviors among men explain the high prevalence of Hepatitis C virus infection in Pakistan.


Summary

To estimate the prevalence and identify factors associated with Hepatitis C virus (HCV) infection among men and women in a hospital community of Karachi (Pakistan), households were selected through systematic sampling from within all areas in the study area. All available adult males within each household were interviewed about potential HCV risk factors. A blood specimen was collected to test for anti-HCV antibodies by enzyme immunosorbent. We used generalized estimating equations while accounting for correlations of responses within families to identify factors associated with HCV infection. The prevalence of HCV infection among women was 0.01% (95%CI: 0.00–0.09) and 0.01% (95%CI: 0.00–0.09) among men. Older age, residency in a slum, and receiving oral blood transfusions, in-patient hospitalizations, dental treatment, and urogenital infections were associated with increased risk of infection (OR: 2.32; 95%CI: 1.20–4.53, 2.64; 95%CI: 1.25–5.53, 1.75; 95%CI: 1.00–3.04, and 1.77; 95%CI: 1.00–3.14, respectively). Among women, all blood transfusions (adjusted odds ratio [aOR] = 2.32; 95%CI: 1.20–4.53), dental treatment (aOR = 2.64; 95%CI: 1.25–5.53), and increasing age (aOR = 2.67; 95%CI: 1.89–3.78) were associated with HCV infection. A very high prevalence of HCV was found in the study population. Among women, unsafe health care practices, male partners being infected, and sharing a dental or injection tools were identified as risk factors for HCV infection. Awareness raising and education are needed to improve the screening of high-risk populations as well as the infection control policies and procedures in medical facilities.

Say:

“Please spend 10 minutes and read the summary of the published paper from your handbook then proceed to group work 1 in your student handbook (p. 35).”

For students: see group work 1 – student handbook, p. 35.

For trainer: see group work 1 – Annex 1, p. 50.

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Group work 1

• Work in groups of 5–7 people. 30 minutes total.

• Please read the summary of the paper by Janjua et al.

• In your groups answer the questions as per the student handbook:

1. What were the significant risks identified in the study?

2. Why was increasing age identified as a risk?

3. What kind of intervention or interventions could be designed if this were the community and area you were assigned to work with?

4. Do you see any role for safety-engineered syringes in this scenario?

Say:

“Divide yourself in groups of 5–7 and work in your groups to answer the questions related to the summary that you have just read.”

Lead a plenary discussion after groups have answered these questions. Allow each group to share their responses for each question, one at a time.

Allow 30 minutes for this activity: 10 minutes to read, 10 minutes for group discussion and 10 minutes for group plenary.
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### Suggested readings

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Journal/Conference</th>
<th>Year</th>
</tr>
</thead>
</table>

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**27**

**Suggested readings**


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**28**

**Session 2:**

**IPC best practices and guidance for safe injections**

---

**29**

**Is this the making of a safe injection?**

---

**30**

**Eliminating unnecessary injections**

**AVOID GIVING INJECTIONS FOR HEALTH CONDITIONS WHERE ORAL FORMULATIONS ARE AVAILABLE AS THE FIRST-LINE TREATMENT.**

---

**State** that eliminating unnecessary injections is the key: to do that, as health care providers, we must avoid giving injections for ailments that can be treated with oral formulations where they are recommended as the first-line treatment.

---

**No need to read the slide — just explain that there are further reading materials on all of the topics addressed here.**

---

**Mention** that, following the background information on unsafe injections and the epidemiological data establishing a strong link between unsafe injections and infections, discussion will now turn to IPC best practices and guidance for safe injections.

---

**Ask** participants to describe what they see in this image: what elements can they identify that may contribute to an unsafe injection?

---

**Allow** 5 minutes in total for this discussion.

---

**Best injection practices guidelines:**

http://www.who.int/infection-prevention/tools/injections/communications/en/
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## 31 Eliminating unnecessary injections contd.
- Eliminating unnecessary injections should be a high priority for preventing infections associated with unsafe injections.
- Injections should only be prescribed and administered when medically indicated.
  - If a medication is prescribed, consider the method of administration.
  - Ask yourself: is an injection really needed, or is there an oral alternative?

## 32 Educational leaflet for patients and communities
- State that the educational leaflet for patients and communities can be downloaded from the link on this slide.

It talks about making safe injection choices, the consequences of unsafe injections and why prevention is the best medicine. It educates patients to ask their prescribers about the need for an injection and to say that they would prefer oral medicines.

[Source](http://www.who.int/infection-prevention/tools/injections/IS_medical-treatment_leaflet.pdf?ua=1)

## 33 Postcard for patients and communities
- State that this postcard or health card has been specifically developed to be placed in patient waiting areas; it could also be distributed within communities.

It highlights three things to ask the health care provider before having an injection: is an injection needed; is the syringe new and opened from a new packet; and is the syringe is a smart syringe which can only be used once?

[Source](http://www.who.int/infection-prevention/tools/injections/IS_postcard.pdf?ua=1)

## 34 Animated video for patients and communities
- State, as mentioned in the previous session, that the animated video developed for patients and health workers describes the problem of unsafe injections, risks associated with reuse of injection equipment and WHO's recommendation on resolving the problem of injection safety.

The video can be downloaded from the link.

[Source](https://www.youtube.com/watch?v=3QmvhlG5oIw&feature=youtu.be)
[Source](https://www.youtube.com/watch?v=3QmvhlG5oIw&feature=youtu.be)
**Educational infographics for patients and communities**

State that these attractive and easy to understand educational infographics have been developed for patients and communities.

They describe in easy-to-understand language:
- the risk of getting a life-threatening illness from unsafe injections;
- what makes an injection unsafe;
- how to identify whether the patient really needs an injection.

State that this educational poster, developed for patients and communities, promotes oral medicines (in patients’ language: “medicines taken by mouth”).

**Poster promoting oral medicines**

To reduce:
- reuse of injection equipment
- accidental needle-stick injuries
- overuse of injections
- unsafe sharps waste

To ensure:
- rational use of injectable drugs
- sufficient supply availability

**WHO guideline on the use of safety-engineered syringes for intramuscular, intradermal and subcutaneous injections in health care settings (handout 7 in the student handbook):**

http://apps.who.int/iris/bitstream/10665/250144/1/9789241549820-eng.pdf?ua=1

State that WHO recommends that all countries should transition by 2020 to the exclusive use of WHO prequalified (or equivalent) safety-engineered injection devices, including reuse prevention (RUP) syringes and sharps injury protection (SIP) devices for therapeutic injections, and develop related national policies to bring about a smooth transition.

