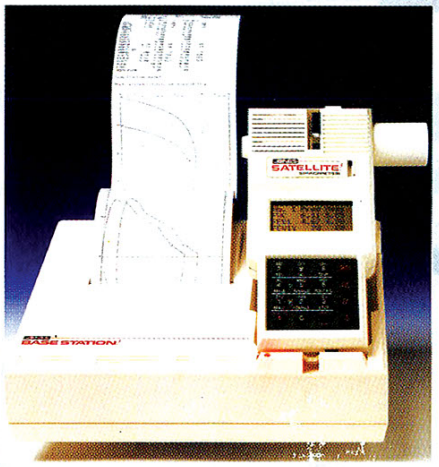
OCCUPATIONAL HEALTH
SOUTHERN AFRICA

Volume 8 No 5 September/October 2002 ISSN 1024-6274
Published by the **Safety First Association**,
Official Journal of the **SA Society of Occupational Health Nursing Practitioners**, the **SA Society of Occupational Medicine**, the **Southern African Institute for Occupational Hygiene**, the **Mining Medical and Other Health Care Professionals Association**

Audiometry, Vision, Spirometry

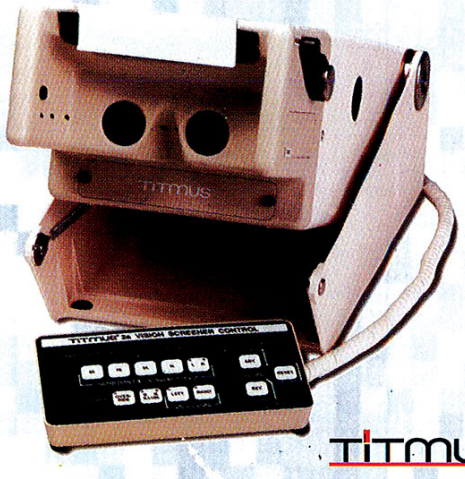
Satellite Spirometer



JONES

Satellite/Base Station³
Subminiature Spirometry System.
New advances in Spirometric Technology now offer simplistic and cost effective diagnostic capabilities

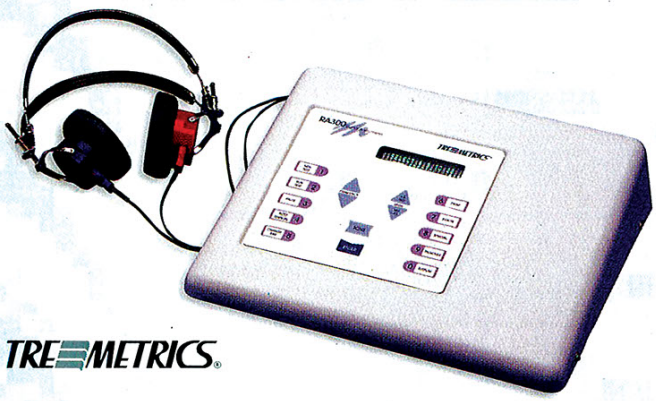
Vision Screener



TITMUS

Titmus Vision Screener
Vision Screening in less than 5 minutes - ease, speed and accuracy

RA 300 Audiometer



TREMETRICS

RA 300 - the Industry standard!
The RA 300 requires minimal operator training and provides valid hearing test results - automatically.
Complies to Regulation 171

XX1 Booth

High Performance Audiometer Booth
Delivered fully assembled - ready to use!

All instruments fully computerised.
Phone now for full technical details.

Established in 1977 by Ken Southcott

Amtronix PTY LIMITED
Innovators in Hearing Health Care

Tel: 011 622 3228
Fax: 011 616 9844
email: xexxis@eject.co.za

Ken Southcott 083 266 4884
Steve Geier 082 464 1055
Elaine Bernberg 083 460 8740

Xexxis Instruments CC

OCCUPATIONAL HEALTH SOUTHERN AFRICA

September/October 2002 Vol 8 No 5

Occupational Health SA is published by The Safety First Association

PO Box 14402 Clubview 0014
Tel/Fax: (012) 654-8349
E-mail: raysaf@mweb.co.za
Cell: 083 273 5513
www.safety1st.org.za

Editorial and Production:
Delinds Publications cc
Debbie Myer *BA (SA)*
Lindsay Myer *MBBCh DA (SA) FFA (SA)*
Tel: (011) 886-5985 Fax: (011) 886-1332
Cell: 083 266 6662 E-mail: delinds@mweb.co.za

Advertising:
Joan de Beurges
Tel/Fax: (011) 804-7520 Cell: 083 430 5164
E-mail: bigred@iafrica.co.za

Subscriptions & Administration:
The Safety First Association
Ray Strydom
Joh Strydom
PO Box 14402 Clubview 0014
Tel/Fax: (012) 654-8349 E-mail: raysaf@mweb.co.za
Cell: 083 273 5513
Subscriptions: R130.00 per annum (excl VAT)

This journal focuses on Occupational Health, Medicine, Hygiene and Safety, Primary Health Care at the workplace, Environmental Health and other employee health benefits.

Contents

The SA Society of Occupational Health Nursing Practitioners **(SASOHN)**
Linda Stokes
Tel: (011) 827-5413
http://www.sasohn.org.za

The SA Society of Occupational Medicine **(SASOM)**
Dehlia Müller
Tel: (012) 667-5160
http://www.sasom.org.za

The Southern African Institute for Occupational Hygiene **(SAIOH)**
Ray Strydom
Tel: (012) 654-8349
http://saioh.org

Mining Medical and Other Health Care Professionals Association **(MMOA)**
Maureen Mason
Tel: (011) 498-7534
http://www.mmoa.org.za

Editorial

SASOM Seminar - White River

A very successful seminar was held at the Greenway Woods Country Estate, White River on 17 August. The theme was occupational and primary health care in the workplace and covered topics of concern and importance to occupational health nursing and medical practitioners. As several of the SASOM guidelines were presented in their updated form and not all society members could travel to White River, it was decided to publish the guidelines in this issue of the journal. Future issues will carry some of the other presentations.

Occupational Medicine Practice

As an introduction to this guideline, Jim Murphy presented some fascinating statistics which indicated the importance of occupational health services (OHS) in industry. He then summarised the developments in the ongoing challenge of the clinic permit system. Although this has taken some time, there is progress. He also mentioned that conditions commonly treated at work sites had been identified and a protocol for each drawn up.

The guideline incorporates principles, aims and objectives of OHS as outlined by the International Labour Organisation and the World Health Organisation. The variety of models of OHS, as well as the duties of the occupational medical practitioner are included. The vital topics of legal and corporate governance compliance, and ethics also have prominence in the guideline.

Sick Leave Certification

As anyone working in industry will know, sick leave certification queries are abundant. The change in the ethical rules by the Health Professionals' Council (HPCSA), stating amongst other aspects, that no diagnosis may appear on a certificate without the patient's informed consent, has increased the dilemma which occupational medical practitioners (OMP) and occupational health practitioners (OHP) face.

