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International consultation on policy guidelines on improving health workers' access to prevention, treatment and care services for HIV and TB

Report of the proceedings and
compilation of presented papers
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Table of content

1. Introduction	5
1.1 Background	5
1.2 Overview of the guideline development process	7
1.3 Purpose / Broad Objective/Assumptions of the meeting.....	8
1.3.1 Purpose	8
1.3.2 Specific Objectives	8
1.3.3 Assumptions.....	9
1.4 The Participants and organizers.....	9
1.5 Overview of the programme.....	10
2. Opening remarks.....	12
2.1. Dr. Teguest Guerma - Director HTM/HIV, WHO (read on her behalf by Dr. Jos Perriens, Coordinator, Systems Strengthening, HIV Dept.)	12
2.2 Dr. Sophia Kisting Director ILO.....	13
2.3 Meeting objectives, Rationale for TREAT Policy & Overview of the Development Process Dr. E. Petit-Mshana HSS/HIV	14
Objective-1: To share information on what exists, the issues and challenges in countries on HCW access to HIV & TB services.	15
3. Country experiences and best practices	15
3.1 Experience of the Americas to promote and protect the health of health workers: Marie Claude Lavoie -WHO Regional Adviser Occupational Health -AMRO/PAHO	15
3.2 Health Care Worker Wellness Centers AFRO/Swaziland, Mrs Khosi Mthethwa	16
3.3 Experiences from West Africa (Dr Juma Kariburyo), Côte d'Ivoire	16
3.4 Experiences from South Africa Dr Shahieda Adams.	17
3.5 Perspectives of participants living with HIV	18
3.6 International Survey on policy practices on HCWs access to HIV/TB services.	19
4. Discussion of Objective 1: Experiences from selected countries and country survey.....	21

Objective 2: To explain the existing policies, guidelines and resources available to assist countries implement work place health and safety programmes.....	23
5. An overview of existing policy guidelines	23
5.1 Joint WHO/ILO guidelines on post-exposure prophylaxis -is (PEP) to prevent HIV infection. Dr. Micheline Diepart WHO/HIV/ATC.....	23
5.2 Joint ILO/WHO Guidelines on Health Services and HIV Dr. Sophia Kisting ILO.....	24
5.3 Global Plan of Action on Workers Health/framework for national policy and programmes for health worker occupational health Susan Wilburn (PHE/OH)	25
5.4 The "WHO policy on TB infection control in health-care facilities, congregate settings and households" Dr. Paul Nunn STB/HTM, WHO	27
6. Summary of discussions related to Objective 2; existing guidelines	28
Objective: 3 To provide inputs on the interpretation of the evidence regarding improving HCW access to HIV/TB services, balancing risks and benefits.....	29
7. Synthesis of Evidence in support of TREAT policy statements: Professor Annalee Yassi BCU	29
Objective: 4 To reach consensus on the policy statements & type of final product needed by member countries, partners and stakeholders (e.g. policy guidelines, policy briefs, advocacy materials, implementation guide)	32
8: Group discussions and suggestions for the recommended policy statements	32
8.2 Summary of decisions by the Guideline group per statement:.....	33
8.3 Plenary discussion on results of all group work.....	38
9: Final group sessions to reach consensus on TREAT policy and implementation strategy	40
9.1 TORs for the Guideline Group.....	40
9.2 General Results of Guideline Group discussions and agreements	41
9.3 Summary of final Guideline Group Consensus on TREAT policy reached on 16, September 2009 .43	
9.4 Stakeholders & Partners Session to discuss on Implementation strategy	44
9.5 Summary of Agreed Way forward and Next steps:	46
Other considerations	47
10. Closing remarks at the end of the three day consultation	47

10.1 Dr. Sophia Kisting: Director for ILO/HIV AIDS Programme. 47

10.2 Dr. Teguest Guerma: the Interim Director of HIV Department 48

Notes on interaction with Guideline Review Committee (GRC)..... 49

1. Introduction

1.1 Background

As part of its efforts to deal with the crisis in human resources for health and support the response to HIV and TB, WHO in collaboration with ILO has engaged in formal consultations with the stakeholders and partners towards developing policy to improve health workers' access to HIV and TB services.

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

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

TREAT — comprise a package of HIV treatment, prevention, care and support services targeted to health workers as vulnerable group

TRAIN — entail measures to empower health workers to deliver universal access to HIV services including pre-service, and in-service with special focus on task shifting.

RETAIN — imply strategies to enable public health systems to retain workers, including financial and other incentives, and measures to improve the workplace as well as initiatives to reduce the migration of health care workers.

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

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

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

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

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

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

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1.2 Overview of the guideline development process

The development of TREAT policy applies WHO guideline for developing guidelines. The process is explained in a WHO publication (WHO Handbook for guideline development, March 2008, accessed through <http://intranet.who.int/homes/rpc/grc/>)

The process entails among other steps creation of Steering Group (SG) and the Guideline (GG) whose membership and roles are given in section 1.4 below.

One of the values of WHO approaches to developing policy guidelines is that it requires a thorough and systematic reviewing of evidence, the result of which serves as the basis for recommending policy options. The development of Health worker TREAT policy has involved extensive consultations and evidence review through the following:

- Extensive literature review, of published literature, related studies and existing initiatives in countries/regions.
- A situational analysis in 5 African countries (Ethiopia, Kenya, Malawi, Mozambique and Zimbabwe), with the aim of identifying gaps, barriers and potential solutions in five key areas as explained in the background section of this report)
- A country survey on policy practices conducted in 17 countries covering all 6 WHO regions exploring the implementation of and existing gaps in current policies, especially with respect to health workers' entitlements, rights, and access to HIV/TB prevention, testing and care.
- PICOT questions to systematically review selected areas of workplace programmes
- Referring to existing guidelines on universal precautions & PEP, TB infection control, occupational safety and health management systems, etc.
- Identifying synergies and ensuring complementary advantage vs. duplications

Wide consultations were conducted through

- Individual and group consultations for coordination & consensus building among stakeholders at all levels.
- Made use of existing opportunities through regional and international forums. So far TREAT policy initiative has been presented and discussed during following events:

- SEARO Workshop with 9 countries on HRH planning for HIV/AIDS in Bhutan July 2007
- AFRO meeting with 11 countries on Task Shifting , Harare, November. 2008
- ICASA in Dakar, Senegal, December. 2008
- Meeting for Government Chief Nurses and Midwives on orientation & capacity building on use of tools and guidelines to scale up nursing & midwifery service delivery in the context of PHC renewal , Nairobi April 2009
- A lunch seminar on TREAT policy consultations and systematic evidence review 2nd July 2009, WHO/Geneva.
- International consultations with the Guideline Group, partners & stakeholders 14-16 September 2009, WHO/Geneva.

1.3 Purpose / Broad Objective/Assumptions of the meeting

1.3.1 Purpose

This International consultative meeting brought together the guideline group members and stakeholders to discuss results of systematic review of the evidence and also to agree on recommended policy options with regard to health workers access to HIV/TB services for the national, regional and global actions.

1.3.2 Specific Objectives

1. To share information on what exists, the issues and challenges in countries on HCW access to HIV & TB services.
2. To explain the existing policies, guidelines and resources available to assist countries implement work place health and safety programmes
3. To provide inputs on the interpretation of the evidence regarding improving HCW access to HIV/TB services, balancing risks and benefits
4. To reach consensus on the policy statements & type of final product needed by member countries, partners and stakeholders (e.g. policy guidelines, policy briefs, advocacy materials, implementation guide)

1.3.3 Assumptions

This summary /feedback report of the consultation focuses on priority actions that need to take place in services at community, health centre and hospital levels whether it is governed by public, private and NGO/Civil Society and Faith Based organizations. Critical political, resource mobilization legal and policy-related activities that must set the stage for scaling up improved health workers' access are beyond the stage of this report. The report therefore assumes that the issues raised in the statements are either in place, in development or need to be developed in each country concurrently with the initiation of HIV and TB services for the health worker. The inputs provide at this consultation have guided and informed this report.

1.4 The Participants and organizers

Participants of this meeting fall under four categories as follow:

- i) The Guideline Group. Selected in accordance with the criteria set by The WHO Guideline Review Committee representing methodology experts, consumers including HCWs, PLWA, programme managers, policy makers; also with a consideration of geographical and gender balance. The role of this group is to advise on the choice of important outcomes for decision - making and developing recommendations; to advise on the interpretation of the evidence with explicit consideration of the overall balance of risks and benefits and to formulate recommendations, taking into account diverse values and preferences.
- ii) Stakeholders and Partners: including representatives from partner organizations such as National International Labour Organization ILO, The Global Fund -GFATM, Global Health workforce Alliance -GHWA, Centre for disease control -CDC; Researchers and Educationists from a number of Academic Institutions/Universities ; Various Associations of Health Professionals (ICN, ICM, WMA) ; The Civil society and Activists such as International Council of +Women -ICW, International AIDS society -IAS and others as shown in the participants list Annex ---.