The guideline was developed to reduce reuse of injection equipment and avoid needle-stick injuries, overuse of injections and unsafe handling of sharps. Implementers have to ensure rational use of injectable drugs and sufficient supplies of injection equipment.
<table>
<thead>
<tr>
<th>38</th>
<th>2015 WHO policy: key elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recommendations for transition to auto-disable (AD), reuse prevention (RUP) or sharps injury protection (SIP) devices for both immunizations and therapeutic injections</td>
<td></td>
</tr>
<tr>
<td>• Recommendation to develop standards for rational use and supply of standard disposable syringes where they remain necessary</td>
<td></td>
</tr>
<tr>
<td>• Call to partners to fund procurement of safety engineered injection devices in all projects</td>
<td></td>
</tr>
<tr>
<td>• Call to industry to switch to &quot;safe&quot; syringes</td>
<td></td>
</tr>
<tr>
<td>• Call to countries to develop national policies and implementation strategies, with a special focus on curative settings</td>
<td></td>
</tr>
</tbody>
</table>

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Ask a student to read the slide. The policy includes the following key aspects:

- descriptions of safety-engineered injection devices known as auto-disable (AD) and RUP syringes, which are specifically designed to block syringes from being reused — these also exist with SIP mechanisms to prevent needle-stick injuries to health care workers and the community;
- recommendations for transition to the exclusive use of WHO prequalified AD/RUP/SIP devices for therapeutic injections in all countries, and development of related national policies;
- a recommendation to develop standards for rational use and supply of standard disposable syringes for specific procedures and settings where they remain necessary;
- requests to donor agencies and development partners to fund procurement of safety-engineered injection devices in all projects including injectable medications, and to finance appropriate quantities of safety-engineered injection devices, single-dose diluents and safety boxes and the cost of sharps waste management, as well as health care workers’ training;
- a request to international and local manufacturers to switch to safety-engineered injection device production as soon as possible and to seek WHO prequalification for their products;
- a recommendation for countries to develop and put in place a strategy for implementing their national

---

2015 WHO policy: key elements:

http://apps.who.int/iris.handle/10665/63650

Source: http://apps.who.int/iris/bitstream/10665/250144/1/9789241549820-eng.pdf?ua=1

2015 WHO policy: key elements

• ... strategies, with a special focus on curative settings
3. Say:

“These are some examples of safety engineered syringes.”

1. Photos 1 and 2 are examples of RUP and SIP syringes, as after the injection the needle is pulled back inside the plunger and the plunger breaks if a little force is applied.

2. Photo 3 is also an RUP and SIP syringe: after giving the injection, while the needle is inside the muscle, the needle can be retracted by pushing a small button on top of the plunger.

3. Photo 4 is an SIP syringe: after giving the injection a sheath or shield is gently pushed to cover the needle, thereby offering protection from needle-stick injury.

4. Photo 5 is an example of an RUP syringe in which the plunger is broken after use, rendering the syringe unreusable.

4. Say that:

- these are “auto-disable” or AD syringes used in immunization programmes worldwide;
- they are usually fixed-dose syringes with a fixed needle and have a metal clip inside the plunger attached to the barrel;
- once the vaccine has been given the vaccinator has to push it slightly and the syringe is locked and cannot be reused;
- the syringe has to be discarded in the sharps box.
## Advanced Infection Prevention and Control Training

### The seven steps to safe injections

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clean work space</td>
</tr>
<tr>
<td>2</td>
<td>Hand hygiene</td>
</tr>
<tr>
<td>3</td>
<td>Sterile safety-engineered syringe</td>
</tr>
<tr>
<td>4</td>
<td>Sterile vial of medication and diluent</td>
</tr>
<tr>
<td>5</td>
<td>Skin cleaning</td>
</tr>
<tr>
<td>6</td>
<td>Appropriate collection of sharps</td>
</tr>
<tr>
<td>7</td>
<td>Appropriate waste management</td>
</tr>
</tbody>
</table>

**Say:**

“All health workers must follow these seven steps to ensure injection safety in their settings.”

**Say** that these steps are:

1. a clean work space;
2. hand hygiene;
3. a sterile, safety-engineered syringe;
4. a sterile vial of medication and diluent;
5. skin cleaning;
6. appropriate collection of sharps;
7. appropriate waste management.

### Best injection practices guidelines

**Say** that these guidelines provide details on adhering to principles of injection safety in a succinct manner, ensuring that the injection is safe for the patient and the health care worker.

### How to give a safe injection – an educational video for health care workers

**Say** that this educational video describes in detail the mechanism of RUP and SIP syringes and provides information about the seven steps to safe injections.

**Video on how to give a safe injection (handout 8 in the student handbook):**

[https://www.youtube.com/watch?time_continue=15&v=nzv4wKQkgQo](https://www.youtube.com/watch?time_continue=15&v=nzv4wKQkgQo)
Step 1: clean work space

A clean work space or workstation is necessary to avoid contamination and allow safe injection preparations.

Ask a student to read the slide.

- The first and foremost step in preparing an injection of any kind is a clean and uncluttered injection preparation area.
- It is absolutely imperative that contamination should be avoided.
- The survival time of some viruses outside the human environment was mentioned in an earlier slide.
- Special attention should be given to contamination for the safety of patients as well as that of health workers.

Step 2: hand hygiene

Always perform hand hygiene:

- Before preparing injection material, before giving an injection, and after giving an injection.

Your 5 Moments for Hand Hygiene

- Also, avoiding injections if skin integrity is compromised by local infection of another skin condition (e.g., weeping dermatitis).

Say:

“As shown in the training video, hand hygiene must always be performed before preparing injection material, before giving an injection and after giving an injection. This is the second step in giving a safe injection.”

Avoid giving injections if skin integrity is compromised due to local infection or any other skin condition, such as weeping dermatitis.


Say:

“Continuing with hand hygiene, this slide provides the details of five moments of hand hygiene and when they should be performed.”

- Moment 1: clean your hands before touching the patient in order to protect him or her from harmful germs.
- Moment 2: hands must be cleaned before any aseptic procedure in order to protect the patient from harmful germs, including the patient’s own germs.
- Moment 3: hands must be cleaned after exposure to body fluids in order...
to protect yourself and the health care environment.
- Moment 4: clean your hands after patient contact or after touching the patient’s immediate surroundings.
- Moment 5: clean your hands after touching any object in the patient’s surroundings when leaving, even if the patient has not been touched. This is needed protect yourself and the health care environment from harmful patient germs.

<table>
<thead>
<tr>
<th>47</th>
<th>Hand hygiene and glove use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The use of gloves does not replace the need to clean your hands!</td>
</tr>
<tr>
<td></td>
<td>You should remove gloves to perform hand hygiene, when an indication occurs while wearing gloves.</td>
</tr>
<tr>
<td></td>
<td>You should wear gloves only when indicated (see the pyramid in the Hand hygiene: why, how and when brochure and in the Glove use information leaflet) – otherwise they become a major risk for germ transmission.</td>
</tr>
</tbody>
</table>

| Say: |
| “Please remember that the use of gloves does not replace the need to clean your hands.” |

| Say | that gloves should be used when indicated, as explained further in the following slides. |
| In many settings, health workers continue to wear the same gloves and manage multiple patients; this can also pose a risk of disease transmission. |

| 48 | State | that the glove pyramid can help in making decisions on when to wear or not wear gloves. |
|     |      | Gloves must be worn according to standard and contact precautions. The pyramid details some clinical examples in which gloves are not indicated, and others in which examination or sterile gloves are indicated. |
|     |      | As stated earlier, hand hygiene should be performed when appropriate, regardless of the indication for glove use. |
|     |      | Briefly, sterile gloves are indicated for any surgical procedure. |
|     |      | Examination gloves are indicated in clinical situations wherever there is potential for touching blood, body |

<p>| Hand hygiene: why, how and when brochure and Glove use information leaflet: |</p>
<table>
<thead>
<tr>
<th>49</th>
<th><strong>Use of gloves and injections</strong></th>
</tr>
</thead>
</table>
| **State** that use of gloves while giving injections needs some clarity. For example, gloves are not required for routine intradermal, subcutaneous or intramuscular injections if your skin is intact or the patient’s skin is intact. However, if contact with a patient’s blood or infectious body fluids is anticipated, gloves must be used. If you have to, wear non-sterile, well fitting and single-use gloves.  
**State** that you must not use the same pair of gloves for more than one patient or wash them for reuse.  
**State** that gloves should be used during venous access injections because of the possibility of blood exposure at the puncture site.  
**State** that it is important to bear in mind that gloves do not provide protection against needle-stick injuries.  
**State** that gloves must be used if the health care worker’s skin is not intact or if the patient’s skin is not intact – for example, in the presence of eczema, burns or skin infections. | **Refer to handout 10 in the student handbook:** [https://www.ncbi.nlm.nih.gov/books/NBK138494/](https://www.ncbi.nlm.nih.gov/books/NBK138494/) |
<table>
<thead>
<tr>
<th>50</th>
<th><strong>Step 3: sterile injection equipment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• WHO recommends syringes with RUP features for all injections.</td>
</tr>
<tr>
<td></td>
<td>• RUP syringes with a sharps injury protection feature are highly recommended wherever possible.</td>
</tr>
<tr>
<td></td>
<td>• Reuse of syringes and needles is a violation of patient safety.</td>
</tr>
<tr>
<td></td>
<td>• Always use a new syringe and a needle opened from a new and sealed package.</td>
</tr>
</tbody>
</table>

**Say:**

“Step 3 in giving a safe injection is the use of sterile injection equipment. It must be used to avoid risk of disease transmission.”