This also necessitated a revision of the SASOM guideline on sick leave certification. Hans van der Merwe discussed the legal and ethical ramifications of sick leave certification, as well as the new requirements as per HPCSA, and presented the simplified medical certificate suggested by SASOM.

Occupational Health Audit

Monitoring and evaluation of OHS, with feedback, are critical steps in the quality management process. Many facets of industry are audited, including safety, product quality and finances. Occupational health, however, is often not integrated into the business management and as such is often not audited. A decision was therefore taken by the bench-marking scientific sub-committee of SASOM, led by Andre Kotze, to update the guideline drawn up by SASOM some time ago.

A major departure from the norm in this audit system, is that a rating system of conformance to acceptable standards, and not a point scoring system is used. It is also emphasised that this is an audit of systems and only gives information as to whether procedures and systems are in place and functioning. It is not a clinical audit and does not assess competence of staff.

NetPage

Stanton provides Internet resources for many other systems of audit and checklists for occupational health practice. Readers are encouraged to assess whether these audit systems and procedures and/or competencies in the various fields of occupational health.

Returning to work

In the disability article in this issue, Kruger provides insight into the many facets related to a decision to return to work and indicates how this can be achieved more successfully.

Instruction 171 and supplement

For the first time a circular instruction issued by the Compensation Commissioner's office is the result of tripartite consultation. Never-the-less, there is still confusion related to its implementation and the transition from Instruction 168. Ramantsi provides clarity on the process and welcomes any queries which people may have in this regard.

Farewell to Dehlia Muller

The Editorial Board joins SASOM in bidding farewell to Dehlia and would like to add their appreciation for all that she has done to assist in the administration of the journal.

Fiona Robinson
Editor

Returning the disabled employee to work or taking the disability benefit route

The fine divide

Sonja Kruger, Manager: Disability Assessment Department, MPF Management Services

Introduction

Imagine waking up feeling sick on a workday morning. How does one decide whether to go to work or stay at home? Does one use very clear and objective criteria? Is a survey of all body systems done and a "go" or "stay" decision made, or is the decision likely to be more subjective? The decision may be based on a baffling number of circumstances unrelated to one's physical condition, including, but not limited to: how much work needs to be done, whether one's colleagues can get along without one, how long it has been since one was last absent, what is happening at work that day, the work-group's norm for "being" sick, whether the employer pays sick leave benefits, whether one has any sick leave accrued, what kind of a raise was given last year, what one's horoscope says, whether it is the first day of the local "Edgars Red Hanger Sale", and so on…….

The decision process is partly conscious and partly unconscious, but rarely simple. Subjective "mental health" considerations play a role in the decision as surely as do purely medical considerations.

It is the same with disability - only more so. If deciding whether to stay home because of illness for one day seems complicated, consider the disabled person's situation. His or her life has been turned upside-down. Personal relationships with family and co-workers have changed. The stresses of reduced income, forced inactivity, dependance on care-providers, and fears about the future conspire to complicate the return to work process.

Employers disadvantage themselves when they underestimate the complexity of disability. It may simplify one's life to believe that "objective" medical findings are the sum total of the disability. But this is not true. In the first place, "objective medical findings" are so rare as to be non-existent. And secondly, disability is more often than not the unhappy intersection of many factors - personal, emotional, vocational, social and economic - as well as medical.

It may seem simple to divide disability cases into 2 categories - villainous malingerers and truly needy, but stereotypes are a convenience one cannot afford if one is serious about disability management and about helping disabled employees return to work. Claims administrators and benefit managers delight in telling stories about their most fraudulent, their most ludicrously malingering client. Such cases are thankfully rare and preventable. In disability as in life, shades of grey predominate.

Understanding the difference between impairment and disability with specific reference to the workplace

Before a disability management program can be initialised the difference between these two concepts needs to be clearly understood.

The World Health Organisation (WHO) defines impairment as "any loss or abnormality of psychological, physiological, or anatomical structure or function". This definition makes no reference to an ability or inability to work. An impaired person is thus not necessarily unable to work, in other words, the person is neither disabled nor necessarily deserving of compensation.[1,2]

At the Tripartite Meeting of Experts on the Management of disability at the workplace held in Geneva, 2001, a code of practice on managing disability in the workplace[11] was developed. In this code a disabled person is defined as follows: "an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of duly recognized physical or mental impairment".

Disability can only be considered to be present if a permanent or temporary impairment results in the individual's inability to perform a task or activity, related specifically to the performance of a remunerative function (job), whether in an occupation for which he was trained ("own occupation") or any alternative occupation he or she may be capable of by virtue of experience, knowledge, re-training or re-skilling. It is therefore clear that true total disability is a derivative of an impairment which is permanent and that the impairment is of such a nature that it renders the individual incapable of carrying out any tasks or activities of a remunerative nature[1,2]

What is diability management?

Understanding the distinction between impairment and disability allows for the implementation of a logical and meaningful disability management program.

Disability management is a proactive program directed at minimising the impact of disability (injury or disease) on each employee's physical capabilities as related to job performance. A disability management program will benefit both the organisation and the members of its workforce by reducing the cost of disability to employers while assisting the disabled employees to return to work.

It is therefore a process in the workplace designed to facilitate the employment of persons with a disability through a coordinated effort addressing individual needs, work

environment, enterprise needs and legal responsibilities[11].

Maintaining an effective disability management program can promote significant "bottom line" advantages to the organisation in important areas such as productivity, benefits and compensation cost management, and prevention, as discussed below[7,8]:

i) Productivity

- A disability management program will maintain self-esteem of injured employees, which can boost productivity through improved morale.
- It assists employees in returning to a healthy, productive life - both at work and at home.
- It reduces disruption in the work place by retaining experienced employees.

ii) Benefits management and compensation cost management

- Reduces direct and indirect costs related to lost time, disability benefits and sick leave.
- Reduces potential lost time.
- Produces results that have a positive impact on other employee benefits, such as sick leave programs and health care programs provided to address injuries and illness that are not work related.

iii) Prevention

- A disability management program should include education and training of employees in safe and healthy workplace practices, which can prevent future injuries and disabilities.
- This type of program can prevent future injuries and disabilities by providing background information for use in establishing guidelines, which can help employers to ensure that a worker's capabilities are appropriate for his/her job.

Forces that sabotage return to work

Before initiating a return to work program and rushing to solve the problem of prolonged and difficult disability cases, it is necessary to examine the forces that sabotage return to work.[3,8,9]

i) Pre-injury state

Retrospective analyses of industrial accidents and illnesses show that warning signals are common. Employees often give clear signals that something is wrong. Employees tell their supervisors, not once but repeatedly, that they're going to hurt themselves. Statements like: "They ought to fasten that rug to the floor", "Someday, somebody is going to break his or her neck", "My wrist gets so sore", "I hate to think what it'll be like after a year of this". If the employee's warnings go unheeded, a resulting disability is likely to be more troublesome and costly. The damage is done long before the "accident" happens.