Partners and stakeholders are not only important contributors in the process of developing health worker TREAT policy, it is considered crucial to work with and involve them in developing the strategy for implementation and monitoring of the envisaged policy at various levels (global, regional, national and sub-national levels). It entails among other things, establishing partnerships for advocating and mobilizing financial support to enable accelerated and effective implementation of this policy in member states.

iii) WHO Staff from Regional & Country teams- most of whom participated and supported the country survey on policy practices with regards to HCW access to HIV/TB services. They are also focal points for supporting future adaptation and implementation of the proposed policy in countries.

iv) Steering Group (also serving as resource persons). The Steering Group is a small group of WHO staff established early in this process to scope the guideline, including the process of defining the content, questions and likely recommendations. It comprises representatives of all involved departments (HIV, STB, HRH, and Occupational Health). ILO and GHWA are also involved as key collaborators.

v) Meeting organizers and facilitation

This consultation was jointly organized and co-funded by the World Health Organization (WHO/HIV Department) and International Labor Organization (ILO). Financial contribution was also received from UNAIDS to support some of the earlier preparatory activities, including the country survey to explore policy practices with regard to health workers access to HIV and TB services. It should also be noted at this juncture that this international consultation is one of the major pre-requisite for developing WHO policy guidelines, whereby at least one international consultation with the Guideline Group members is necessary so as to ensure consensus across regions and among key stakeholders regarding refer WHO Handbook for guideline development accessed at <http://intranet.who.int/homes/rpc/grc/>

Keeping in consistency with WHO policy guideline development requirements, the meeting was chaired and facilitated by the Guideline Group Chairs. As stated in the above cited WHO Handbook for developing guidelines, "the functioning of a guideline group is critical to the quality of a guideline. The role of the Guideline Group is explained under sub-section (i) above.

1.5 Overview of the programme

The programme for the international consultation on HCWs TREAT policy was organized to meet the above given four objectives

The procedure consisted of paper presentations followed by plenary discussions. The whole of second day and part of day three were utilized for group work to review the presented evidences, discuss and reach consensus on policy options, as well as proposing an implementation strategy. At the end of each day the organizers, facilitators (including the Guideline Group chairs) and resource persons met for de-briefing and evaluation of the day's event, followed by agreeing the strategy for the next day.

Day one (Monday 14th September 2009)

The events during first half of day one, included the opening speeches by the two Directors of HIV/AIDS (WHO and ILO), followed by an introduction of the background and rationale for TREAT Policy, as well as an overview of the development process. A series of presentations were made to share information on what exists, the issues and challenges in countries on HCW access to HIV & TB services as stipulated under section no. 4 below. Experience were shared from The Americas on how they promote and protect the health of health workers; From Swaziland on Health Care Worker Wellness Centers; from Côte d'Ivoire on existing policies/practices on HCW access and faced challenges; as well as the problem of TB and HIV in health care workers in South Africa .

In addition to country experiences there was a presentation on the results from an International Survey that explored in depth the policy practices on HCWs access to HIV/TB services in 17 countries, representing all six WHO Regions. The survey results were complemented by an elaborative presentation on the synthesis of evidence, with regard to implementation of policies to improve HCWs access to prevention, diagnosis, treatment, and care services for HIV and TB, covered a wide range of studies and their outcomes which support the recommended TREAT policy options.

The second half of day one was spent to tackle the 2nd objective of the consultations, which it to explain the existing policies, guidelines and resources available to assist countries implement work place health and safety programmes. There were sessions over viewing existing Policy Guidelines including

- Joint WHO/ILO guidelines on post-exposure prophylaxis -is (PEP) to prevent HIV infection.
- Joint ILO/WHO Guidelines on Health Services and HIV.
- Global Plan of Action on Workers Health/framework for national policy and programmes for health worker occupational health
- The WHO policy on TB infection control in health-care facilities, congregate settings and households².

On Day two (Tuesday 15th September 2009) the presentation on the proposed policy statements was followed by group work. Groups were given specific terms of reference, as elaborated under section 8.1.

² Due to unavailability of the presenter on day one this presentation was given on day two, but it is shown here to ensure consistency of reporting events under the relevant objective.

Day three, Wednesday 16th September 2009: Objectives 3 and 4 to provide inputs on the interpretation of the evidence regarding improving HCW access to HIV/TB services, balancing risks and benefits; and to reach consensus on the policy statements & type of final product needed by member countries, partners and stakeholders (e.g. policy guidelines, policy briefs, advocacy materials, implementation guide) were met on the day three. Main events included the following:

- Guideline Group Session to discuss & reach consensus on the Recommended³ Policy Guidelines on Health Workers Access to HIV/TB Services (based on reviewed evidence and results of group work)
- Other participants (Stakeholders, partners, WHO staff) -continued to discuss on operationalizing strategy/Implementation plan
- Presentation by the guideline group on agreed policy recommendations and suggestions to WHO & ILO on the Way Forward & Next Steps
- CLOSING REMARKS by the Directors of HIV/AIDS (WHO and ILO)

2. Opening remarks

2.1. Dr. Teguest Guerma - Director HTM/HIV, WHO (read on her behalf by Dr. Jos Perriens, Coordinator, Systems Strengthening, HIV Dept.)

The opening remarks read on behalf of The Interim Director HIV/AIDS World Health Organization emphasized that the expected outcome of this meeting is recommendations on policy options that will reinforce accelerated implementation of best practices to ensure health workers access to prevention, diagnosis, treatment, care and support services, based on the evidence that will be presented and discussed.

Further, the Director's speech highlighted some of the issues based on findings from the conducted studies that have stimulated the initiative towards TREAT policy guidelines. Specific examples were cited from the reports of two studies namely that were commissioned by HIV Department, including a situational analysis covering five SSA countries with high HIV

³ The guideline group will advise WHO and partners on policy options regarding health care worker access to HIV and TB services.

prevalence, as well as the country survey that covered 17 countries representing all WHO regions. As stated, both studies show many gaps and inconsistencies in the implementation of policies and guidelines to protect HCWs and provide them with services for HIV/AIDS and TB. It was re-emphasized that HCW access to such services is crucial in consideration of their role in bringing services close to the people in need towards universal access goal, and also in line with PHC renewal.

"Building on existing guidelines such as, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection; Joint ILO/WHO Guidelines on Health Services and HIV and WHO policy on TB infection control in health-care facilities, congregate settings and households; the recommended policy on Health worker TREAT will reinforce accelerated implementation of best occupational and non-occupational health practices for health workers with or with risk to be exposed to HIV/AIDS and TB".

Furthermore, the Director's speech underscored the necessity to take into consideration the endorsement by the World Health Assembly of the Global Plan of Action on Workers' Health calling on all member countries to develop national programmes for the occupational health of health care workers; as well as the existence of internationally agreed conventions, guidelines and codes of practice on occupational health in the health sector which are nevertheless insufficiently implemented.

2.2 Dr. Sophia Kisting Director ILO

Dr. Sophia Kisting Director ILO The ILO Director for HIV/AIDS also stressed the need to tackle the issues around discrimination and stigma that prevent health workers from accessing care, as well as the need to ensure that care is given within the workplace. It was noted that ILO is currently working on an international labour standard for HIV/AIDS and TB with input from front-line workers. The HIV Director of ILO complemented the initiative saying, " I am very excited to be here and to be part of this, it is the first time, being in a meeting where health workers are talking not only about access to services for others but access to service for themselves, many time this is forgotten, that HCW need to be given priority for accessing services so that they are well and available to provide services to the people in need". She concluded by reassuring the participants that ILO will continue to work jointly with WHO and other partners in support TREAT policy initiative, reiterating the need to involve all key stakeholders at all levels.

2.3 Meeting objectives, Rationale for TREAT Policy & Overview of the Development Process Dr. E. Petit-Mshana HSS/HIV

Giving the background on TREAT initiative and process involved the presenter highlighted on key challenges including high demands from diseases of major public health concern on Health Systems which is enormous especially due to HIV/AIDS, TB, Malaria and other important diseases and related health problems. Meanwhile, as pointed out, there are not enough Human Resources for Health (HRH) to deliver basic health services whereby as reported in the WHR 2006 (<http://www.who.int>)

- Critical HRH shortage affects 57 countries worldwide, of which 36 in Sub-Saharan African
- 4 million Health Care Workers are needed to fill gap
- Sub-Saharan Africa (SSA) faces greatest challenge: 11% of world population; 24% Global burden of disease; only 3% world's health workers and 1% health expenditure
- Countries far from reaching UA goal by 2010 e.g. ART coverage only 31% at end of 2007.
- Most SSA and other Low Income countries (LIC) not on track in MDG 4,5 & 6

It was re-emphasized that Universal Access (UA) and Millennium Development Goals (MDGs) commitments need to be matched with HRH development and new health systems capacity. Moreover, it was noted that TTR initiative is timely, especially in response to Primary Health Care renewal, especially in support of its reforms on universal coverage to improve health equity and services delivery which focuses on people-centred health systems.

Who is the TREAT policy for?

It was explained that there is wide range of beneficiaries and stakeholders for the envisaged policy guidelines on health worker access to HIV and TB services including:

- Health care providers, especially those living with or exposed to HIV & TB are the main beneficiaries
- Decision makers in countries e.g. those responsible for legislation, planning, and allocating resources
- Programme managers, infection control focal points, hospital administrators, heads of health facilities and the various health professional bodies (unions, councils and associations).
- Community and family care providers

- Educators and trainers of health workers
- Civil societies, as well as partners in health and HIV/AIDS

In concluding the presenter emphasized the critical need to have in place policy implementation strategies and programmes integrated with and supported by existing national HRH plans and financing mechanisms such as MTEF, SWAp etc.