WHO recommends RUP syringes for all injections.

Always use a new syringe and a needle opened from a new packet.

**WHO guideline on the use of safety-engineered syringes for intramuscular, intradermal and subcutaneous injections in healthcare settings**

http://www.who.int/infection-prevention/publications/is_guidelines/en/

<table>
<thead>
<tr>
<th>51</th>
<th><strong>Using sterile injection equipment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discard the needle or syringe if the package has been punctured, torn, damaged or moisture found inside.</td>
</tr>
<tr>
<td></td>
<td>• Punctures, tears and damage constitute breaks in sterile packaging.</td>
</tr>
<tr>
<td></td>
<td>• Breaks in a sealed package can lead to contamination.</td>
</tr>
</tbody>
</table>

**Say:**

“Ensure that the package is intact and there is no moisture inside the package. If there is any suspicion of break in packaging please discard the syringe and use a new one.”

<table>
<thead>
<tr>
<th>52</th>
<th><strong>Inspect the packaging</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A visual inspection of packaging provides ample detail to decide whether or not to use the syringe.</td>
</tr>
<tr>
<td></td>
<td>• While doing a visual inspection check for the type of syringe, volume (e.g. 2, 3 or 5 ml), needle size (e.g. 23 gauge), it is also very important to check the lot number and expiry date.</td>
</tr>
<tr>
<td></td>
<td>• Mention that some packaging also describes how the syringe was sterilized and what kind of packaging is used (e.g. blister packaging, which is most common, and comprises a permeable membrane that allows the ethylene oxide gas to pass through during the sterilization process).</td>
</tr>
</tbody>
</table>
Say that a substandard syringe can also be identified on visual inspection.

Click once to show substandard printing. Explain, further, that printing on the packaging will not be consistent or the expiry date and lot number may not be mentioned.

Click a second time. Point out that a substandard syringe will not be straight and may have inconsistent graduation lines.

Click a third time. Mention the foreign body inside the syringe, suggesting compromised sterility.

Click once. Say:

“Step 4 in giving a safe injection is preventing contamination.”

Ask the participants why it is important to use single-dose vials rather than multidose ones.

Click a second time. Explain that there have been many outbreaks associated with use of multidose vials.

Mention that the preservatives inside the multidose vial do not eradicate the chances of microbial contamination.

Say that a literature review on infection control practices published in 2012 assessed the contribution of single-dose vials independently for infection.

After reviewing 60 reports the authors found good evidence that contamination of multidose or single-dose vial can contribute to infections.
Say: “Always pierce the vial with a sterile needle and avoid leaving the needle in the stopper.”

Ask the participants why.

Click once. Explain that a needle left in the septum is an open door for contamination.

Click a second time. Mention that this practice, along with the reuse of injection equipment on another or even on the same patient, can lead to cross-infection.

Say that multidose vials should be dedicated to a single patient whenever possible.

Say that if a multidose vial must be used in some situations, it should only be kept and accessed from the nursing station.

Say that if a multi dose vial is found in a patient treatment area, it should be dedicated for single-patient use only.

Say that “treatment area” means any operating or procedure room.

Click once and say: “Use ‘pop open’ ampoules rather than the ones that require a metal file to open them.”

Ask the participants why.

Click a second time and explain that ampoules that require a metal file can break more easily and lead to laceration of fingers: lacerations can
## Advanced Infection Prevention and Control Training

### Lead to contamination of injectable substances.

<table>
<thead>
<tr>
<th>59</th>
<th>Preventing contamination – protecting fingers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Protect fingers with a clean barrier (e.g., a small gauze pad) when opening ampoules.</td>
</tr>
<tr>
<td></td>
<td>- A clean barrier may protect fingers from ampoule breaks.</td>
</tr>
</tbody>
</table>

**State** that protecting fingers with a clean barrier like a gauze while opening ampoules can prevent injury to fingers if ampoule breaks.

---

### Say:

**“Step 5 in giving a safe injection is skin disinfection.”**

**Explain** that disinfecting the skin is necessary prior to giving injections. Mention that methanol or methyl alcohol should not be used as skin disinfectants. These are not suitable for human use.

**State** that 60–70% alcohol-based solution should be used on a cotton wool ball or single-use swab and the area wiped from the centre working outwards, avoiding the same area. It should be allowed to dry for 30 seconds.

**State** that cotton balls stored in a multi-use container should be avoided, as they may be a source of infection.

---
Say that:
- for intradermal and subcutaneous injections soap and water is sufficient;
- for intramuscular injections, the evidence is lacking, so soap and water and 60–70% alcohol should be used;
- for immunization injections soap and water is sufficient;
- for venous access 60–70% alcohol is required.

Refer to handout 11 in the student handbook.

**Step 6: Appropriate collection of sharps**

- Never recap needles.
- Place uncapped syringes and needles directly into sharps containers immediately after use.
- Sharps containers should be accessible, at every point of care and always within arm’s reach.

“Step 6 is one of the most important steps in injection safety: appropriate collection of sharps.”

Say:

“After giving an injection, do not attempt to recap the needle; place the syringe and the needle in the sharps container. The sharps container should ideally be placed within arm’s reach.”

Say:

“Do not attempt to open the sharps container or safety box. It should be stored in a secure place prior to its final disposal. The sharps container must not be filled more than three quarters full.”
<table>
<thead>
<tr>
<th>Page</th>
<th>Text</th>
</tr>
</thead>
</table>
| 64   | **Educational poster for communities – needles and syringes are not toys**

Say that this educational poster has been developed to raise awareness within communities that children may play with syringes dumped on community waste sites. Children should be told to not to play with any sharps found.


| 65   | **Seal sharps containers for transport to a secure area**

Once closed and sealed do not open, empty or reuse sharps containers.

- Presence of sharps outside sharps containers leads to needle-stick injuries.
- Opening, emptying or reusing sharps containers leads to needle-stick injuries.
- In some countries, used syringes have a value and they can be reprocessed and repackaged, leading to infection among patients.
- A 2003 study found plastic dealers ready to sell used syringes to investigators after washing them.

**Say** that:
- opening the sharps container can lead to needle-stick injuries;
- in some countries, syringes are reprocessed and repackaged, becoming a source of infection;
- a study from Pakistan published in 2003 found that dealers of used plastic were willing to sell used syringes to investigators after washing them.

| 66   | **Step 7: appropriate waste management**

- Many health care facilities in low- and middle-income countries have contaminated sharps in their surroundings.
- Sharps in the environment expose the community to needle-stick injuries.
- In many settings children start to pick up and play with sharps, as they are dumped in community waste sites.