Injured feelings sometimes take longer to heal than physical injury. The employee may feel wronged and damaged, and blame the employer for the injury.

Disability can also serve as an escape from administrative or disciplinary action. Many disability problem cases are poorly educated. Many have no preparation for any other work than the unskilled or semi-skilled labour they have done all their lives. They have spent their life depending on a strong back. When it is no longer functional, they have no other skills with which to return. For a worker doing physically demanding work, even minor physical disability can be career threatening.

ii) Reaction to accident

Adjusting to change is a basic life skill at which some people are better than others. Problem "disability" cases tend to be the "others". Disability always requires adjustment to change. Whereas life affords us the opportunity to grow accustomed to the idea of our mortality gradually, even leisurely, disability thrusts it upon us. Disability threatens not only our physical integrity but also our mental self-concept and emotional balance. Even minor disability demands mourning of what has been lost and acceptance of what is left.

The disability benefit contributes to this reluctance to adapt and move on with one's life. It rewards a backward-looking orientation. To maximise benefits, the claimant often feels it necessary to focus on the past, to devote energy to maintaining anger about the incident, and, of course, to ensure that there is not too much recovery as this reduces the magnitude of the permanent disability award.

iii) Domestic factors

Family and friends can prolong the disability claim. They may assure the employee that he/she is in fact very disabled. With such encouragement and such expectations, how can the disabled party go back to work without losing face?

On the other hand, family and friends may not be at all supportive. The family is likely to lose patience the longer the claim goes. In the face of declining sympathy and increasing suspicion of exaggeration, the employee may either accept the accusation as valid and return to work, or emphasise the disability even more. Family disharmony, sexual dysfunction, separation and divorce are common accompaniments to disability.

iv) Emotional problems

Are problem disability cases "nuts"? Be careful how you answer this question! Psychological stress cases are the fastest growing category of disability benefit claims[6]. Even claims with a purely physical original injury can turn into psychological stress cases if benefits or rehabilitation are delayed or denied. Surprisingly, the person's attorney may be the first to make the diagnosis. The employee's treating physician may refer for psychological services, out of a sense of frustration. This is exactly the point where an employee assistance program can assist.

v) Alternative lifestyle

Disability can seem to be an acceptable lifestyle for some people. Some disabled employees stay disabled. They get used to a disabled lifestyle although such a. is not without drawbacks. Disabled persons usually have to live on less income. They may need to be less active and they may have to put up with a succession of doctors, claims administrators and rehabilitation councellors - some who try to push them out of the disability support system.

A disabled lifestyle can however have advantages too. On the one hand disabled persons have time, freedom and autonomy they're never experienced in a job. Some use the disabled lifestyle as time to prepare for another life and others settle into the disability channel as a permanent life style and join the culture of the disabled, living as retired persons.

Returning to work has important benefits

Studies have repeatedly shown that individuals heal quicker when they remain as physically active as possible to avoid losing muscle tone. The loss of physical conditioning from

inactivity may actually hamper the healing process. Early return to work has a positive effect on the physical as well as the emotional well-being of an injured or ill person[3,8]. People often associate their self-esteem with their job role. With the loss of work there is a loss of income.

A decrease in the amount of time spent with others can lead to a feeling of isolation. Self-esteem and self-confidence are often reduced with the loss of work[3,9].

Tips for helping injured employees return to work [3,8,9]

- Implement a formalised transitional work program (TWP) which is documented and adhered to. The occupational health practitioner (OHP) is the ideal person to co-ordinate this program.
- The OHP, the worker's supervisor and the safety co-ordinator need close interaction in implementing the program and returning employees to work through the TWP.
- Be prepared to take a proactive role in the injured employee's return-to-work process.
- Communication with the employee is essential. Take a proactive role in talking with the employee about his/her injuries.
- Call the employee while he is off work and be positive about his return and recovery. Tell the employee that he is missed at work and that the occupational health staff will work with him to accommodate his return to work.
- Ask the employee to identify tasks that he is capable of performing, and job modifications that would allow him to perform these tasks.
- Always consider job modifications for the injured employee and have some possible modified job tasks and jobs in mind for him before he returns to work.
- Let the employee ease into a full-time work routine if necessary.
- Inform the employee's colleagues about his return-to-work process.
- Provide support and recognition to employees who must "fill in" to perform the duties of a disabled co-worker.

Important features of a transitional work program (TWP) [3,8,9]

A TWP represents a pro-active disability management strategy that formalises the RTW process by providing organisation, structure and accountability.

It is a company-wide plan, which recognises the employer's, and employee's responsibilities and active participation in the rehabilitation of the ill or injured worker.

TWP assignments must be meaningful and productive; these assignments must contribute to the company's operations and provide the returning worker with a meaningful job.

The TWP must have a therapeutic component and focus on removing or minimising the worker's residual limitations.

It should encourage the use of environmentally focused interventions including job modification and accommodation strategies.

Overview of duties of employers and if no option, the pension fund and/insurer

Employers have a large responsibility when it comes to injured/ill employees. When all avenues have been exhausted and it is not possible to return the employee to the productive workforce the disability benefit route should be the last option. Insurers and pension funds have rules that disability claims are measured against and it is by no means a given that a claim will be approved. In most cases the claimant needs to prove total permanent disability for his own and/or similar occupations. Others again require total permanent disability for the open labour market.

Experience has shown that employers discharge employees because they are unable to perform duties due to medical reasons without an attempt to return the worker to work, or without even considering reasonable accommodations. The worker then applies to the insurer/pension fund but does not qualify for disability benefits in terms of the rules and is left with enormous financial hardship.

Conclusion

Recent legislation[4] passed in southern Africa and currently in draft, highlight the rights of disabled people. Employers have a responsibility in accommodating employees with disabilities – even more so when the disability occurred as a result of an occupational injury or disease. The occupational health nursing practitioner plays a vital part in the disability management program of the organisation right from designing the program to implementing it. Her involvement in returning the disabled employee to work is of great value.

References:

1. Cocchiarella L, & Andersson GBJ. Guides to the evaluation of permanent impairment. 5th edition, AMA press, 2000.
2. Demeter SL et al. Disability Evaluation. St Louis: Mosby, 1996.
3. Shrey DE, Lacerte M. Principles and Practices of Disability Management in Industry. Boca Raton: CRC Press, 1995.
4. Employment Equity Act No 55, of 1998 and Code of Good Practice on Key Aspects of Disability in the Workplace. Pretoria: Government Printers, 1998.
5. International Colloquium on Job retention and Return to Work Strategies for Disabled Workers (0nline). 1998, Washington D.C. Available from: http://www.gladnet.org/infobase/return%20to%20work/wash_col.htm
6. Enable Works: Injury Prevention & Work Rehabilitation (Online) (7 screens). Available from: http://www.enableworks.co.nz/rehab.asp
7. International Research Project on Job Retention and Return to Work.