Objective-1: To share information on what exists, the issues and challenges in countries on HCW access to HIV & TB services.

3. Country experiences and best practices

3.1 Experience of the Americas to promote and protect the health of health workers: Marie Claude Lavoie -WHO Regional Adviser Occupational Health -AMRO/PAHO

Advances in the Americas relate to policy, collaboration and activities.

The Regional Polities on Occupational Health and Safety Goal 14 states: 80% of the countries of the Region will have in place a policy of health and safety for the health workers, including the support of programs to reduce work-related diseases and injuries.

Workers health requires collaboration among Governmental, international and Non-governmental organizations as well as WHO/PAHO Collaborating Centers and centers of excellence in Occupational Health.

Activities related to promoting and protecting the health and safety of health-care workers include training, vaccination of HCWs, surveillance systems and an online course for HCWs.

Specific examples were reported from Venezuela, (prevention of occupational transmission of infectious diseases), Peru (Immunization for Hepatitis B immunization and training on prevention of needle stick injuries), 2009 Immunization week in the Americas, beginning with health-care workers and a program in Trinidad and Tobago, that produced a number of tools.

3.2 Health Care Worker Wellness Centers AFRO/Swaziland, Mrs Khosi Mthethwa

Following a needs assessment survey Wellness Centers were created to bring added value to HCW- access to health services as a basic right, also reducing migration and loss of the work force, 50% of which (4,000) consists of nurses in a country where 50% of women aged 25-49 are infected with HIV.

Principles and core values of the centres include; high standard of quality care; gender equality; confidentiality and advocacy; rights based approach, professional code of conduct, and accessibility as well as availability of services

The latter consist of primary health services FP,ANC, treatment of minor ailments, BP check ups , mobile outreach, HIV counseling, psychotherapy, testing and management. A wellness centre is a fully accredited HIV and TB centre. There are other activities such as training, and a vegetable garden to support nutritional needs for clients. Pre - service health workers like the student nurses are eligible for inclusion in the programme.

The centre is overseen by a Board, which includes a resource mobilization committee. Sources of funding are the MoH, ICN, Danish Nurses Association, Stephen Lewis Foundation, Global Fund and BD. Technical and some financial support are received from WHO. However resources including human resource to respond to the demand created are limited.

3.3 Experiences from West Africa (Dr Juma Kariburyo), Côte d'Ivoire

Since 2002, Côte d'Ivoire has known a socio-political crisis, however a peace accord was reached in March 2007 and presidential elections are expected in November 2009, with the hope of transition from an emergency to a developmental phase. Côte d'Ivoire is the West African country most affected by HIV/AIDS with a prevalence of 4.7% in the general population.

The main components of the Treat, Train and Retain initiative include Policy, legislation and services for better safety and wellbeing of HRH, prevention of HIV in care settings, access to counseling and testing for HRH, management of TB infection in health care settings and access to care and support for health care workers who know to be sero-positive.

Among various policies is a draft National safety policy for patients within health care settings (pending approval)

With relation to (free) access to HIV/AIDS and TB services for health workers, the following constraints exist: insufficient qualified human resources equipment and management capacity, loss of institutional memory due to high mobility of qualified staff, insufficient number of trainers in the region, work overload due to integration of HIV management in district health care. The policy / guideline process is further incomplete; various documents exist, however, they still require dissemination to peripheral levels and a training plan. The majority of documents exist moreover in English, their French versions being delayed.

Laws and policies exist, but are not sufficiently implemented; services also exist (free ARV, and other services), but they are not sufficiently used by health workers There are insufficient incinerators and safe needle disposal boxes in health facilities, especially in the zones most severely affected during the recent socio-political crisis, which shows the impact on war on health personnel and infrastructure.

3.4 Experiences from South Africa Dr Shahieda Adams.

TB and HIV/AIDS incidence and prevalence are extremely high in South Africa, which also has the highest number of confirmed MDR and XDR cases in region. This is specified and confirmed by a number of studies.

Various relevant legislations and policies exist, while there are also different models of service provision, including work place based services such as staff clinics. The private sector plays a significant role, offering and researching models of service delivery.

There are further National schedules for training and dissemination of information, documents and guidelines. Awareness of the new guidelines is adequate; however, their dissemination and implementation are inadequate.

There remain, in addition, substantial barriers to full implementation of effective measures due to overburdened clinic staff, high staff turnover and continued stigma around TB and particularly drug resistant TB. Health workers have poor knowledge of legislation and rights with uneven access to care and OH services; there are concerns about confidentiality and they cause delays in seeking treatment, especially for ARV.

There is no simplified well-disseminated national strategy for Government and employers to provide care for HWs; there is fragmentation of legislation and responsibilities shared between departments; a lack of preventive focus, lack of enforcement, with delays in compensation.

3.5 Perspectives of participants living with HIV

Presented by Dr. Alice Welbourn, Dr. Lydia Mungherera and Dr. Raoul Fransen-Dos-Santos.

The presentation told of:

- Shattered dreams of a nurse in Latin America,
- A cohort of 22 doctors who died in Uganda, 11 due to AIDS and 5 due to suicide because of a know or suspected HIV diagnosis (Uebel at all, 2007)
- Low PEP uptake of female health workers in Kenya, “since they were at risk every night in their marriage beds”
- Scare of stigma by a HIV positive psychiatric nurse in UK since fellow health workers had made negative comment and shown worries about tending to an HIV positive patient
- Human rights violations in health care settings; experiences of HIV positive women in Namibia

The meeting was reminded by the presenters, about the existence of individual health workers who are open about their HIV status, acting as “Champions” fighting for the rights of those in similar circumstances. The presentation highlighted work on a Model AIDS law, support for HIV positive priests from the church, through the Strategies for Hope Trust (UK), and initiatives by UNICEF, UNAIDS, WB and African Ministries of Education related to supporting HIV positive teachers. If priests and teachers can be targeted why not health workers?

WHO was reminded of:

- Human Rights Framework: Win-Win
- Do no harm
- Precautionary principle [le – cf environmental health
- Efficacy AND effectiveness-level 4 trials
- Identify champions
- Identify other champions who are still working in front-line health care – interview *their* “friends” to see what they think
- Make a movie about them, show in Vienna

- Showcase wellness center also
- Enlist support from your champions to identify other win-win situations

Useful links regarding champions were provided by the presenters including:

Maura Mea www.strathope.org/d-audio-maura.htm

Lydia Mugerera www.strathope.org/d-lydia.htm

Raoul Franssen <http://www.ijasociety.org/content/12/1/4>

Canon Gideon www.strathope.org

3.6 International Survey on policy practices on HCWs access to HIV/TB services. .

Presented by Eileen J Petit-Mshana HRH HIV/SSH

A questionnaire survey in 17 countries from all WHO Regions revealed that many key policy and legislation documents exist. However, they were inconsistent, not comprehensively detailing HWs health and safety and occupational HIV and TB infections in health care settings. Gaps exist particularly in relation to policies addressing TB in the work place, TB in health care settings, health and safety with relation to HIV / AIDS at the workplace and health care settings as well as measures to protect HWs from TB & Hepatitis B & C. Countries address the gaps by developing new or revising existing policies; many of these documents from 2008 and 2009 exist only as drafts. However, some policies for instance those on compensation were difficult to apply. Policy documents were further not widely disseminated and there were no properly scheduled training plans. HWs, especially in the public sector did not know their rights.

Enforcement leaves a lot to be desired; many programs, action plans and guidelines did not include all important areas for intervention such as provision of protection against discrimination or provision of general health care for family members of health workers.

The most accessible method for HIV testing and access to ART was routine services in own facility, however only 50% offered special staff services in the facility. Health workers and

families had access to TB treatment like the rest of the population. Other interesting findings⁴ from the survey are cited below:

- Provision for occupational safety and health for HWs 11/16 (69 % of countries that responded)
- Provision for HW priority access to HIV/TB services 10/16 (56 %)
- Provision for protection of HW against discrimination at work place 9/16(56%)
- Action plan has provision of general medical care to HWs/family 10/16 (63%)
- MOH has set improving HW access to HIV/TB services as high national priority 7/12 (58 %)

Moreover, private sector involvement existed in the majority of countries, but no country could quote a study on cost to the private sector employer related to provision of HIV / TB services to health workers.

It was recommended that:

- The policy formulation process needs technical support and that -checklists, guidelines and mechanisms for implementation of policies should be developed
- Advocacy for translation of policies into services and programs is essential
- There is a need for integrated policy and action plans; policies must be streamlined and more comprehensive
- More studies are needed on the costs of providing HIV services to HCWs, while -HCWs must play a central role in planning and implementing programs and services. -disease surveillance among HCWs is essential
- Policies, codes of practice and guidelines concerning stigma and fear of discrimination must be available at the facility level and monitored
- Policy and legislation enforcement requires management, monitoring, supervision and evaluation
- Compensation requires close collaboration of labour offices and wide dissemination of information is necessary so workers are aware of rights, entitlements and procedures

⁴Although total no. of countries involved in the survey is 17, we give denominator and percentage of only those which responded to that particular question.