**Say:**

“The seventh and final step in giving a safe injection is managing sharps.”

It has been observed that in many countries contaminated sharps can be found in the surroundings; this can expose the community to injuries and, as mentioned earlier, children can pick up the syringes and play with them as if they were toys.

---

Page 27 of 56
Say that health care waste treatment should depend on local policies and prevalent conditions. When considering options, the following factors should be kept in mind:

- environmental factors;
- quantity and characteristics of waste;
- requirements of technology;
- cost;
- operation and maintenance requirements.

Say that:

- the process of steam-based treatment consists of decontaminating infectious and sharps waste by subjecting it to moist heat and steam for a defined period of time, which depends on the size and load of the content;
- another option is burning, which reduces waste volume and weight, but releases pollutants and requires flue gas treatment to minimize pollutants such as sulfur oxide or heavy metals;
- in chemical treatment, infectious waste is decontaminated using chemicals.

Say that:

- autoclaving of waste is carried out in a metal vessel designed to withstand high-pressure steam, which is introduced in the vessel and then removed (the water used in the process is considered nonhazardous and can be disposed of accordingly);
- microwave technology works around microwave energy and produces moist heat and steam; it requires electricity between 230 and 400 volts.
### Incinerators

**Dual chamber without flue gas treatment**
- Primary chamber burns at or above 850°C
- Secondary chamber has burners that burn at 1100–1200°C
- Requires electricity between 220 and 400 volts or fuel for generator

**Say that:**
- the dual chamber incinerator has two chambers and can be used without flue gas treatment;
- it is one of the most common methods of handling health care waste and is widely utilized worldwide;
- there are two chambers: the first burns at or above 850°C and the secondary chamber burns at 1100–1200°C;
- it requires electricity between 220 and 400 volts or fuel for generator.

### Incinerators contd.

**Single chamber without flue gas treatment**
- Drum and brick and designed to meet immediate need
- Can work on wood, coconut shells etc.

**Say that:**
- the single-chamber incinerator is made of drum and brick and designed to meet immediate need;
- it can even work on wood or coconut shells;
- the efficiency of this type of incinerator may reach 80–90% and result in destruction of 99% of microorganisms and a dramatic reduction in the volume and weight of waste;
- however, many chemical and pharmaceutical residues will persist if temperatures do not exceed 200°C;
- in addition, the process will cause massive emission of black smoke, fly ash and potentially toxic gases.

### A useful website

**State** that this is a useful website related to health care waste management.
- The database is a web tool, developed by the Health Care Without Harm Global Team, to help staff responsible for procuring health care waste treatment technologies to identify alternatives to incinerators.
- Searching the database involves four steps: select country, select health-care waste treatment technologies database (handout 12 in the student handbook): [http://medwastetech.info/](http://medwastetech.info/)
| 73 | **In summary**  
- Unsafe injections, including unnecessary injections, are a global problem.  
- Reuse of syringes and needles is a risk factor in transmitting bloodborne infections.  
- Contamination (unsafe use of vials or preparing injections in unsanitary areas) is also a major risk.  
- Following the seven steps to preparing and giving an injection can reduce the risk to patients and health workers.  
- WHO's key recommendation to use safety-engineered syringes for therapeutic injections should be adopted.  

State that:  
- unsafe injections are a global problem;  
- bloodborne infections can be transmitted when syringes and needles are reused;  
- preparing injections in a contaminated environment is a serious risk factor, and so is use of single-dose vials on more than one patient or multidose vials;  
- by following these seven steps the chances of infection transmission can be eliminated for patients and health workers;  
- health systems should adopt WHO's recommendation to use safety-engineered syringes. |
| 74 | **Key resources summarizing the seven steps**  

Ask one or two participants to summarize the seven steps to safe injections.  

State that this leaflet covers all key aspects of injection safety such as:  
- the responsibility of injection providers to ensure that each injection given is safe;  
- types of syringes to be used;  
- preventing contamination;  
- needle-stick injury protection;  
- hand hygiene;  
- managing sharps appropriately. |
Further, the next three slides showcase additional resources available, summarizing the seven key steps to giving a safe injection.

No need to read the slide – just explain that there are further reading materials on all of the topics addressed here.

---

**Suggested reading**


Say:
“Building on the steps for giving a safe injection, session 3 of this module will cover needle-stick injuries and prevention.”

State that there are many examples from low- and middle-income countries where needle-stick injuries and their reporting is a problem.

- Studies from Iran, India and Nigeria indicate that needle-stick injuries occur among almost 50% of health care workers, but their reporting is quite low.

- A cross-sectional study in a teaching hospital in Tehran in 2013 collected data from 344 health workers. Only 50.2% of injuries had been reported, while 67.8% of respondents had experienced a needle-stick injury. A point to note is that of all the injuries, 71.1% were due to injections.

- A study in a tertiary care hospital in rural India collected data on needle-stick injuries from 220 nurses and doctors in 2012. 49% reported experiencing a needle-stick injury but only 31.2% reported it.

- Another cross-sectional study was conducted among 122 health workers in Nigeria in 2014. 51% reported experiencing a needle-stick injury in the past 12 months and 62% did not report it.
Types of needle that cause needle-stick injuries
- Hypodermic needles
- Blood collection needles
- Suture needles
- Needles used in intravenous delivery systems

State that these are the types of needle that can cause a needle-stick injury.

They include:
- hypodermic needles, which are commonly used on conventional disposable syringes;
- blood collection and suture needles;
- needles used in intravenous delivery systems.

When needle-stick injuries occur

Sudden patient movement during the injection
- Recapping the needles
- Transferring body fluids between containers
- Failing to dispose of used needles properly in a puncture-proof safety box

State that there are certain situations in which a health care worker is vulnerable to injuries, for example:
- if the patient makes sudden movement while giving an injection;
- when recapping needles, which is a common practice;
- while transferring body fluids between containers;
- if used needles are not properly disposed of in a safety box or sharps container.

If you get a needle-stick injury

Take the following actions immediately.

1. Wash the wound with soap and water.
2. Inform your supervisor and follow the needle-stick injury reporting mechanism of your health facility.
3. Identify the source patient, who should be tested for HIV, hepatitis B and hepatitis C infections.
   Note: tests should be carried out after patient counselling and consent.
5. Read WHO best practices for injections and related procedures toolkit.

Say:

“If you experience a needle-stick injury, take the following actions.”

1. Wash the wound with soap and water.
2. Inform your supervisor and follow the needle-stick injury reporting mechanism in your health facility.
3. Identify the source patient, who should be tested for HIV, hepatitis B and hepatitis C after counselling and taking informed consent.
4. Be tested for HIV, hepatitis B and hepatitis C.
5. Follow WHO guidelines.

Best practices for injections and related procedures toolkit:
Say that the risk of acquiring HBV depends on three things.

- First is the degree of contact with blood.
- Second, if the source is both hepatitis B surface antigen and hepatitis B e antigen positive the chances are higher and range from 22% to 31%: hepatitis B e antigen is an indicator of high infectivity.
- Third, if the blood is only contaminated with hepatitis B surface antigen the chances are between 1% and 6%.

State that post-exposure prophylaxis (PEP) for HBV is based on hepatitis B vaccine given either alone or combined with hepatitis B immune globulin (HBIG).