   Strategies for Disabled Workers Study Report Sweden. Anders Karlsson Swedish Council for Work Life Research. 1998 (Online); (13 screens).

   Available from: http://www.gladnet.org/infobase/return%20to%20work/sweden.htm#transitionbetweenbenefits
8. Returning the injured worker to work. (Online). 2001; (2 screens. Available from: http://www.gracelands.org.nz/work_outcomes.htm
9. The Canadian Petroleum Safety Council. Volume 10. Return-to-work program. (Online), 1999. Available from:

   http://www.rmis.com/sites/worretur.htm
10. State of Minesota: Department of employee Relations. Tips for helping injured employees return to work. (Online), 2000; (5 screens).Available from:

    http://www.doer.state.mn.us/ei-dismg/retrntps.htm
11. International Labour Organisation - Draft Code of practice on managing disability in the workplace. Tripartite Meeting of Experts on the Management of Disability at the Workplace - Geneva. (Online); 2001 (4 screens). Available from:

    http://www.ilo.org/public/english/employment/skills/disability/draftcod.html

The World Health Organization (WHO)/ International Labour Organization (ILO) Joint Effort on Occupational Health and Safety in Africa:

Update 5 - WHO Collaborating Centres

A WHO Collaborating Centre (CC) is a national institution designated by the WHO Director-General to form part of an international collaborative network carrying out activities in support of WHO's mandate for international health work and its programme priorities. The activities may take place at the country, inter-country, regional and/or global level. CCs include departments within ministries, universities or national research institutes. Institutions in developing countries are particularly sought when they can play a strategic role in strengthening geographical coverage. An entire institution with recognized scientific standing, or a department or laboratory within an institution may apply to become a CC after completing a two-year period of joint activities. In its application, the institution commits to collaborate with WHO on certain joint activities.

After initial acceptance by WHO, review and re-designation occur every four years thereafter. The CC may use the title, logo and official letterhead of "WHO Collaborating Centre" in matters related to its work on behalf of WHO. WHO CCs play a strategic role in helping WHO meet two major needs insofar as they contribute to implementing WHO's programme priorities in close coordination with the technical unit at headquarters and in the six regional offices, and strengthen institutional capacity in countries and regions.

Key functions of WHO CCs include:

- collection, provision and dissemination of information
- participation in collaborative research
- education and training, including research training
- advice on scientific, technical and policy issues

In line with the WHO policy and strategy of technical cooperation, a WHO CC must participate in the strengthening of country resources, in terms of information, services, research and training, in support of national health development. Exchange of experience and collaboration among centres is facilitated by meetings held at country and regional levels and on specific topics. Physical meetings, which have traditionally been the basis for such exchanges, continue to be an important part of this process.

WHO CCs in Occupational Health

The importance of occupational health and the long tradition of collaboration between the International Labour Organization (ILO) and WHO is reflected in the early creation of a Joint ILO/WHO Committee on Occupational Health and its first meeting in 1950. This Committee has met periodically for over 50 years and provides guidance to ILO and WHO regarding their programmes and particularly their opportunities for collaboration.

The Occupational Health Programme at WHO headquarters has always been small in size. Thus, the activities to improve workers' health have been carried out with the substantial support of its CCs. These centres represent a substantial component of the world's ministerial, academic and professional communities in occupational health. Additional contributions are provided by the WHO Regional offices and the three Non-governmental organizations (NGOs) in formal relation to the Occupational Health Program: the International Commission on Occupational Health (ICOH), the International Occupational Hygiene Association (IOHA), and the International Ergonomics Association (IEA).

A list of CCs in occupational health is maintained and regularly updated by the CC in Nancy, France, the *Institut national de la santé et de la recherche médicale* (INSERM), and can be accessed via their web site (www.grand-est.nancy.inserm.fr/who_och/). In addition to contact information, it also informs about expertise, priority areas and the terms of reference for each centre.

In Africa there are currently two CCs in occupational health:

- High Institute of Public Health (HIPH), Alexandria, Egypt

- Institut de Santé et de Sécurité au Travail (ISST), Tunis, Tunisia

And three institutes in the application process of becoming a CC in occupational health:

- National Centre for Occupational Health (NCOH), Johannesburg, South Africa
- Occupational and Environmental Health Research Unit (OEHRU), University of Cape Town, South Africa
- Université Nationale du Bénin (UNB), Cotonou, Bénin

The WHO Global Network of CCs in Occupational Health

In June 1990, the Global Network of WHO CCs in Occupational Health was formed at a meeting in Helsinki at the Finnish Institute of Occupational Health, with the intent to strengthen communication and coordination among the centres. The first meeting of the Network was held in Moscow in September 1992, with meetings held approximately every two years thereafter: in Beijing in 1994, Bogota in 1997, Helsinki in 1999, and Chiang Mai, Thailand in November 2001. The next Network meeting will be in Iguassu Falls, Brazil in February 2003.

The Network meeting in Beijing in 1994 led to the development of a key policy document, the *WHO Global Strategy on Occupational Health for All* (www.who.int/oeh/). It was approved by the World Health Assembly in 1996, thus setting the future direction for, and fuelling and motivating the activities of, the WHO Occupational Health Programme. Its eight major priorities for workers' health are listed below:

Priorities of the WHO Global Strategy in Occupational Health for All

- strengthening of international and national policies for health at work
- promotion of a healthy work environment, healthy work practices, and health at work
- strengthening of occupational health services
- establishment of appropriate support services for occupational health
- development of occupational health standards based on scientific risk assessment
- development of human resources
- establishment of registration and data systems and information support strengthening of research.

The recent Network meeting in Chiang Mai, Thailand, in November 2001 had as its main objective the establishment of the 2002–2005 Work Plan. At the end of the meeting, 15 Task Forces saw the light of day. The four year Work Plan contains an impressive range of project commitments. They focus on various priority areas in occupational health and will result in products which range from documents and brochures to training courses for occupational health personnel and/or students, from translation of occupational health materials to the establishment of questionnaires, guidelines and increased international collaboration. The 15 Task Forces comprise the following areas:

1. World Health Assembly Resolution on Occupational Health
2. Intensive partnership in Africa
3. Child labour and adolescent workers
4. Elimination of silicosis
5. Health care workers
6. Health promotion activity
7. Mental health and stress at work
8. Promotion of OS&H in small enterprises and in the informal sector
9. Prevention of musculoskeletal disorders
10. Preventive technology
11. Training of occupational health and safety personnel
12. Internet resources and networks
13. National and local profiles and indicators
14. Cost-effectiveness of interventions
15. Global burden of disease

Intensive Partnership in Africa

The objective of Task Force 2 is to improve conditions and environment of work in Africa, thus reducing the burden of occupational disease and injuries through intensified co-ordination of occupational health and safety activities. Sub-tasks include:

- Training of occupational health and safety (OHS) experts in Africa
- Preparation of community profiles on OHS in Africa
- Dissemination of information

The sub-tasks will involve contributions from a variety of institutions including, the NCOH, OEHRU (University of Cape Town), Finnish Institute of Occupational Health (FIOH), National Institute for Working Life (Sweden), Institute of Occupational Health Sciences (Switzerland), Italian Authority for Health and Safety at Work (ISPESL), the University of Michigan (USA) and WHO/AFRO.