4. Discussion of Objective 1: Experiences from selected countries and country survey

Following the presentations on country experiences participants responded by questions and discussions, raising the following issues:

- Comprehensive services which deal with all components are not available in any one country.
- The issue was discussed whether the ultimate goal having guidelines, or an advocacy document? It was concluded that it is to ensure that there is guidance available for countries to facilitate access for all health workers to HIV prevention, treatment and care services, and to convey the message to employers that health workers are entitled to health services.
- On the issue of compensation, countries vary in what they provide and lack of clarity is a challenge. Wage protection is to be preferred to a monetary lump sum.
- The international survey considered all types of policies. The main problem is what actually happens with the policy. Policies exist but there is disconnect between policy and implementation. It is often not known or understood. Among private practitioners there is also a mismatch between what they know and what they do.
- It was recognized that issues of partnership are key to implementation to ensure sustainability of initiatives.
- Workplace programs should also be used to address HIV and TB transmission outside of the workplace
- Since little data exist regarding the burden of HIV as a workplace issue, it was recommended that we must make sure that we can make an evidence based case for why this issue is worthy of attention.
- In connection to enforcement of policies, questions to be addressed include:
 - How to put emphasis on HIV positive peer CHAMPIONS.
 - How can improved enforcement of existing policy and legislation be advocated for
 - Need to be specific about responsibility for M&E (Health workers? Departments of labour?) → health and safety committees can take on this role since government enforcement is difficult to change
 - How will the policy address lay health workers?
 - Community workers are vital to provision of services, but are not necessarily captured by formal guidelines. We need to define what “health worker” is It is one of the issues that should be explicitly addressed in the document, also, how would compensation be addressed for community health workers?
 - Reaching out to unpaid workers
 - Training essential for health workers
 - Integration of Occupation Health with IPC using existing PHC structures

- Specific “wellness centre” approach; may be decentralised or use outreach for staff and their families
- Structures and policies may exist but their operationalisation may be challenging
- Government input for development and implementation of programmes is essential

Specific Questions and responses (Q and R) following presentation on PAHO experiences

Q: How can PAHO/WHO ensure HCWs have access to properly certified and high quality respirators, particularly in developing countries? How can PAHO/WHO ensure health facilities are constructed according to policies?

R: There are number of respirators on the market which meet certain specifications, which are currently being examined. Procurement is going to be a key issue – therefore organizations such as UNITAID will play a key role as strategic partners.

Q: How can PAHO/WHO ensure health facilities centers are designed according to policies already in place?

R: WHO will have to establish several generic guidelines for hospitals which have been started in collaboration with Russia, Harvard, and CDC.

Questions and responses (Q and R) following Country survey presentation

Q: How were the particular countries selected? They seem to be mostly all low prevalence countries?

R: Guidelines should be applicable to both high and low income areas and varying regions of prevalence

Earlier study by Liz Corbett focused on high prevalent countries in Eastern and Southern Africa .

Other countries from AFRO were selected at the second stage of the survey to serve as a comparison and to provide a larger picture of what is happening across the large and diverse continent of Africa

Q: Was gender dimension considered?

R: Research was restricted to the data available; however this is an important issue to be discussed during the group work.

Objective 2: To explain the existing policies, guidelines and resources available to assist countries implement work place health and safety programmes

5. An overview of existing policy guidelines

5.1 Joint WHO/ILO guidelines on post-exposure prophylaxis -is (PEP) to prevent HIV infection. Dr. Micheline Diepart WHO/HIV/ATC

The joint WHO/ILO project was initiated in 2005 and followed the normal process including systematic review and a consensus meeting.

Scientific evidence of PEP efficacy is and will remain limited; there was no and there will not be randomized trial for logistic and ethical issues, however, a retrospective study with a single ARV (AZT) showed 87% averted infections. The policy affirms that PEP is (secondary) prevention, while primary prevention of exposure is a standard of care in all health settings and further deals with:

Legal and human rights issues: Non-discrimination, Confidentiality, Informed consent, A basic right for HCWs?, Free access?, Compensation rights?

Integration of PEP into HIV/AIDS policies and services;

PEP availability and eligibility; Where, Who, How? Eligibility criteria include “a recognised risk of exposure”

Counseling and risk evaluation are critical; while testing strongly is recommended for both source and exposed persons.

Policy implementation requirements include national guidelines and policies, operational guidelines, PEP specific services, Capacity for HIV testing and counseling, Service delivery sites, Procurement, Training, Monitoring and evaluation

In the report from the UA indicator: In 2008, 107 of 110 reporting low- and middle-income countries declared having a national policy or protocol to provide post-exposure prophylaxis versus 69 of 73 reporting low- and middle-income countries in 2007. In 2008, 44 countries reported an increase in number of health facilities with post-exposure prophylaxis available from 3516 in 2007 to 4150 in 2008. The availability of post-exposure prophylaxis services is higher at the tertiary levels of the health care system.

HCWs access to PEP; Of 349 HCWs who reported injuries, 43 (12%) HCWs accessed PEP; Of 829 HCWs, 19.4% (161) indicated that they would not access PEP if exposed policy implementation: Perceived barriers to accessing PEP, Unavailability of PEP in most health settings – long distance, Lack of knowledge about PEP, Testing as a pre requisite to accessing PEP, Lack of test kits, Lack of confidentiality leading to fear of stigma, Lack of compensation after exposure

Ways forward policy implementation: Statement 11; "Ensure universal availability of PEP services at health facilities with appropriate training of counselors and information on the risks and benefits provided to all staff" Ensuring primary prevention, Monitoring and evaluation of Health Care workers safety conditions

5.2 Joint ILO/WHO Guidelines on Health Services and HIV Dr. Sophia Kisting ILO

Joint ILO/WHO Guidelines on health workers and HIV/AIDS were developed following an Experts Meeting in April 2005 within the framework of the 2001 United Nations Declaration of Commitment on HIV/AIDS. The guidelines reflect the principles of the ILO Code of Practice which apply to all aspects of work and all workplaces including the health sector and have seven sections:

Legal & Policy Framework refers to national laws & policies which provide the framework for action, specifying the roles of various actors

The Health Sector as a Workplace section emphasizes recognition of HIV/AIDS as a workplace issue with need for a workplace policy, the protection against stigma and discrimination, confidentiality, gender equality and social dialogue

Occupational Safety & Health covers the need for employers to address prevention, hazard identification, risk assessment & control and information & training.

Exposure Incident Management, whereby exposure prevention is the primary strategy for reducing occupationally acquired infections.

Care, treatment and support to healthcare workers infected and affected by HIV/AIDS reducing the loss of essential skills and experience and minimizing disruption in the provision of care, respecting the rights of workers to remain in employment.

Knowledge, education and training, including the capacity to generate process and disseminate knowledge regarding effective OSH strategies;

Research and development in the interest of governments, employers and workers;

However, since the guidelines were developed, the context has changed and is still changing, for instance resource availability for HIV/AIDS programmes increased and more PLHIV are currently on treatment (approximately 4.0 million) with further up-scaling required in a time of financial and economic crisis. There is need for stronger collaboration between HIV/AIDS and TB programs, Health System Strengthening (HSS) and increased involvement of the private sector in view of shortage of health workers in many low and middle income countries. Advances were further made around Pre-exposure prophylaxis while the need is recognized to enhance the implementation of various guidelines including the Joint ILO/WHO Guidelines.

5.3 Global Plan of Action on Workers Health/framework for national policy and programmes for health worker occupational health Susan Wilburn (PHE/OH)

Following the WHO Global Strategy on Occupational Health for All (1996), the Global Plan of Action on Workers' Health, 2008-2017 was endorsed by the 2007 WHA " to provide leadership for activities related to workers' health, to formulate and implement policies and action plans, and to stimulate inter-sectoral collaboration".

Partnerships for implementation includes ILO, ICOH (and other professional organizations), Unions, Employers, and a network of 70 Collaborating Centres on Occupational Health.

Improving the health of all workers is the goal, with focus on primary prevention, taking into account that 25% of the Global Burden of Disease is due to occupational and environmental risk factors. Specific objectives are to develop and implement policy instruments for workers health, to protect and promote health at the workplace, to improve the performance of and access to

occupational health services, to provide and communicate evidence for action and practice and to address workers health through other (non-health) policies.

Health care workers are workers constituting a group of 59 million; including direct care providers to medical waste handlers. Healthcare Workers Occupational Hazards include among other, biological hazards, e.g. influenza A H1N1 (swine), H5N1 (avian), SARS, TB, HIV, Hepatitis) and stress / violence (staffing shortages, shift rotation)

Three million occupational exposures in healthcare workers to blood-borne pathogens are occurring per year, among those, 37% of Hepatitis B, 39% of Hepatitis C and 4.4% of HIV are due to needle stick injuries

Although only 1,000 HCW deaths per year occur from occupational HIV, all can and should be prevented, also because fear and stigma affects care and migration PAHO (07), AFRO (WHR06); working conditions/risk being a top 10 push factor.