- Health workers who are not vaccinated against hepatitis B must be given the initial dose immediately after exposure.
- If the source of the exposure is unknown or is hepatitis B positive, among unvaccinated health workers or those with incomplete vaccination, vaccination should be initiated and doses should be completed, and if HBIG is available it should be given.
- For those vaccinated with three or more doses no PEP is required.
- If the source is hepatitis B negative and the health worker is unvaccinated or has incomplete vaccination, all doses should be completed.
- For those vaccinated with three or more doses no PEP is required.
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Content</th>
</tr>
</thead>
</table>
| 86   | Efficacy of HBV PEP | Say that:  
- the efficacy of multiple doses of HBIG alone, if initiated within one week of exposure, has found to be in the range of 70–75%;  
- the efficacy of the HBV vaccine series alone has been found to be in the range of 70–75%;  
- combining HBIG and the HBV vaccine series increases efficacy to 85–95%. |
| 87   | Follow-up for HBV-exposed health workers | Say that:  
- testing should be conducted after 1–2 months to determine whether antibodies are formed;  
- if HBIG has been given in the last 3–4 months then it may not be possible to determine the vaccine response. |
| 88   | Exposure to HCV | Say that:  
- risk of HCV transmission is relatively low;  
- one study indicated that HCV transmission is possible only from hollow-bore needles;  
- HCV is rarely transmitted from the mucous membrane. |
| 89   | Management of HCV exposure | State that:  
- there is no recommended PEP for HCV-positive blood and immunoglobulins or antiviral agents are not recommended;  
- there is no vaccine for HCV yet;  
- after HCV exposure, baseline testing for antibodies should be performed, along with alanine aminotransferase (ALT);  
- Follow-up testing for antibodies to hepatitis B should take place among those who receive vaccine in response to exposure.  
- Testing should be done 1–2 months after the last dose.  
- If HBIG has been given in the past 3–4 months it is not possible to determine the response to the vaccine.  
- Risk of HCV transmission is relatively low.  
- Seroconversion rate after accidental percutaneous exposure from an HCV source is 1.8% (range 0–7%).  
- One study indicated transmission from hollow-bore needles only.  
- HCV is rarely transmitted from exposure of mucous membrane or nonintact skin to contaminated blood.  
- No PEP is recommended following injury involving HCV-positive blood.  
- Immunoglobulin and antiviral agents are not recommended.  
- There is no vaccine against HCV.  
- Identify infection and refer for evaluation of treatment options.  
- Steps after HCV exposure are:  
  - baseline testing for antibodies  
  - alanine aminotransferase (ALT).
### Advanced Infection Prevention and Control Training

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**Follow-up for HCV exposure**

- Test for anti-HCV and ALT 4–6 months after exposure.
- Test for ribonucleic acid 4–6 weeks after exposure if early diagnosis is desired.
- Confirm repeatedly positive results in anti-HCV enzyme immunoassays with supplemental tests.
- If health care worker is seroconverted refer to a specialist.

**State** that:
- the health care worker should be tested for anti-HCV and ALT 4–6 months after exposure;
- if early diagnosis is desired a ribonucleic acid test called PCR can be performed 4–6 weeks after exposure;
- supplemental tests may be needed for a definitive diagnosis;
- once infection is confirmed, the health care worker should be referred to a specialist for treatment.

#### 91

**Exposure to HIV**

- Risk of HIV transmission after a percutaneous injury is approximately 0.3%.
- Risk may be higher in countries with higher prevalence or in health care settings where reuse of medical supplies and equipment is higher and overall safety standards are low.

**Say** that:
- the risk of HIV transmission after a percutaneous injury is approximately 0.3%;
- it should be noted that risk may be higher in countries that have higher prevalence or in health care settings where reuse of medical equipment is higher and safety standards are low.

#### 92

**HIV PEP following occupational exposure**

<table>
<thead>
<tr>
<th>PEP recommended</th>
<th>PEP not recommended</th>
</tr>
</thead>
</table>
| PEP is recommended if exposure meets all the following criteria:  
  - the exposure took place within 72 hours;  
  - the exposed individual is not known to be HIV infected;  
  - the source of exposure is HIV infected or of unknown status;  
  - exposure was caused by one or more of the following:  
    - blood, body tissue, visibly blood-stained fluid;  
    - concentrated virus, cerebrospinal fluid;  
    - synovial fluid, peritoneal fluid;  
    - pericardial fluid, amniotic fluid.  | PEP is not recommended if any of the following apply:  
  - more than 72 hours has elapsed since the exposure;  
  - the exposed person is already HIV positive;  
  - exposure was to body fluids from a person known to be HIV negative (unless suspected of being high risk and in the "window period");  
  - exposure was to noninfected body fluid (feces, saline, urine or semen);  
  - only intact skin was exposed. |

**State** that the table describes in detail in which situations PEP is recommended and when it is not recommended.
- PEP is recommended if the exposure took place within 72 hours and the exposed individual is HIV negative.
- PEP is recommended if the source of exposure is HIV infected or of unknown status.
- PEP is also recommended if exposure was to blood, body tissues, visibly blood-stained fluid, or cerebrospinal, synovial,
peritoneal, pericardial or amniotic fluid.

- PEP is not recommended if the time elapsed has been longer than 72 hours and the exposed person is already HIV positive.
- PEP is not recommended if exposure was to body fluids from an HIV-negative individual unless the person is suspected of being high risk and may be in the “window period”.
- No PEP is required if intact skin was exposed.

### Say that:

- if the exposure was such that there was a deep puncture or spontaneous bleeding, or the splash was significant to the mucus membrane, then PEP is recommended;
- if the puncture was through a hollow-bore needle or other sharp object that was visibly contaminated with blood, PEP is recommended.

### Evaluation of HIV infection

<table>
<thead>
<tr>
<th>Type of exposure</th>
<th>Source HIV positive</th>
<th>Source HIV status unknown</th>
<th>Source HIV negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous injury,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>more severe</td>
<td>Recommended two-drug regimen</td>
<td>Consider HIV prevalence in population or subgroup</td>
<td>DO NOT recommend PEP provided there is no risk that the source person might be in the &quot;window period&quot;</td>
</tr>
<tr>
<td>Percutaneous injury,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>less severe</td>
<td>Recommended two-drug regimen</td>
<td>DO NOT recommend PEP</td>
<td></td>
</tr>
<tr>
<td>Splash, more severe</td>
<td>Recommended two-drug regimen</td>
<td>Consider HIV prevalence in population or subgroup</td>
<td>DO NOT recommend PEP provided there is no risk that the source person might be in the &quot;window period&quot;</td>
</tr>
<tr>
<td>Splash, less severe</td>
<td>DO NOT recommend PEP, two-drug regimen optional</td>
<td>DO NOT recommend PEP</td>
<td>DO NOT recommend PEP</td>
</tr>
</tbody>
</table>

### Say that this slide provides detail of the type of exposure, status of the source and whether or not PEP should be provided.

- In first row, please note that if the percutaneous injury was severe and the source is HIV positive, the two-drug regimen is recommended, but if the HIV status of the source is unknown then HIV prevalence in the population or subpopulation should be considered before deciding whether or not to initiate PEP.
- With a serious percutaneous injury, if the source is HIV negative, PEP is not recommended provided there is assurance that the source person is now in the “window period”.
Advanced Infection Prevention and Control Training

• The second row shows that if the percutaneous injury was less severe and the source person is HIV negative and not in the “window period”, no PEP is required. PEP will be required if the source person is HIV positive and the percutaneous injury is less severe.
• The same is applicable to splashes, as set out in the last two rows.