IOHA through it member societies is supporting the University of Witwatersrand/ NCOH Masters in Public Health (MPH) and Diploma (DPH): Occupational hygiene programme. The American Conference of Governmental Industrial Hygienists (ACGIH) will provide eleven occupational hygiene field practitioner mentors for the incoming students during the course year of 2003. The British Occupational Hygiene Society (BOHS) through the University of Birmingham, UK are providing a lecturer to teach some course work. It is intended that most of the students from this class will serve as mentors to future classes.

A new method of community profiling for OHS is being developed by the FIOH. The profiling is appropriate for developing countries and is a rapid assessment tool to measure the potential OHS hazards in a village, community or district; to determine what has been done to control or eliminate the hazards; and to define how to overcome impediments to better hazard control. It is a rapid field method, but provides data on social capital, disabilities, informal sector operations, child labour and a range of data key to understanding public and occupational health.

The intention of the NCOH is to apply the profiles in three settings in the SADC region over the next four years, but the application will depend on success of funding proposals.

A Clearing House has been established at the NCOH to serve the southern African region. The Clearing House collates and disseminates information on OHS legislation and policy in the region; research programmes; training opportunities; practical solutions to hazard control; and international initiatives in the region. The collation and dissemination is facilitated by a network of practitioners and officials in the region.

CCs on the Internet

Although the Network primarily still works in traditional ways using traditional methods of communication, it is currently engaged in broadening its methods, especially with respect to increased use of the Internet. As most individual CCs have excellent web sites, Task Force 12 will work intensively with the individual centres to enhance the exchange of information and communication through the development of web sites and appropriate links.

The traditional role of the CCs has always been the preparation of information materials, and WHO has been using traditional channels for the provision and dissemination of such materials.

Increasingly, the Internet has become a useful and efficient tool for these processes. The WHO Occupational Safety & Health web site (http://www.who.int/oeh/) contains all the WHO documents on occupational safety and health, as well as the 2002–2005 Global Work Plan.

Moreover, the Programme has now established a joint web site with the European Agency for Safety and Health at Work (europe.osha.eu.in) in order to increase the accessibility of scientific and practical information to support occupational health practice, training, research and communication. In addition, the WHO/ ILO Joint Effort on Occupational Health and Safety in Africa has recently implemented a web site at *sheafrica.info*, a name which stands for Safety, Health and Environment Africa. The web site provides for communication among occupational health professionals throughout Africa.

Lastly, an extension of the work of the CCs in occupational health and a vehicle for communication of occupational safety and health information is the Global Occupational Health Network (GOHNET). Recognising the need for advocacy and awareness raising, its establishment was agreed upon at the Network meeting in Helsinki in 1990. GOHNET is, therefore, an initiative of WHO and its Network of CCs. It provides developing and industrializing, as well as developed, countries with occupational safety and health materials via a newsletter, conventional mailings, and a CD-ROM containing a compilation of all WHO occupational safety and health documents. Conventional mailings remain important due to the often-remote locations of occupational safety and health professionals in some developing countries, and their limited access to Internet technologies.

This is the fifth of a series of articles on the WHO/ILO Joint Effort on OHS in Africa. In the sixth article information will be provided on the ILO CIS Centres Network.

For further information on the Joint Effort contact:
Dr. Marilyn Fingerhut
fingerhutm@who.int

SASOM ANNUAL YEAR-END SEMINAR

"Compensation Update and Common Occupational Health Dilemmas"

SASOM National Executive Committee welcomes you all to attend their annual year-end seminar. At this exciting event not only will there be a refresher on the compensation acts, news on the progress of the merging of these acts and information about the improvements in the compensation offices, but information will be shared on topical issues and current research. These will include post traumatic stress disorder, upper limb disorders, skin diseases, treatment of HIV/AIDS and the epidemic of stress. One of the SIMRAC projects, an analysis of emergency care for miners, will also be launched.

When: 29 November 2002

Where: Marie Curie Lecture Theatre, Wits Medical School.

The seminar will be followed by the SASOM AGM and annual dinner at the Sunnyside Park Hotel.

Don't miss out on the SASOM event of the year!

Sick leave certification guidelines

Hans van der Merwe, Occupational Medical Practitioner, SASOL

Background

The issuing of a correct sick leave certificate is important as it can result in disciplinary action being taken against a medical practitioner who commits an offence.

Health practitioners are concerned about the implications of disclosing a certified diagnosis to a third party, employee-patient job security, disciplinary action, professional ethical conduct and a perceived need to revise the HPCSA requirements of a sick leave certificate, that will satisfy legal requirements.

Employers are concerned about poor certification practices resulting in substantial productivity losses, and among other factors, not meeting important legal requirements.

Purpose

To issue the revised sick leave certification guidelines.

Scope

It's to be used by health practitioners, employee-patients and employers.

Legal references (summary)

Basic Conditions of Employment Act, Section 22, **Sick leave**, proof of incapacity and Section 23(2) stating that the medical certificate must be issued and signed by a medical practitioner or person who is certified to diagnose and treat patients and who is registered with a professional council established by an Act of Parliament.

Employment Equity Act, Section 59 deals with "Breach of Confidentiality" (1) Any person who discloses any confidential information required in the performance of a function in terms of the Act, commits an offense.

Labour Relations Act, Schedule 8, Code of Good Practice: Dismissal, sub-sections (10); dealing with "Incapacity: Ill Health or Injury…" and sub-section 11, dealing with "Guidelines in Cases of Dismissal arising from Ill-health or Injury…"requiring an employer to have knowledge of the "**extent**…," the "**degree** of incapacity…," and the "**seriousness** of the illness or injury…"

Mine Health and Safety Act (MHSA) Section 15 protects the **employee's confidentiality** and the principle of **informed consent** in relation to disclosures:

Occupational Health and Safety Act Section 36 states that, "no person shall disclose any information concerning the affairs of any other person obtained by him in carrying out his functions in terms of this Act, except (a) to **the extent to which it may be necessary for the proper administration** of a provision of this Act; for the purposes of the administration of justice; or at the request of a health and safety representative or a health and safety committee entitled thereto".

Promotion of Access to Information Act (PAIA) states that personal information may be withheld from a third party (section 63).