Occupational Health Hierarchy of Controls in order from most to least effective (applied to biological hazards); (1) Immunize health-care workers, (2) elimination or substitution of sharp (eliminate unnecessary injections, jet injectors, needleless IV systems, blunt suture needles), (3) engineering controls (ventilation, safer needle devices, sharps containers),(4) administrative controls (policies and training programmes – segregate and isolate patients with respiratory transmission risk, eg. TB), (5) Work Practice Controls (Universal Precautions, no recapping, provision & placement & removal of sharps containers), (6) Personal Protective Equipment (gloves, masks/respirators, gowns, etc)
www.who.int/hiv/pub/prev_care/healthservices/en/index.html

A new initiative is the Partnership between WHO (HIV/AIDS, TB and OH), ILO AIDS, UNAIDS, and the World Economic Forum to establish working group on implementing TB and HIV treatment and control measures in the workplace. It recognizes the vulnerability of persons with AIDS to become infected and die from Tuberculosis – especially MDR and XDR TB, addressing gap in TB infection control in health-care and other workplace settings and understands the opportunity to achieve synergies in prevention and treatment programs and the fact that health workers on the ground must integrate the management of all health issues for the sustainability of health systems. The goal is to use the workplace as site for health interventions for prevention, treatment and care. A tool kit for TB/HIV in the workplace is in development, while revision of WHO/ILO Guidelines for Workplace TB Control Activities is being considered.

5.4 The "WHO policy on TB infection control in health-care facilities, congregate settings⁵ and households" Dr. Paul Nunn STB/HTM, WHO

A policy on TB infection control is required to guide countries on what to do and to provide an evidence base for the recommendations. Evidence based on Systematic review found Higher incidence of TB in staff in HCFs and congregate settings; that a combination of controls does work, and that administrative controls should be given priority.

Managerial activities at national and sub-national level are part of the managerial framework for the implementation of TB IC in health care facilities, congregate settings and households, facilitating funding proposal development, enhancing visibility and others.

Administrative controls at health facility level consist of strategies to promptly identify potentially infectious cases (triage), separating them, controlling the spread of pathogens (cough etiquette) and minimizing time in health care settings by prioritizing care, rapid laboratory time around time, ambulatory treatment and use of community treatment models.

Environmental controls & personal protective equipment include effective ventilation. Simple natural ventilation may be optimized by maximizing the size of the opening of windows and locating them on opposing walls. Well-designed, maintained mechanical ventilation systems can help to obtain adequate dilution when natural ventilation alone is insufficient. Use of particulate respirators is recommended for health workers when caring for patients or suspects with infectious TB; In particular, health workers should use respirators during high-risk aerosol-generating procedures associated with high risk of TB transmission (e.g. bronchoscopy, intubation, sputum induction procedures, aspiration of respiratory secretions, and autopsy or lung surgery with high-speed devices) and when providing care to infectious MDR-TB and XDR-TB patients or people suspected of having infectious MDR-TB and XDR-TB.

Protection of HCWS: Encourage TB diagnostic investigation when signs and symptoms suggestive of TB occur or when exposed to smear-positive and culture-positive TB patients. Encourage HIV testing; If HIV-positive, make available a package of care, including IPT, ART, if needed, job relocation, and screen for TB. It was further recommended that policy makers at country level should make the crucial decisions to restrict development of drug resistance to prevent the spread of MDR and XDR will, especially among PLH.

⁵ E.g. Prisons, jails, military barracks, homeless shelters, refugee camps, dormitories and nursing homes.

In conclusion, evidence is one of the elements on which a recommendation is based. Cost, programmatic issues and facility TB IC assessments are equally, if not more crucial to determine the choice of controls and the best combination to be implemented.

6. Summary of discussions related to Objective 2; existing guidelines

The PEP: presentation focused on policy of PEP for HIV infection referenced specifically to statement #11 and to the WHO/ILO policy paper. Recommendations should outline strategies to improve health worker understanding of available prevention measures & reporting (e.g. PEP)

It was noted that less than 15% of people at work have access to occupational health services

There is further a continuing need to recognize the link between worker safety and patient safety

Also, infection control efforts should be better linked with occupational health efforts

-Comment on the required annual testing of HCWs in health care settings.

R: This has fallen out of favor because it does not prove to be cost effective (developed countries), but the question is coming out for high incidence areas – is it cost effective again?

It was noted that direct linkages between the presentations and the guidelines were only made with relation to one of the 12 specific statements (Statement # 11⁶ on PEP availability).

Comments from Paul Nunn's presentation on WHO policy for TB infection control:

-It was said strong parallels exist between Dr. Yassi and Dr. Nunn's presentations as both conducted systematic evidence reviews which found weak/moderate evidence but with strong recommendations to implement policy.

-Collaboration between current efforts and the newly developed TB document is important. This is especially pertinent given that issues surrounding TB has not been discussed to the extent of issues surrounding HIV/AIDS.

⁶ Statement 11 on PEP in the original draft now appears as statement 10 in the GG recommendations resulting from Sept. international consultations -refer table under section 8 of this report.

-Should be aware of the discrepancy between resource-based policy vs. evidence-based policy (Recommended policies do not always match to what is going on at country level)

Q. Should a new statement be added focused on implementation of TB infection control?

R: Most likely not, as it can be incorporated into other statements, but there is a need to look for synergies between HIV and TB in dealing with this issue.

Q: Management/achievement of isolation in homes within the community.

R: Focus on home care in high HIV prevalence settings (example provided of Scotland where over 50% of infections were from hospitals). Effort should go into management of the home with support from communities through advocacy and education.

-Safety of HCWs is collaborative effort that should include a synergy of HIV and TB efforts. Must also take into consider the safety of others not just “drivers”

Objective: 3 To provide inputs on the interpretation of the evidence regarding improving HCW access to HIV/TB services, balancing risks and benefits

7. Synthesis of Evidence in support of TREAT policy statements: Professor Annalee Yassi BCU

Consultant Professor Annalee Yassi of BCU reported on her work on synthesis of the various sources of evidence linking them to the draft TREAT policy statements.

The World Health Report 2006 and various other sources point to the global health workforce crisis, showing the lowest level of expenditure on HR in the African Region, which together with South-East Asia region is among the two regions with the highest burden of disease.

It was put forward that there is a need to “Put your own oxygen mask on first, before you help another passenger”. Health care workers need to be empowered by their employers to consider their own health and safety as paramount to the safety of the organization as this will result in better health and safety for workers and their patients alike.

Extensive evidence was listed in the background showing that HCWs are at higher risk for HIV & TB, while HIV+ HCWs are at exceptionally high risk because of occupational exposures.

The consultant further reviewed evidence collected through various studies during the Guideline Development Process-to-date including the

Report by Liz Corbett: “Health worker access to HIV/TB prevention, treatment and care services in Africa: situational analysis and mapping of routine and current best practices” and the Survey commissioned by the Steering Committee: “Health Workers Access to HIV and TB prevention, treatment, care and support services: A survey of 17 countries gathering evidence on policies, practices and legislation in to identify gaps in policy and barriers to implementing related policies related to improving HCWs access to HIV and TB services.

The basic Liz Corbett study concluded that

- Gaps exist in current national policies
- Even when good policies exist, they do not always percolate to facility level due to lack of information or resources or absent allocation of responsibility
- While progress has been made to provide access to HIV and TB testing, considerable strengthening of sexual and occupational HIV prevention, TB infection control, and prevention of RB in HIV positive workers is needed
- Staff have generally good access to ART, mostly at own facility, however, it lacked confidentiality or priority and was less accessible for family members. Staff also value cheapness and convenience
- Stigma issues are greater for testing than for access to ART
- There exists considerable interest in self-testing
- Post exposure prophylaxis (PEP) is far from available and is not well understood
- TB infection control is well understood but poorly implemented. Regular testing is rare.
- The main protection offered to HIV+ HCWs against TB infection is assignment to low exposure duties; value of ART and IP is poorly understood
- Lack of key training and guidance; inadequate documentation; poor dissemination of information on available services, rights and entitlements

The survey of country Policy Practices involved WHO HIV country officers was reported on in section 3.6.

Further evidence, was presented linked to individual policy statements. The reader is referred to the consultant's report on Recommendations from the Guideline Group for Policy Recommendations on Improving Health worker Access to Prevention, Treatment and Care Services for HIV and TB, which form an integral part of this meeting report.

Comments and discussion arising from Dr. Yassi's presentation:

-Safety of HCWs is a key issue, however we must ensure that HCW not only are aware of their occupational hazards but are also offered training and education.

-Be more careful of the language used in discussion so there does not appear to be a shift in the focus of the consultation. Perhaps the term "workplace programs" should be used rather than occupational health, which will make clear that access for HCWs remains the key issue, regardless of how the disease is contracted.

-UNAIDS is coordinating a think-tank regarding the coordination of methodologies for evaluation of behavioral interventions. Ground is shifting on research methods as combination evaluations are replacing RCTs.

-safety of health workers is the issue. We recognize the magnitude of the problem of HIV/AIDS, but are we equipping health workers with the knowledge of how to manage the disease?? Education and training should possibly constitute its own statement.