95

Issues of PEP counselling

- PEP is for 28 days only and is not a treatment for HIV.
- HIV treatment is based on a combination of antiretrovirals to be taken continuously.
- Adherence is of high importance.
- Recommendations should include use of condoms and avoidance of donating blood, semen or organs until a test six months after exposure is negative.
- Information on contraception should be given to women of childbearing age.
- Information on alternatives to breastfeeding should be given to lactating mothers.

Say that it must be emphasized to the health care worker that PEP is not a treatment for HIV, as it only lasts for 28 days.
- HIV treatment comprises a combination of antiretrovirals, which have to be taken continuously and with good compliance.
- After exposure it is recommended that condoms should be used in sexual acts and blood, organ and sperm donation should be avoided until a test at least six months after the exposure is negative.
- If the health care worker is a woman of childbearing age, contraception should be emphasized.
- If the health care worker is a lactating mother, alternatives to breastfeeding should be recommended.

96

Follow-up for HIV exposure

- The aim of follow-up visits is to:
  - support PEP adherence
  - prevent or treat side-effects of PEP
  - identify possible seroconversion
  - Evaluation within 72 hours is important to monitor possible drug reactions.
  - Test for HIV antibodies at baseline, six weeks and six months after exposure.
  - If seroconversion occurs, refer for treatment, care and support.
  - Test for HIV antibodies if illness compatible with an acute antiretroviral syndrome occurs.

Say that the purpose of follow-up visits is to ensure adherence to PEP, prevent or treat any side-effects of PEP and to identify possible seroconversion.
- Drug reactions have to be monitored within 72 hours of initiating treatment.
- HIV testing is recommended at baseline, six weeks and six months after the exposure – if at any stage there is seroconversion the
### Reporting HIV exposure

- Reporting of the incident is important to evaluate the safety of working conditions and appropriate measures.
- All reports should be confidential.
- Information will be useful for future prevention.
- For example, an incident of exposure can be helpful in evaluating health practices, policies and even products in use.
- Data collected are of two kinds:
  - data for risk assessment and post-exposure engagement
  - data that describe the circumstances of exposure—these are helpful in making recommendations for future prevention.


### Questions

- Have you ever experienced a needle-stick injury?
- In your opinion what factors contributed to your needle-stick injury?
- Did you report it or not?
- Have you ever noticed a sharp being disposed of inappropriately? Did you report it to someone?
- How would you initiate a needle-stick reporting system in your facility and at the country level?

### Group work 2

Amelia was working late in the afternoon and she was about to finish when her colleague informed her that she was having difficulty collecting a blood sample from a patient. Amelia took the sample successfully and, after taking the needle out and keeping pressure on the patient’s hand to stop the bleeding, she tried to reach the sharps box, which was behind her. In doing so, she was stuck by another needle in the sharps box.

Amelia thought the needle had been exposed to the environment for some time and it seemed dry, so there was little risk of acquiring an infection. She therefore refused post-exposure prophylaxis for HIV. At a subsequent follow-up, however, she found out that she had contracted HCV and HIV.

**Questions**

1. What factors contributed to the exposure?
2. Would it have been possible to prevent this exposure?
3. Would it have been possible to use a safety-engineered syringe to prevent the needle-stick injury? If yes, what type of syringe?
4. What kind of practice at work could have prevented this needle-stick injury?

### For students: see group work 2 – student handbook, p. 37.

### For trainer: see group work 1 – Annex 1, p. 55.

### Say

- It is essential that all needle-stick injury incidents are reported in order to assess the safety of working conditions and take appropriate measures.
- It is important that all reporting is confidential.
- This kind of information will be useful for future prevention.
- The data are of two types: data for risk assessment and post-exposure engagement, and data that describe the situation when the incident occurred.

### Ask

- How would you initiate a needle stick reporting system in your facility?
- How would you initiate similar reporting mechanism at the country level?

### Allow

5 minutes for interactive discussion.

### Ask

- a participant to read the scenario and questions.

### Say:

“Divide yourself in groups of 4–5 and work together to answer these questions.”

### Allow

30 minutes for group work and responding to questions.
State that the fewer unnecessary injections are given, the lower the chance of injury to health workers.

Say:

“In other words, ‘less is more!’”

State that this has already been mentioned in previous slides but is emphasized here as a reminder.

- WHO recommends syringes with RUP features.
- WHO also recommends syringes with SIP features.
- For example, in the syringe in the left picture the needle retracts inside and the syringe becomes locked.
- In the picture on the right there is a hood on the needle: this should be pushed gently after the injection is given – it covers the needle, limiting the risk of needle-stick injury to the health worker.

State that:

- syringes with SIP features cost more than RUP syringes; this could be an issue in some low- and middle-income countries;
- however, manufacturers can be involved in discussions and prices may be negotiated;
- further, the ministry of health can work on reducing levies and taxes to bring prices down.
<table>
<thead>
<tr>
<th>103</th>
<th><strong>Protecting yourself and others</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ensure that all staff in your area are educated on the risks of needle-stick injuries and given appropriate training.</td>
</tr>
<tr>
<td></td>
<td>• This is especially important for housekeeping staff or sanitation workers who do not have medical or nursing training.</td>
</tr>
<tr>
<td></td>
<td>• Take time to explain risks, especially if you observe risky or dangerous procedures or behaviours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>104</th>
<th><strong>Reminder: protect the community</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ensure waste is disposed of properly within the facility. It is your responsibility to ensure that NO infected waste reaches the community, where these items can be attractive to children to play with.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>105</th>
<th><strong>Leaflet on needlestick injuries</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“This is a leaflet on preventing needlestick injuries. It provides information about types of needle that can cause a needle-stick injury, when such an injury might occur and what to do if it happens.”</td>
</tr>
</tbody>
</table>

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State that this is an important slide.  
- It must be ensured that all staff in your area are educated on the risks of needle-stick injuries and given appropriate training. 
- One group that is often neglected, even though it is also at risk, is housekeeping and sanitation staff. 
- They do not have medical or nursing training and are often less well educated. 
- They should be included in these efforts and any incorrect practices should be corrected.

State the following, as a further reminder. 
The definition of a safe injection includes the imperative that an injection must not result in waste that is dangerous to others. It is the responsibility of health care workers and all others to ensure that waste is disposed of properly and does reach community waste sites.

Refer to handout 13 in the student handbook.
### 106

<table>
<thead>
<tr>
<th>State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Page two of the same leaflet provides guidance on protection and how, as a health care worker, you can protect others.”</td>
</tr>
</tbody>
</table>

### 107

<table>
<thead>
<tr>
<th>Suggested reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS What should I do if I injure myself with a used needle? Available at: <a href="https://www.nhs.uk/chq/Pages/2557.aspx?CategoryID=72">https://www.nhs.uk/chq/Pages/2557.aspx?CategoryID=72</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No need to read the slide – just explain that there are further reading materials on all of the topics addressed here.</td>
</tr>
</tbody>
</table>

### 108

<table>
<thead>
<tr>
<th>State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In this last session we are going to cover implementation strategies for injection safety.”</td>
</tr>
</tbody>
</table>

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### Advanced Infection Prevention and Control Training

**Page 43 of 56**

| 109 | **To reduce:**
|     | - reuse of injection equipment
|     | - accidental needle-stick injuries
|     | - overuse of injections
|     | - unsafe sharps waste
| **To ensure:**
|     | - rational use of injectable drugs
|     | - sufficient supply availability

**State** that, as mentioned previously:
- WHO recommends that all Member States should switch to exclusive use of RUP syringes for all injections;
- WHO’s guideline was developed to curtail the reuse of injection equipment, avoid needle-stick injuries, prevent overuse of injections and reduce unsafe management of sharps;
- it aims to ensure rational use of injectable drugs and sufficient supplies of injection equipment.