"Personal information" is defined as: "information about an identifiable individual, including, but not limited to "information relating to the education or the medical, criminal or employment history of the individual or information relating".

Ethical rules

Health care practitioners are bound to maintain confidentiality, and may only divulge information to third parties if the patient consents, if the law so requires or if ordered to do so by a court of law. One instance where the law requires of a medical practitioner to disclose, would, for example, be where the doctor knows that a person is employed as a driver and is medically unfit to do so.

The Health Professions Council of South Africa's (HPCSA) contains a section on certificates and reports. It should be noted that it deals with certificates and reports generically.

Ethical rule 20 on the Granting of a sick leave certificate for illness/injury without containing the following information is regarded an offence:

(a) the name, address and qualifications of the practitioner;

(b) the name of the patient;

(c) the employment number of the patient (if applicable);

(d) the date and time of the examination;

(e) whether the certificate is being issued as a result of personal observations by the practitioner during an examination, or as the result of information received from the patient and which is based on acceptable medical grounds;

(f) a description of the illness, disorder or malady in layman's language if the patient has provided informed consent for it to be disclosed;

(g) whether the patient is totally indisposed for duty or whether the patient will be able to perform less strenuous duties in the work situation;

(h) the exact period of recommended sick leave;

(i) the date of issue of the certificate of illness; and

(j) a clear indication of the identity of the practitioner who issued the certificate."

Rule 21 If pre-printed stationery is used, words that should be deleted should in fact be deleted.

Rule 23 To refuse to issue a brief, factual report to a patient where such patient on reasonable grounds requires information concerning himself, is also prohibited.

It should be noted that this rule requires "a description of the illness, disorder or malady in lay man's (sic.) language". Since the advent of these guidelines, South Africa adopted a Bill of Human Rights that protects the right to privacy and confidentiality, and a number of laws were enacted, dealing with issues of information, privacy and discrimination. Health issues have also received more prominence, due to HIV/AIDS. As more employers become involved with the medical welfare of their employees, via medical schemes, occupational health practitioners or merely in coping with the impact of HIV/AIDS, the matter becomes more pressing. This implies a revision of the ethical stance taken in this regard.

Furthermore, the HPCSA has previously ruled as follows on the acceptance of a sick leave certificate:

The Council is not in a position to pronounce on the legal position in terms of relevant legislation as regards an employer accepting or refusing to accept a certificate of illness.

Council is, however, of the opinion that an employer does have the right to refuse accepting a medical certificate where circumstances exist (whether of a medical or other nature) justifying such refusal. Naturally such a refusal, warrants discretion and must be judicially exercised.

The exact wording stated on a certificate is of utmost importance. If an employer is of the opinion that a registered person acted unprofessionally in any way, the employer is at liberty to lodge a complaint against a specific person registered with the Health Professions Council.

This ruling of Health Professions Council is not in any manner intended to undermine the value of sick leave certificates.

A health professional can on behalf of an employer, if the need occurs, query a sick leave certificate and shall consult the health professional, who had issued the sick leave certificate, but shall under no circumstances revoke the opinion of the implicated health professional, without prior consultation.

Summary content

A sick certificate is an important legal document and should always be factually correct. Fraudulent information can result in criminal charges against a certifying health practitioner, as well as disciplinary action by the relevant Health Professions Council.

References

- Certificates of Illness - views of the recent ruling, SAMJ, Edition 91, No 9.
- Guidelines on Occupational Medicine Practice - SASOM 2002
- HPCSA - Ethical ruling - May 2001
- Human Right for Doctors - SAMA September 2001
- Sick Certificate guidelines, SAMJ, Edition 70, 1986.
- Medical certificates for sick leave and or reasonable accommodation: Exposition of The Law And Recommendations - SAMA, November 2001.
- SASOM Sick leave Certification Guideline - 1986

Addendum A

SAMA-SUGGESTED SAMA PRO FORMA MEDICAL CERTIFICATE

Dr's letterhead (name, qualifications, address, contacts, etc.) plus MP + practice number a

** Delete if not applicable. This medical certificate is based on the requirements set by the Basic Conditions of Employment Act, the Labour Relations Act and the Employment Equity Act.*

PATIENT PARTICULARS

Full names and surname: (b) (c) = employment number, if applicable

MEDICAL EXAMINATION

Date and time of examination: (d)

This certificate is issued as a result of *personal observations by the practitioner during an examination and/or *information received from the patient and which is based on acceptable medical grounds. (e)

EXTENT OF ILLNESS/INCAPACITY

The patient will not be able to perform * some / * all of his/her duties based on medical reasons. (g)

Note that a diagnosis and further details may only be provided with the patient's informed consent (see reverse side of this certificate). (f)

DURATION OF INCAPACITY

S/he will be * unable / * partially able (as set out above) to fulfil their duties for the period starting on (h) _____ and ending on _____

*** REASONABLE ACCOMMODATION (IF APPLICABLE)**

S/he will require reasonable accommodation in the form of _____ in accordance with above incapacity (e.g. amended duties, amended work schedule, changed workplace, etc.)

*** FOLLOW-UP MEDICAL EXAMINATIONS (IF APPLICABLE)**

S/he will be required to visit me for follow-ups on the following dates: _____ or at regular intervals of *once a month / *once a year / *….. for the following year ending on _____

SUPPLEMENTARY INFORMATION

A copy of the SA Medical Association (SAMA) Guidelines and enquiries in relation to medical certificates is available from the SAMA head office on request.

_____ _____

Signature: Dr XYZ (j) Date (i)

PATIENT INFORMED CONSENT (f)

I am a patient of doctor _____ who has discussed with me the nature of my illness, disorder or malady. I am aware of the fact that I have the right to confidentiality. I hereby *consent / * affirm that I do not consent to the release of information regarding my illness, disorder or malady to my employer/teacher/lecturer should they so request from dr XYZ.

_____ (f) _____

Patient Signature and Date Witness

Note: Small letters (a) - (j) correlate with the requirements as per ethical rule 20.

Addendum B

Medical Certificate
(Simplified version)

Dr's letterhead (name, qualifications, address, contacts, etc.) plus MP number (a)

* Delete whichever is not applicable

Undersigned hereby certifies that:

Patient..... (b) .....

Employment number..... (c) .....

was examined by me on

..... (d) ..... (date and time of first examination)

and must see me again

..... (date and time of next examination)

*In my opinion/as I was informed/the patient is unfit for normal duty/fit for alternative duty (e) and (g) (h)

from..... to and including.....

*Nature of Illness/Operation/Injury/Alternative duty (f)

.....

.....

(j) (i)

....

Signed (Stamp) Date

1. I have read the certificate
2. I am satisfied with the contents
3. If necessary, the diagnosis of my illness may be disclosed

(f)

....

Note: Small letters (a) - (j) correlate with the requirements as per ethical rule 20.