-perhaps the term workplace programs should be used instead of occupational health to be clear that access for the health workers as a whole is the issue at hand REGARDLESS of the method of transmission

-UNAIDS is coordinating a think-tank around the coordination of methodologies for evaluation of behavioral interventions. Combination evaluations are being developed to replace traditional randomized control trials.

Objective: 4 To reach consensus on the policy statements & type of final product needed by member countries, partners and stakeholders (e.g. policy guidelines, policy briefs, advocacy materials, implementation guide)

8: Group discussions and suggestions for the recommended policy statements

Following the presentation on the synthesis of evidence, participants worked along the lines of the terms of reference (8.1). The result of this group work is shown in appended PowerPoint presentations and summarized in a table (section 8.2). General issues that were discussed that are not linked to specific statements are presented in section 8.3.

8.1 Terms of Reference for the Guideline Group discussion

Working groups Terms of Reference

1. The working groups will review the 12 statements and the synthesis of evidence related to each of the 12 statements
 - . Each working groups will review an assigned subset of the 12 statements.
 - The working groups will discuss and develop implementation strategies to support the 12 statements
 - .Review the assigned statements and synthesis report on evidence and determine
 - Are these important priority actions for WHO/ILO guidance?
 - If yes, consider these statements for the comprehensive synthesis of policy to improve health worker access to prevention, diagnosis, treatment, and care services for HIV and TB (Health Workers "Treat" Policy).
 - Are these statements already covered by existing policy of WHO and/or ILO? (Yes or No)
 - Consider the 4 presentations made in the opening session on the WHO/ILO joint PEP guidelines for HIV prevention, the ILO/WHO joint guidelines on health services and HIV/AIDS, the WHO policy on TB infection control in health-care facilities, congregate settings and households, and the WHO Global Plan of Action on Workers Health.
 - If YES, consider challenges to implementation (what have been the problems in implementing existing guidelines) and determine strategies to reinforce and operationalize the statements.
 - IF NO, review the evidence in the synthesis and evidence review and determine if the evidence is strong enough to support the adoption of WHO/ILO policy

2. After review of the statements and the evidence, develop a strategy for implementation of the policy statements at the national, regional and local (institutional) level.

8.2 Summary of decisions by the Guideline group per statement:

The recommendations from the group discussions are presented in the form of a table. The statements are listed in their original form as discussed. For the modified statements, the reader is referred to the “Recommendations from the Guideline Group” report. In this report, the statements have been presented in a different, more logical order.

In order to guide the reader, the following table will mention both the original number (O #) and the New Number (N #).

Statement	O #	N #	Key issues	Conclusions / Suggestions
1. Establish new, or strengthen existing, occupational health services for all health workers, providing a context within which the specific recommendations made concerning access to HIV and TB services can be realised.	1	3	No complementing implementation strategy to many existing occupational health guidelines	The group reached that consensus that the evidence for this statement is HIGH. Further evidence is unlikely to change our confidence in the estimate of effect Modify statement slightly
2. Introduce new, or refine existing, national policies that ensure priority access for health workers to services for the prevention, treatment and care of HIV and TB.	2	1	Access def; family members, gender, GIPA; Guideline must define access and provide guidance on the extent to which family members (infected and affected) are given services and benefits. There should be an explicitly stated provision in the guidelines, ensuring priority access of care, treatment and services for women HCWs the majority are women.	Add family members and gender dimension and support Partly addressed in PEP; need more to stress priority to HCW
3. Introduce new, or reinforce existing, policies that prevent discrimination against health workers with HIV or TB, and the adoption of interventions aimed at stigma reduction among colleagues and supervisors.	3	2	Difference between discrimination and stigma is that while discrimination is an action, stigma is a perception. However a clear concise definition must be written in guideline. Two separate issues were raised 1) at national level there should be policies in place to prevent stigma and discrimination and 2) enforcement of implementation of such programs in the workplace. Ignorance and lack of knowledge feeds into stigma, therefore question was raised if education /dissemination of information is enough	
4. Disseminate policies in the form of guidelines and codes of practice for application at the level of health facilities, and provide adequate budgets for the	4	7	Disseminate policies in the form of guidelines and codes of practices for application at the level of health facilities, and ensure provision of budgets for the training and material inputs to	

Statement	O #	N #	Key issues	Conclusions / Suggestions
training and material inputs required to make them operational.			make them operational Ensuring joint mission across sectors/diseases and social sectors	
5. Develop mechanisms for monitoring the availability of policy guidance at national level, its dissemination and application at facility level, and to the extent possible, its impact on the operation of health services and the health and productivity of health workers. These mechanisms should involve representatives of the health workforce, independent experts, public and private sector employers, and regulatory bodies.	5	14	Develop set of key indicators to monitor involving HCWs by both ILO and WHO (collaborative effort) A health and safety committee is vital to the successful uptake of a workplace HIV program. Improve reporting by explaining importance of monitoring and potential for benefits Who is responsible for M&E of HW's access to prevention and care services? Hard to identify from the evidence who is responsible, but it is recommended that a coordinator should be recruited with those responsibilities.	It is a priority but needs to be reworded.
6. Adopt good practices in occupational health and the management of HIV and TB in the workforce from private industry, including peer education programmes, staff welfare committees, and unambiguous policies on non-discrimination	6	8	-Evidence from access to care, treatment and services at grassroots levels by employers to HCWs needs to be documented and disseminated at all levels. -The centralization of good practices was suggested as a mechanism with adoption and adaptation.	The group decided that the evidence is MODERATE Suggestion: include NGOs, civil societies, and professional bodies with emphasis on primary health care at community levels
7. Establish and provide adequate financial resources for programmes to prevent, the occupational or non- occupational transmission of HIV and TB among health workers	7	9	Evidence limited but strong view for guidelines existence – referring to synthesis report where experiences in costing recommendations is limited	Suggestions for modification: Add family members Add Treatment care and support
8. Design and implement, in conjunction with health workers' representatives, of programmes for regular, free, voluntary, and confidential testing for HIV and TB, including intensified case finding in the families of health workers with TB.	8	5	Provide a list of essential supplies to ensure infection control in the workplace. Working from the bottom-up at all levels Health worker reps, unions, management, and all stakeholders should be involved There must be champions to advocate for	The group felt that evidence to support the adaptation of this policy HIGH. The statement on comprehensive services could be used to modify the

Statement	O #	N #	Key issues	Conclusions / Suggestions
			testing	statement.
9. Provide free access to ART and TB treatment for health workers in need, and facilitate the delivery of ARV drugs to health workers when their own facility is not an ART treatment centre.	9	11		Existing guidelines: e.g. PEP guidelines, TB IC guidelines Wording Suggestion: remove “access” and replace with: “Provide free HIV and TB treatment for HW in need, and facilitate the delivery of ARV drugs to HW when their own facility is not an ART treatment centre” “Access” is covered by other statement
10. “Ensure universal availability of a comprehensive package of prevention and care for all HIV positive HW, including IPT and CTX prophylaxis, with appropriate information on the benefits and risks provided to all HW offered this protection”	10	12	No IPT policy and implementation in many countries, but where it does exist implementation is slow Availability of CTX and Isoniazid in many countries however knowledge of access is very limited.	Guidelines exist on continuum of prevention and care, 3Is for TB for HIV infected people, joint ILO/WHO guidelines on Health services and HIV) Evidence of benefits of CPT and IPT is included in TB guidelines
11. The universal availability of PEP at health facilities, with appropriate training of counselors and information on the benefits and risks provided to all staff.	11	10		

Statement	O #	N #	Key issues	Conclusions / Suggestions
12. Establish schemes for compensation, including as appropriate paid leave, early retirement benefits and death benefits in the event of occupationally acquired disease.	12	13	Need to define compensation, what is the package to be offered to HCWs? Take example from cases of industrial workplace compensation packages which offer replacement to of loss of income due to a workplace related accident. There is also a consideration for compensation for acquiring a “fear” provoking disease and the emotional, psychological stress which results. -Principle of providing compensation is a value based right, raising the morale of the health care worker	
“Integrate HW access to HIV and TB services policy into a more comprehensive HW occupational health policy that is linked to the infection control policy. Policy development and implementation should be conducted with a strong coordination between the different departments of the MoH”	N E W	4		
Develop and implement training programs for pre-service and in-service and continuing education concerning access to TB and HIV prevention, treatment and care services.	N E W	6		

8.3 Plenary discussion on results of all group work

A lot of points were raised around the issue of stigma. Distinguishing between stigma and discrimination was thought helpful: discrimination is more easily addressed by a formal guideline whereas stigma is much more complex; gross under-reporting is an issue; stigma can increase even when there is a high level of information. Internal stigmatization is also a big issue that should be addressed.

This may ultimately be what prevents people from seeking services. UNAIDS and the positive networks have developed the stigma index to examine trends associated with stigma. There is a paucity of literature that focuses on positive attitudes and support as opposed to the negative aspects.

We also need additional studies on stigmatization within the health workers specifically. Other forms of stigma should also be considered in the proposed guidelines: stigma against gay health workers, female health workers in some cultures, foreign health workers. Sexual reproductive health issues are further all relevant to ALL health workers regardless of whether they are positive or if they are positive, how they acquired HIV is irrelevant. Concrete action plans about what we can actually do to combat stigma are not clear, perhaps a guideline is not the place to do this: it could be accompanied by steps/action plans to actively combat stigma in the workplace. Openly positive advocates (champions) are necessary to lead the way.