**WHO guideline on the use of safety-engineered syringes for intramuscular, intradermal and subcutaneous injections in health care settings:**
[http://apps.who.int/iris/bitstream/10665/250144/1/9789241549820-eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/250144/1/9789241549820-eng.pdf?ua=1)

| 110 | **Group work 3**
|     | - Work in groups of 3-5 people – a facilitator will join each group.
|     | - In your groups discuss and develop a strategy to implement the WHO policy and injection safety best practices learned so far, at both:
|     |   - national level (group 1)
|     |   - health care facility level (group 2).
| **Questions**
| 1. What strategy would you use to implement the WHO policy-recommendations and injection safety best practices learned so far, both at the national level and in a health care facility?
| 2. Who are the key players involved in supporting such a strategy?
| 3. Who is the target audience for such a strategy?
| 4. What resources are needed for successful implementation of such a strategy?

**Ask the participants to divide themselves into groups of 4–5.**

They should be asked to discuss and develop a strategy to implement the WHO policy and injection safety best practices learned so far, at both:
- national level (group 1)
- health care facility level (group 2).

The activity should last one hour: allow 30 minutes for group discussion and 15 minutes for reporting from each group.

**For students:** see group work 3 – student handbook, p. 38.

**For trainer:** see group work 1 – Annex 1, p. 57.

| 111 | **Key features of a national injection safety implementation strategy/campaign**
|     | - Political commitment
|     | - Communication strategy for advocacy and awareness-raising
|     | - Budget allocation and strategy for donor engagement
|     | - Industry engagement/procurement strategy
|     | - Target audience and stakeholder engagement strategy
|     | - Health care worker safety, education and training
|     | - Public awareness-raising and patient education and involvement
|     | - Evaluation plan and indicators

**Say** that the key features of any national or state or provincial injection safety implementation strategy include the following:
- political commitment from the ministry of health and other key stakeholders;
- a communication strategy for advocacy and awareness-raising for patients and communities;
- budget allocation for injection safety and a donor engagement strategy;
- target audience and stakeholder engagement;
- education and training for health care workers;
### Key features of an injection safety campaign at the facility level

- Commitment by facility management;
- Budget allocation for injection safety;
- Sensitization and awareness strategy for health care workers at the facility;
- Procurement of safety-engineered devices;
- Training plan for health care workers (including nurses, physicians, paramedics, housekeeping and sanitation workers);
- Patient education plan/material at inpatient and outpatient levels;
- Waste management;
- Ongoing evaluation plan and indicators.

### State

The previous slide referred to stakeholders at the macro level, such as the ministry of health and state/provincial health departments. In order to improve injection safety at the facility level, the key features are more or less the same, with some modifications:

- commitment by facility management (director or medical superintendent) to address the problem;
- sensitizing all categories of health worker in the facility;
- a training plan for all health care workers;
- allocation of budget to address the problem;
- distribution of educational material for patients in outpatient and inpatient settings;
- ongoing evaluation.

### Say

- Injection safety is a complex problem and requires a multimodal strategy and collective effort.
- There is no quick fix, as there is with many other public health problems.
- However, a multimodal campaign will produce positive results, preventing infections among patients as well as health care workers.
“To give a national example, I would like to share the progress made in injection safety in India since the start of the WHO injection safety campaign in 2016. As a result of targeted and well planned advocacy by WHO, and by the country office in particular, the Ministry of Health and Family Welfare realized the gravity of the problem and showed great leadership and commitment to address the issue.

The State of Punjab, where the injection safety pilot intervention is in progress, has developed a comprehensive plan. The key features include conducting a baseline assessment and introducing safety-engineered syringes to the health system. In addition, 40 model injection safety centres were established at the district level, as well as teaching and nursing institutes, to serve as training sites. A communication campaign was also rolled out, targeting patients and communities.”

State that the next three slides show advocacy leaflets developed for key targets groups such as ministries of health, donors and clinicians.
<table>
<thead>
<tr>
<th>Page</th>
<th>Advocacy Leaflets</th>
<th>Statement</th>
<th>Advocacy Leaflets</th>
</tr>
</thead>
<tbody>
<tr>
<td>116</td>
<td>Advocacy Leaflets for Health Care Providers, Professional Associations and Industry Members</td>
<td>State that other target groups include health care providers, professional associations and industry members.</td>
<td>Advocacy leaflets for health care providers, professional associations and industry members: <a href="http://www.who.int/infection-prevention/tools/injections/communications/en/">http://www.who.int/infection-prevention/tools/injections/communications/en/</a></td>
</tr>
<tr>
<td>117</td>
<td>Advocacy Leaflets for Patient Associations, Civil Society and Media Organizations</td>
<td>State that these advocacy leaflets highlight the role each of these key groups can play and the kind of action required from them to improve injection safety. They also address the kind of strategies needed to address the problem.</td>
<td>Advocacy leaflets for patient associations, civil society and media organizations: <a href="http://www.who.int/infection-prevention/tools/injections/communications/en/">http://www.who.int/infection-prevention/tools/injections/communications/en/</a></td>
</tr>
<tr>
<td>119</td>
<td>Suggested Reading</td>
<td>No need to read the slide – just explain that there are further reading materials on all of the topics addressed here.</td>
<td></td>
</tr>
</tbody>
</table>
**State** that the field of injection safety at WHO headquarters comes under the remit of the Infection Prevention and Control Global Unit.

**Thank** the participants for their time and attention.
Annex 1

The same pre- and post-training test (p. 49 below) should be distributed to participants at the beginning and end of this module to gauge their knowledge of injection safety. The pre-training test will develop a baseline, measuring existing knowledge, and identify knowledge gaps. The post-training test will assess the knowledge gained through the module.

This page contains the answers to the test; please ensure two copies of the master form on p. 49 are printed for each student. Hand one out at the start of the session to collect initial data from participants and the other at the end to assess progress.

FORM WITH ANSWERS – for trainer

Advanced IPC knowledge exam: injection safety

All questions are multiple choice. Please circle one answer or all that apply as per each question’s instructions.

Injection safety

1. Which bloodborne infection has the highest chance of transmission due to unsafe injections? (Please circle one answer.)
   a. HIV
   b. Hepatitis C virus infection (HCV)
   c. Hepatitis B virus infection (HBV)
   d. HBV and HCV
   e. HIV has no chance of transmission due to an unsafe medical injection

2. For skin disinfection, which of the following can be used? (Please circle one answer.)
   a. Methanol or methyl alcohol
   b. 60–70% alcohol-based solution (isopropyl alcohol or ethanol)
   c. Cotton balls stored in a wet container
   d. A, B and C

3. Needle-stick injuries can be prevented by using which of the following? (Please circle one answer.)
   a. Reuse prevention (RUP) syringes
   b. Sharp injury prevention (SIP) syringes
   c. Disposable syringes
      All of the above
Advanced IPC knowledge exam: injection safety

All questions are multiple choice. Please circle one answer or all that apply as per each question’s instructions.

Injection safety

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   b. 60–70% alcohol-based solution (isopropyl alcohol or ethanol)
   c. Cotton balls stored in a wet container
   d. A, B and C

3. Needle-stick injuries can be prevented by using which of the following? (Please circle one answer.)
   a. Reuse prevention (RUP) syringes
   b. Sharps injury protection (SIP) syringes
   c. Disposable syringes
   d. All of the above
Group work 1

Instructions

• Work in groups of 5–7 people – a facilitator will join each group.
• First, read the abstract below of a paper by Janjua et al.
• In your groups answer the questions presented at the end.