Guidelines on occupational medicine practice

Jim Murphy, Occupational Health Manager, Barloworld, South Africa

The SASOM Guideline "Medical Officer in Industry" has been updated and split into 2 new guidelines, namely:

- Guidelines on Occupational Medicine Practice
- Guidelines on Ethical and Professional Conduct for Occupational Health Practitioners.

Both these guidelines have been endorsed by the SASOM executive.

Occupational health is concerned with any substance, process or circumstance which may affect a person's health or safety in the workplace. Occupational medicine is the medical discipline that is concerned with the interrelationship between work and health.

In 1984, the International Labour Organisation's (ILO) annual International Labour conference outlined three fundamental principles:

- Work should take place in a safe and healthy environment
- Conditions of work should be consistent with workers' well-being and human dignity
- Work should offer real possibilities for personal achievement, self-fulfilment and service to society.

The joint ILO/World Health Organisation (WHO) committee in 1992 stressed that the scope of occupational health is very broad, involving the disciplines of occupational medicine, occupational hygiene, safety, ergonomics, engineering and toxicology.

Occupational health contributes to "sustainable development", as outlined in the Rio Declaration on the Environment and Development, which emphasises peoples' rights to lead "healthy and productive lives in harmony with nature". Sustainable development implies development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

The collaboration of employers and employees in occupational health programmes is essential for successful occupational health practice.

1. Occupational health services

More and more, commercial industrial and state enterprises are now employing occupational medical practitioners, nurses and other health professionals to run occupational health services for their employees. Broadly, their task is to supervise and promote the health and welfare of the workforce as well as the environmental conditions at work where these may have an effect on health. The type of health services provided will vary with the type and size of the organisation and location in relation to other health services and will be influenced strongly by management philosophy and attitudes. It is suggested that providing both occupational and preventive medical services at the work site would be in the interest of workers and organisations alike. Ethical, regulatory, organisational and economic restrictions will influence decisions on the scope of such occupational health services.

The aims and objectives of occupational health services as formulated by the ILO and WHO are to:

- Protect workers from hazards at work (protection and prevention principle)
- Adapt work and the work environment to the capabilities of workers (adaptation principle)
- Enhance the physical, mental and social well-being of workers (health promotion principle) as well as their ability to conduct a socially and economically productive life
- Minimise the consequences of occupational hazards, accidents and injuries, and occupational and work-related diseases (the cure and rehabilitation principle)
- Provide general health care services for workers and their families, both curative and preventive, at the workplace (the primary health care principle)

2. Models of occupational health services and practices

There are a variety of models to meet the needs of a wide range of enterprises within industry and the State:

- **In-house model**

- Large enterprises in the private and public sectors.

These facilities may employ multidisciplinary staff such as occupational medical practitioners, nurses, occupational hygienists, ergonomists and social workers.

In addition primary health care may be provided to workers and their families.

- Smaller enterprises

The service may be staffed by one or more occupational health nurses and a part-time visiting occupational medical practitioner.

- *Medical Director/Adviser*

Some organisations, particularly multinational corporations employ an expert to advise top management on health, safety and environmental matters, and to co-ordinate external service providers.

- **External Service Providers**

Occupational medical practitioners, nurses and other health professionals work for an organisation that provides a contracted out service to enterprises.

- **Hospital Referral Clinics**

These serve as expert referral centres. They are staffed by occupational medical practitioner specialists, who may also conduct research.

3. Duties of occupational medical practitioners

The functions of the occupational medical practitioner include:

- Workplace risk assessments
- Assisting the organisation with legal and corporate governance compliance
- Clinical occupational health
- Health promotion initiatives
- Managing stress and substance abuse
- Advice on planning and organisation of work, including ergonomic aspects and substances used
- Participation in the analysis of occupational injuries and diseases.

♦ Workplace risk assessments

Risk assessments are a requirement under the Mine Health and Safety Act and the Occupational Health and Safety Act and its Regulations. This is best conducted by a multidisciplinary team that includes the occupational medical practitioner, occupational health nurse, occupational hygienist, ergonomist, safety engineer, health and safety representatives and managers of areas concerned.

Steps in risk management and assessment

- Consider all activities, both routine and non-routine, including foreseeable emergencies.
- Identify the hazards
- Identify individuals or groups that may be exposed to hazards (include operators, contractors, maintenance, public, etc)
- Determine and assess/rate the health and safety risks
- Determine whether the current control measures are adequate
- Eliminate or reduce the identified risks
- Monitor
  - effectiveness of control measures
  - health status of those at risk

♦ Legal and corporate governance compliance

- Legal

There are no overarching statutory requirements on the provision of workplace occupational health services.

The occupational medical practitioner must, however, have a good working knowledge of all relevant legislation such as:

- The Occupational Health and Safety Act (Act No. 85 of 1993) and its regulations such as the Hazardous Chemical Substances Regulations, Lead Regulations, Asbestos Regulations, etc.
- The Mine Health and Safety Act (Act No 29 of 1996)
- The Occupational Diseases in Mines and Works Act (Act No. 78 of 1973)
- The Compensation for Occupational Injuries and Diseases Act (Act 130 of 1993)
- Employment Equity Act (Act No. 55 of 1998)
- Basic Conditions of Employment Act (Act No. 75 of 1997)
- Medicines + Related Substances Control Act 101 of 1965 and its amendments (1997 and 2002)

Under the Mine Health and Safety Act, a mine must engage the services of an occupational medical practitioner to conduct its medical surveillance programme. The occupational medical practitioners must take every measure that is reasonably practicable to:

- Promote the health and safety of employees at the mine
- To assist employees in matters related to occupational medicine.

- Corporate governance

The revised King Report on Corporate Governance has significantly increased company directors' obligations as regards 'triple bottom line' performance for stake holders. The concept of triple bottom line and sustainability refers to balancing and integrating corporate management and reporting as regards:

- Economic/financial
- Social, and
- Environmental (including health and safety) issues.

Occupational medical practitioners can assist organisations with the following issues that should be reported on:

- Whether the company and subsidiaries comply with applicable law regarding safety, health and the environment (SHE)
- How legal compliance is tested and SHE performance monitored
- What benchmarking criteria against industry norms are used
- What efforts are made regarding continued improvement in SHE efforts.

In addition, the board of directors should:

- Ensure that it understands the social and economic impact that HIV/AIDS will have on business activities
- Adopt an appropriate strategy, plan and policies to address and manage the potential impact of HIV/AIDS on business activities
- Regularly monitor and measure performance using established indicators
- Report on all of the above to stakeholders on a regular basis.

Thus occupational medical practitioners have an important role to play in the implementation of policies and strategies, and arranging appropriate treatment for people living with HIV/AIDS.

♦ Clinical occupational health

The purposes of health examinations are:

- to assess the fitness of a worker to carry out designated duties
- to assess any impairment that may arise from exposure to harmful substances or processes.