Compensation was also extensively discussed. Even with a no-fault compensation scheme, there is often a payment gap. There is an ongoing debate in many regions as to who is responsible for paying for initial treatment in the event of an occupational acquisition of HIV. South Africa for example, has not approved their policy in this regard although it was drafted over five years ago. Workers compensation has essentially been compensation for lack of income, while it should recognize both loss of income and payment for distress that is involved in an occupationally acquired illness. Wage loss, impairments and medical aid are all components of compensation, however, this will not be included in the statements themselves, but in a component toolkit or companion guide. Many health workers do further not know their rights in regards to occupational health. Most issues of compensation are governed by labour laws and therefore the ministry of labour, however, compensation is going beyond the access level and therefore must include all key players. There needs for instance to be closer coordination between WHO and ILO in regards to compensation policies

Access is ultimately what pushed the TREAT initiative in the beginning. It is important to define the word ACCESS. What exactly is meant by access? Based on the findings, it is evident that people are still NOT going to services or do not have them available. This is why we need to

keep the word ACCESS in the document. We need make sure that we make a good case with good evidence and a good position as to WHY healthcare workers should be a priority for access to HIV/TB treatment and care services. "Access (for HW)+ access (for all) = access"; There needs to be more studies supported that assess WHY health workers are not accessing treatment. Access can be achieved through outreach by trade unions and professional associations delivering education and training regarding health worker occupational health rights.

We must keep in mind that the focus of this consultation is on the TREAT component. Many of the important issues brought up over the past few days are already included in all/most formal occupational health policies / legislations / procedures and should therefore not be dwelled upon. On the other hand, rights to a safe workplace and environment should not be excluded even though they are addressed elsewhere. We must address the fact that health workers on the whole remain unprotected. Trainees have been forgotten in much of the literature and studies to date and also deserve attention.

Emphasis on prevention was rated important; a group member made the motion to insert a statement or phrase at the beginning of the document to highlight prevention strategies, another participant supported the statement above as a pre-amble.

Implementation was also a topic of discussion. Some felt health and safety committees should be further addressed in the detail as effective mechanisms. It was further suggested that implementation of the product will be up to groups and governments at the country level supported by WHO headquarters and regional offices. We should recommend something that will make it through the WHO processes which can then be adapted at the country level. Language in recommendations should be translated into national legislation. There will be national adaptation of whatever we produce here. Trade unions, associations etc are further responsible for incorporating these policies into their mandates.

Involvement and linkages were also mentioned. For instance, it was suggested that the new Positive Practice Environment (PPE) campaign in which WHO and ILO have been very supportive should be integrated with these efforts. The ministries of labour must be consulted; front line health workers and openly positive individuals must be more involved; this process must also involve community partners.

The format of the document to be produced was also discussed. It was suggested that we collapse guidelines to make them more usable with sub-headings and statements to support them in more detail below. There was a motion by one participant to have, concise main statements followed by detail elsewhere

The question was raised whether these are minimum standards or are we recommending everything that SHOULD be done, or can we produce something that is in between and considers best practices but also resource availability.

It was also suggested that we should not agonize over the precise wording of the text of statements since these will eventually be expanded upon. However, -the preamble and the opening of the document is important to set the tone and introduce priorities.

The issue of the GRC requirements raised concern. The handbook for guidelines development was considered NOT at all applicable to the majority of the key issues at hand. How can this be addressed? How do we find a way to make quality recommendations even if they do not meet the criteria of WHO guidelines committees, grading, etc? One participant suggested re-forming the product to steer away from these barriers

OVERALL CONSENSUS:

- The group supports the content and general phrasing of the 12 overall statements
- The group supports the 2-3 suggested additional statements.

9: Final group sessions to reach consensus on TREAT policy and implementation strategy

During the final session participants were divided into two groups; group-1 consisted purely of Guideline Group members discussing and reaching on the final policy recommendations; the second group, consisting of all other participants (stakeholders, partners and WHO staff) discussed the implementation strategy and way forward. The results were as follows.

9.1 TORs for the Guideline Group

To discuss & reach consensus on the Recommended policy guidelines on HCW access to prevention, diagnosis, treatment & care services for HIV and TB

Based on presented evidence (synthesis report, survey report etc) plus recommendations from the group work & in line with given 4 objectives:

- Is there a need for such policy
- If not what type of product do you propose? (policy briefs, advocacy materials, implementation guide or strategy etc).

- What should it address (statements to be carried forward –old & new ones)

Based on evidence that was presented grade each statement using the provided table (Annalee will present the table)

- Provide a summary of recommendations to WHO & ILO on how to move this agenda forward (in form of GG resolutions)

Based on whether we go for policy guidelines or other options advise on

- What to be done, when, where and by who?

9.2 General Results of Guideline Group discussions and agreements

There is consensus among members of the GG that there is a need for a policy guideline from WHO/ILO

There were several suggestions for the type of final product will come out of this consultation?

- i) Form two documents
 - The first is a policy document with executive summary, with reference to resources and websites from supporting documentation (directed towards MoH, policy makers, etc)
 - The second document should be brief, user friendly summary (can call an implementation guide), orientated towards simplicity, with checklists and practical wording (useful for implementation in the field)
- ii) No need to form two documents as an implementation guide can have strategy attached. Rather advocacy materials should be provided at ground level for aid in implementation.
- iii) Whether or not it is approved by GRC, creation of different layers of documents may be warranted. (inclusion of advocacy materials, handbooks, etc). For example; A document of Sexual reproductive Health formed one document which targeted 1. policy issues, 2, systems issues, 3. advocacy issues – hybrid flexible format with different partners backing different aspects of the document

A critical issue is implementation at the country level, especially retention of HCWs at the country level – implementation on ground level should be driven by training involving all different groups/civil societies

Consultation should be done with Swaziland Nurses Association and Lesotho Nurses Association who have already developed policy documents and have implemented similar services at the country level.

Question posed: The document the group is debating over whether it should be a WHO policy guideline, however much of the evidence may not pass GRC requirements. Therefore, what steps must be taken to move around this issue?

Some of the statements are normative statements which rely on common sense, value based, therefore these statements do not require high quality of evidence to provide strong recommendations. Focus on evidence for only those statements which are action oriented.

In the end, participants reached consensus, accepting statements as a policy guideline, not advocacy material hence next steps relate to the provision of advocacy materials at the ground level. Countries can take statements and create advocacy material or collaborate with existing strategies already in place to increase access for HCWs.

Suggestion, if we are to move forward as a WHO policy guideline:

- The guidelines must look like a WHO document.
- Once more the guidelines must lay out clearly policies and services for health workers at all levels of services. Options for the inclusion of families must be made.
- It must clearly put the access issues for management of the health worker to HIV and TB health care services as integrated services.
- Inclusion of the community and institutional health worker who is infected and those who are affected as a result of the diseases must be clearly stated .The Public, Private and Professional bodies (associations and councils, also training institutions) must be given clear guidance on their responsibilities in access and for ensuring surveillance of safety in the workplace as well as assuring that enforcement of safety practices are carried out.
- **Training** of employers and employees as part of the system of increasing access is essential and it should be an integral part of the treat policy guideline .
- **Training:** Collaboration with teams preparing the training materials is critical to this process as guidance of who should be trained and the numbers to be trained and monitoring of the trained personnel should be spearheaded from within the treat team with linkages to the curriculum and training development team as a systematic approach to increasing quality services.

Pending on the results of ongoing negotiations with GRC another option could be

- To publish under ILO – however, it was noted that as the policy is about HCWs ILO's logo might not carry the same weight compared to WHO logo (or both WHO and ILO logos).

9.3 Summary of final Guideline Group Consensus on TREAT policy reached on 16, September 2009

After extensive discussion among Guideline group members, consensus was reached as presented below by Mary Higgins (on behalf of GG members).