Health care risk factors among women and personal behaviors among men explain the high prevalence of hepatitis C virus infection in Karachi, Pakistan.


Summary

To estimate the prevalence and identify factors associated with hepatitis C virus (HCV) infection among men and women in Karachi, Pakistan. We conducted a cross-sectional study of adult men and women in a peri-urban community of Karachi (Jam Kandah). Households were selected through systematic sampling from within all villages in the study area. All available adults within each household were interviewed about potential HCV risk factors. A blood specimen was collected to test for anti-HCV antibodies by enzyme immunoassay. We used generalized estimating equations while accounting for correlation of responses within villages to identify the factors associated with HCV infection.

Of 1997 participants, 476 (23.8%) were anti-HCV positive. Overall, HCV infection was significantly associated with increasing age, ethnicity, and having received ≥2 blood transfusions, ≥3 hospitalizations, dental treatment and >5 injections among women. Among women, ≥2 blood transfusions [adjusted odds ratio (aOR) = 2.32], >5 injections during the past 6 months (aORs = 1.47), dental treatment (aOR = 1.31) and increasing age (aOR = 1.49), while among men, extramarital sexual intercourse (aOR = 2.77), at least once a week shave from barber (aOR = 5.04), ≥3 hospitalizations (aOR = 2.50) and increasing age (aOR = 1.28) were associated with HCV infection.

A very high prevalence of HCV was found in the study population. Among women, unsafe health care practices, while among men extramarital sex, shaving from a barber and hospitalizations were associated with HCV infection. Efforts are needed to improve the safety of medical procedures to reduce the transmission of HCV in Pakistan.
Questions

1. What were the significant risks identified in the study?
2. Why was increasing age identified as a risk?
3. What kind of intervention or interventions could be designed to address this problem if this were the community and area you were assigned to work with?
4. Do you see any role for safety-engineered syringes in this scenario?

Trainer answer notes

1. The most significant risk identified is exposure to unsafe injections. Other risks identified include: ethnicity and having received ≥2 blood transfusions, ≥3 hospitalizations, dental treatment and >5 injections among women. Note: looking closely at the data it seems that among women the OR for blood transfusion is higher than that for injections, but the authors have emphasized the risks related to injections.

2. HCV was significantly associated with increased age because the longer the person lived, the more she/he was exposed to risky health care practices, or to repeated visits to the barber in the case of men.

3. In line with WHO’s five key elements of a multimodal strategy to improve IPC in a health context (see http://www.who.int/infection-prevention/publications/ipc-cc-mis.pdf?ua=1), examples might include:
   a. using WHO-recommended RUP syringes in order to reduce the risk of reuse of (system change – “build it”);
   e. educating health providers on the appropriate steps for preparing and using injections (training and education – “teach it”);
   f. performing routine audits of safe injection practices in the catchment area and providing feedback on performance, including gaps identified (evaluation and feedback – “check it”);
   g. educating the community to understand the risk of unsafe health care practices, such as reuse of injection equipment (communications and awareness-raising – “sell it”);
   h. empowering the community to question the need for an injection and the type of syringe used – often the social structure is such that community members are intimidated by health care providers and do not ask any questions (safety climate – “live it”);
   i. requiring the health administration body for the area to enforce regulation to ensure that all injections are safe and only prescribed when needed (safety climate – “live it”).
4. RUP syringes are designed to prevent reuse. After administering the injection, with a slight push these syringes are disabled and cannot be used again. They have been specifically designed to prevent reuse.
Group work 2

Instructions

• Work in groups of 5–7 people – a facilitator will join each group.
• First, read the scenario below.
• In your groups answer the questions presented at the end.

Scenario

Amanda was working late in the afternoon and her shift was about to finish when her colleague informed her that she was having difficulty collecting a blood sample from a patient. Amanda took the sample successfully and, after taking the needle out and keeping pressure on the patient’s hand to stop the bleeding, she tried to reach the sharps box, which was behind her. In doing so, she was stuck by another needle in the sharps box.

Amanda thought that the needle had been exposed to the environment for some time and it seemed dry, so there was limited risk of acquiring an infection. She therefore refused post-exposure prophylaxis for HIV. At a subsequent follow-up, however, she found out that she had contracted hepatitis C virus and HIV.

Questions

1. What factors contributed to the exposure?
2. Would it have been possible to prevent this exposure?
3. Would it have been possible to use a safety-engineered syringe to prevent the needle-stick injury? If yes, what type of syringe?
4. What kind of practice at work could have prevented this needle-stick injury?

Trainer answer notes

1. Three factors contributed:
a. lack of knowledge of the health care workers – had she been exposed to a training or refresher course she would have remembered the risk factors for acquiring bloodborne infections;

b. not following WHO guidelines, which recommend that sharps/safety boxes should always be in easy reach while performing an injection-related procedure on a patient;

c. not handling the puncture site appropriately, as recommended by the WHO guidelines.

2. Yes: if the sharps/safety box was within arm’s reach she could have seen the needles protruding from the aperture and would have been more careful.

3. Yes. Beside a RUP syringe, another type of safety-engineered syringe is one with SIP features, as covered in the session. This type of syringe has a protective mechanism. In some syringes there is a shield on top of the needle which covers the it after the injection procedure is completed. In another type, the needle retracts inside the barrel, either with a push of a button on the plunger or by gently pulling the plunger backwards after the injection procedure.

4. Adhering to universal precautions would have prevented it:
   a. having the sharps/safety box within arm’s reach
   b. using SIP syringes
   c. having updated knowledge of what to do after a needle-stick injury.
Advanced Infection Prevention and Control Training

Group work 3

Instructions

- Work in groups of 5–7 people – a facilitator will join each group.
- In your groups discuss and develop a strategy to implement the WHO policy and injection safety best practices learned so far, at both:
  - national level (group 1) and
  - health care facility level (group 2).

Questions

1. What strategy would you use to implement the WHO policy recommendations and injection safety best practices learned so far, both at the national level and in a health care facility?
2. Who are the key players involved in supporting such a strategy?
3. Who is the target audience for such a strategy?
4. What resources are needed for successful implementation of such a strategy?

Trainer answer notes

1. The strategy would include the following elements:
   a. introducing RUP syringes to the health system;
   b. educating injection prescribers on rational prescription of injections;
   c. educating the health workforce on injection safety;
   d. empowering the community by increasing their knowledge and awareness of risks associated with unsafe injections.
2. At the national level, key players are within the ministry of health, such as the minister, commissioner, secretary or director-general of health. At the facility level, it would be the individual(s) in charge of the facility, such as the medical director or manager, the person responsible for procurement of medical equipment and senior nursing, paramedical and housekeeping/janitorial staff.
3. At the national level, the ministries of health and finance are target audiences, along with regulatory bodies responsible for maintaining the quality of injection equipment. Individuals in charge of central stores are crucial at all levels.
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At the facility level, the audience would be similar. Some examples include the hospital administration (leadership) for decision-making and acquiring the necessary resource allocation, central stores for aiding in procurement and health care workers and other front-line users of injection equipment (including those responsible for waste disposal).

4. Budget allocation for injection equipment is the critical factor. Identifying the decision-makers responsible for injection safety is important, as is ensuring that WHO-recommended syringes are used in the health system.

At the facility level, the individual in charge of hospital administration needs to work on the budget to procure injection equipment and related products such as sharps/safety boxes. Moreover, budget lines need to be allocated for training of health workers and housekeeping/janitorial staff, and money also needs to be allocated for printing and posting job aides at nursing stations and in patient waiting areas.