Final proposal/recommendation:

Move forward as a WHO policy guideline based on the work and evidence presented thus far. Submit work to GRC and based on the GRC approval/denial consider alternative options which are available

Steps to move forward:

- 1. Consensus in group that the 14 statements which came out of group presentations are the final statement**
- 2. Document will be in the form of the WHO, GRC endorsed, guideline (if this does not work then other levels of publication will be considered)**
- 3. Implementation must take into consideration bringing in groups not represented in this consultation at this stage of the process as a way of ensuring effective implementation).**
- 4. Given limited time to discuss evidence, discussion will be continued via email which will be followed by a teleconference.**

9.4 Stakeholders & Partners Session to discuss on Implementation strategy

9.4.1 Terms of Reference

Operationalising HCWs policies & guidelines

- Consider the issues & challenges related to implementation of policies & guidelines for HCW access to HIV/TB & other services as presented by the 4 groups:
 - Categorize these issues under main themes as per given table by Annalee (or you may agree on another format)
 - Summarise recommendation i.e. what need to be done to address these issues (consider recommendations by groups)
- Accelerating implementation of existing policies & guidelines
 - Required Actions, Roles & responsibilities (at global, regional & country level)
 - What to be done, by who, where and when.
 - Role of WHO & ILO

9.4.2 Proposal on implementation strategy from group work by partners and stakeholders

i) Issues and challenges related to policies and guidelines for health worker access to HIV and TB

- Advocacy, Adaptation, Dissemination
- Consultation on draft policy guidelines
- Advocacy and Adaptation on the use of the policy guideline
- Dissemination and Implementation
- Mobilization and Allocation of resources
- Monitoring and evaluation
- Modality/processes

ii) Consultations

By June 2010: HQ/Regional consultation

- Regional Level
- a regional advocacy meeting with WHO, ILO, ministries of health, finance and labour should occur
- Country Level
- with WHO, ILO, ministries of health, finance and labour should occur also with trade unions, professional associations, civil society and HWLWA/TB

iii) Advocacy and Adaptation

- By December 2010: National Advocacy
- With ministries of health, finance and labour should occur also with trade unions, professional associations, civil society and HWLWA/TB
- Development of an implementation plan at the country level
- focal point/leadership present existing guidance a realistic dissemination plan must be developed including training and orientation for health workers
- guidance on how to use and how to involve health care worker committees
- Utilization of existing mechanisms (e.g. CCMs)
- invite parties not previously involved (such as occupational health)

iv) Dissemination and Implementation

- virtual meetings and other innovative methods to prioritize funds for implementation (e.g. SharePoint, websites, etc)

v) Mobilization and Allocation of resources

- advocacy work with donors is necessary to make health workers a priority to establish the funds necessary for implementation
- country ownership: governments themselves must also commit funds to provide these necessary services
 - a. Assisting countries to integrate TREAT policy guidelines with HRH policies and strategic plans , linkages with existing national financial mechanisms (MTEF & LTEF, SWAp, etc).

- Other existing funding mechanism should be explored (Global Fund, PEPFAR...)

(e.g. a concrete proposal should be submitted to the Global Fund to ensure that health workers are a priority)

- Global Fund: the activities of these proposed guidelines could fit within HIV and TB opportunities, best if integrated

vi) Monitoring and Evaluation

- monitoring and evaluation group should be established within WHO/ILO specific to this initiative
- work plan needs to be linked to target with measurable results of successes
- Performance based implementation
- Link to UNAIDS PCB 9 priority outcomes
- Link to data gathering process of the national composite index on the UNGASS declaration

vii) Modality/processes

- “pouch” or political mobilization
- the political dimension is crucial (Issues of stigma, discrimination)

Consultation/Planning→ Implementation→ Evaluation

Joint WHO/ILO responsibility

- e.g. advocate through existing global and regional forums (WHA, RPM, ICASA, ILO int. conferences etc.)

9.5 Summary of Agreed Way Forward and Next steps:

Proposed way forward by the Guideline Group in the process of developing/finalization of HW TREAT policy guidelines

1. Revising/editing of the final 14 statements
2. General consensus among the group that there is strong recommendation for Benefits and Values and preferences
3. Strengthening of recommendation table for all statements (This should have been completed by members of the guideline group during the consultation, however since

this was not accomplished, there will be a need of tele-conference with all GG members after the revision of statement to reach final consensus on the contents.

4. Prepare tables on all statements which can be circulated to the GG for approval via distant communication, given limited amount of time remaining this will be supplemented by a teleconference to add to the transparency of the process.
5. The Guideline group members reached decision that the final product will be in the form WHO policy guideline approved by GRC and endorsed by both WHO and ILO. As suggested by the GG members, this is crucial, since lesser than policy guidelines might not be given the attention it deserves **(if this does not work then other levels of publication will be considered)**

Other considerations

- ILO comment: caution that meeting does not go off track – stick to what the primary goal was i.e. policy on HCWs access to HIV/TB services -building on TTR strategy.
- Regarding approval of this policy, it should be noted that GRC is not talking about quality of evidence, but the Protocol used not in -line with WHO/GRC requirements consider possibility to realign and correct the process and protocol
- The guideline Group while appreciating the process involved with GRC approval, requested that if possible TREAT policy guidelines be produced before end of 2009., especially bearing in mind that this has been waited for since 2006 when WHO, ILO and IOM jointly launched TTR strategy as a way of contributing to efforts towards universal access goal

<p>"We have been waiting for this since 2006, there is no time for debates any more we want TREAT policy out there being implemented ----" - by a +HW and member of GG</p>

10. Closing remarks at the end of the three day consultation

10.1 Dr. Sophia Kisting: Director for ILO/HIV AIDS Programme.

KEY AREAS NOTED / ADDRESSED DURING THE CLOSING

- -WHO and ILO will work to strengthen linkages to work for improving the health of health workers at all levels (national, regional, country)
- -group will overcome the process protocol to move the guideline forward in order to deliver the final product

- -we must continue working to overcome any procedural issues from standing in the way of these critically important issues
- -TB must not be forgotten
- -an implementation plan is essential
- -resources must be made available to address the health of health workers
- -emphasis on local ownership, where actors of the workplace own what should be done as part of the implementation process
- -ILO is committed at the highest level to this issue

10.2 Dr. Teguest Guerma: the Interim Director of HIV Department

KEY AREAS NOTED / ADDRESSED DURING THE CLOSING

- The total of 67 participants were formally invited
- The total of 51 participants attended.
- The 4 objectives were achieved successfully and all participants were satisfied with the outcome of the consultation process.
- Feedback provided by the group led to the Director responding with reassuring words on the following:
- The role of the HIV Department at the highest level in moving the agenda forward especially in relation to strengthening the dialogue with the Guidelines Review Committee. If it is decided to be another product other than a guideline advocacy from the highest level to produce what is required based on recommendations from the Guideline Group.
- The proposed plan to ensure that there is collaboration with other WHO Departments especially TB and Reproductive Health and also with ILO, UNAIDS and Global Fund.

She also explained that she noted that the group is determined to produce additional evidence for the guidelines by, reaching out to other groups for more evidence which may be normative statements that are important rather than delaying and looking for factual /scientific evidence. She agreed that it is critical for us to move forward with support from WHO and other partners. She reassured the participants that, WHO/HIV Department at the Global level will work with all relevant partners at the highest level to ensure that regions and countries are supported with the necessary tools, resources and technical support to turn the recommendations into action. Last but not least the involvement of civil society is imperative and we look forward to supporting sub-regional groups and countries to implement recommendations from this consultation.

She concluded by congratulating the participants for going beyond TREAT, by discussing train and retain, looking at compensation for injuries as well as results of treatment.

With these few words on the key issues she declared the consultative meeting closed.

Notes on interaction with Guideline Review Committee (GRC)

GRC members arrived at 2pm on day-3 and were given brief summary of meeting discussion thus far by the chair. The need of input from GRC regarding discussions and efforts thus far was reinforced.

The issue was brought up again regarding best research methods for behavioral policy guidelines as they do not fit into the structure of the traditional systematic evidence review. While there was understanding to the role of the GRC, there was a general feeling that the process was inhibiting the development of vital guidelines.

GRC comments:

- GRC does not adjudicate issues of health, motherhood, etc – only adjudicate policy process!

- advised that the task is to take the available evidence which has been acquired through a transparent and reproducible process to make recommendations.

- GRC members stressed the fact that even though there may be low quality of evidence, strong recommendations can still be made as long as these decisions are clearly outlined.

- recommended two avenues for the group 1) follow the process and submit the final guideline to GRC for approval or 2) take policy to ADG for signed approval

What is the difference between a meeting report and WHO policy guideline?

R: Meeting report can also be published as a WHO document; however it will not be a WHO guideline, thus not carrying the same weight

GRC is not trying to prevent policy recommendations, simply want recommendations based on the highest level of evidence.

At operational level in the country, title of the document will affect the implementation process in the facilities. If this document is NOT a WHO guideline, then there is a danger that the document will be another one which will sit on the shelves.

Suggestion that all statements are an important piece of the entire document, therefore all statements which have clearly outlined evidence should go into the main policy document

while the other statements are processed through other venues (secondary documents/advocacy materials)

Q. Does GRC reject the entire document if it does not meet standards, it is an all or none process?

R: No, like getting review of the paper, once again it is about process not content.

Q. If guideline is rejected by GRC can you go to ADG? R: Yes

GRC is primarily interested in transparency, and the ability to replicate the process.

Aim should be for the highest document possible (WHO policy guideline), however the statements which do not pass the bar due to lack of evidence, etc and it is important to participants must not be lost in the cracks.

Consensus that the highest level document is a WHO policy guideline but carries weight due to the rigorous research put into the development of the guideline – question posed to GRC then is, from what has been shown thus far is there a reason for concern the guideline will not pass GRC approval? – determined this discussion will take place at a later date and time b/w core group and GRC

Two main issues from GRC:

1. Formulation of questions has improved
2. Systematic evidence review has not met GRC guidelines, however this does not mean group can't move forward

Statement made that when the TTR strategy was launched in 2006, very little changed, therefore warranting the strong need for a policy guideline.

Worried that there are some statements have a lot of evidence, however most of the statements rely on common knowledge.

What is the evidence behind a recommendation? Outline in detail – then explain why we are still recommended this?

Question posed to GRC: Specifically what is the issue in the systematic evidence review done by Professor Yassi? R: Predesigned protocol to minimize bias and make process reproducible

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