- Pre-placement medical examinations

- Serve as a baseline health evaluation
- Helps ensure that the right person is placed in the right job, and the person will not be a danger to himself or herself, and to others.

• Medical Surveillance
- This involves medical examinations and biological monitoring or workers exposed to specific hazards
- The extent and frequency depends on the level of risks, and statutory requirements. Examples would be chest X-rays and lung function tests for workers exposed to dust, and audiometry for those exposed to noise.

The objectives of periodic health surveillance include:
- detecting as early as possible any adverse health effects due to work hazards
- detecting occupational diseases.

• Advice on fitness to work

This may include:
- Assessments to authorise the resumption of work after a long absence due to illness.
- Recommendations on adaptation of the workplace to accommodate the worker.
- Assessments for temporary or total disability/ill-health retirements.

♦ Health promotion initiatives

These aim at improving the overall health status of employees and may include:
- Assessments of conditions such as hypertension, elevated cholesterol, and diabetes
- Stress management
- Changing habits such as smoking, diet, alcohol and drug abuse.

♦ HIV/AIDS Strategy

HIV/AIDS may be far more of a strategic business issue than occupational health and, as stated previously, occupational medical practitioners may be required to assist organisation in the implementation of an AIDS strategy that includes prevention as well as care and treatment for people living with HIV/AIDS.

♦ Information to workers and employers

All employees should be told the nature of hazards that they are exposed to, and what preventive measures can be taken.

Employees should be informed of results of medical surveillance.

♦ First aid services and emergency preparedness
- First aid training
- Emergency treatment in cases of injury or illness
- Collaboration with other emergency services in cases of severe injury or disasters.

♦ Rehabilitation

This may involve rehabilitation specialists such as occupational therapists and physiotherapists.

The occupational health service can facilitate an early return to work.

♦ Primary health care

Many work site health facilities provide primary health care in additional to occupational health.

This includes:
- the treatment of minor ailments
- the management of chronic conditions such as hypertension and diabetes for individuals that are not members of a medical aid scheme.

A permit/licence is issued under the Medicines and Related Substances Control Act (101 of 1965) and its amendments, which allows clinics to purchase, keep and dispense medicines. The conditions for the permit/ licence include:

*-a medical practitioner full-time or part-time in service
* a nurse full-time in service
* effective internal control of medicines
* the service is not for profit
* an approved list of medicines and protocols
* registration is subject to renewal.

In addition, the clinic must be designated under the Nursing Act, which allows the doctor in charge to authorise the nurse to diagnose, prescribe and treat.

The conditions include:
- A competent registered nurse
- The nurse must not perform tasks beyond her scope of practice or competence
- Treatment protocols with algorithms for conditions at the clinic including emergencies
- Open channels of communication between the doctor and nurse
- The doctor must visit the clinic for a prescribed period of time.

In future it is envisaged that health professionals involved in the prescribing and dispensing of medicines will have to prove their competence in the prescribing and dispensing of medicines.

♦ Leadership and Support

Leadership and support must be given to the occupational health nurse who is the backbone of the onsite health service.

♦ Research

Occupational medical practitioners should contribute to research in consultation with employer and worker representatives. Occupational Medical Practitioners involved in research are bound by ethical considerations, and each participant should give individual consent.

4. Qualifications of an Occupational Medical Practitioner

• It is recommended that any occupational medical practitioner working for an organisation either part-time or full-time should hold as a minimum qualification a Diploma in Occupational Health. It is unlikely that a medical doctor can fulfil his or her required role successfully without an occupational health qualification.

• Occupational medical practitioners cannot held the position of either "Occupational Health Practitioner" or "Occupational Medical Practitioner" as defined under the Occupational Health and Safety Act, and the Mine Health and Safety Act, unless they hold an occupational medicine qualification. This would preclude the doctor from performing certain examinations as required under these acts and their regulations.

- The Diploma in Occupational Health (DOH) may be obtained from any of the following universities: Cape Town, Free State, Natal, Pretoria, Stellenbosch and Witwatersrand (in conjunction with the National Centre for Occupational Health – NCOH). The diploma course is generally a part-time programme of 8 x 1 week blocks of didactic training over a 2 year period with lectures, research projects, industrial site visits and examinations.
- Doctors wishing to specialise should obtain the Fellow of the Faculty of Occupational Health (FFOH) through the College of Public Health of the College of Medicine of South Africa.

5. Appointment to a post and remuneration

The Health Professions Council of South Africa requires that any post for an occupational medical practitioner in industry must be advertised to enable all doctors to apply as a matter of etiquette. The medium usually used for their advertisements is "Occupational Health Southern Africa" journal, the "South African Medical Journal" or the press. The employer has the right to appoint any doctor in the same way that other employees are recruited.

An occupational medical practitioner's appointment cannot be regarded as being owned by the incumbent and cannot therefore be passed on or sold to a successor in lieu of goodwill.

It is mandatory that a proper letter of appointment (or contract) be drawn up between the Occupational Medical Practitioner and the Employer and be signed by both parties.

This should state very clearly:

- The duties of the Occupational Medical Practitioner
- The hours of work and times of attendance (especially important for the part-timer)
- Remuneration (see below)
- Provision for emergency cover outside normal hours of attendance.
- Provision of a locum or a deputising service when the Occupational Medical Practitioner is away
- The line responsibility of the Occupational Medical Practitioner
- There should be a stipulated time period to give notice of resignation, applicable to both parties.

Remuneration

- Remuneration of the occupational medical practitioner, whether full-time or part-time, would be negotiable between employer and doctor. SASOM updates guidelines on fees for industrial practice and its National Secretariat can be contacted for advice.
- For the part-time occupational medical practitioner it is recommended that details of remuneration are clearly stated in the contract or letter of appointment.
- Routine interval attendance at the work site, for which the recommended rate per hour of attendance should be used as a guideline. The fees for contract practice are regularly reviewed.
- Travelling expenses can be calculated using a government expense claim rate, the recommended Automobile Association rate or flat rate negotiated with the employer.
- Emergency, extra, non-routine attendance, e.g. an emergency visit to the work place for an accident or acute illness can be remunerated on a fee for service basis or incorporated under the general retainer payment blanket clause.
- All routine examinations, such as biological monitoring and health surveillance examinations would be part of the normal duties at the work site. When specialised examinations have to be performed at the doctor's rooms or other medical facilities, these could be charged for on a fee-for-service basis or capitation arranged over and above the normal remuneration. The same would apply for treatment of injuries on duty outside the works clinic when accounts would be sent to the Compensation Commissioner.
- No charge to any outside institution should be made by the occupational medical practitioner, whether to medical aid societies, insurance companies or Compensation Commissioner, for any consultation or professional activity performed at the works medical facility during routine attendance. It should be noted that, under the permit system, medical care is to be provided free of charge/not for profit.
- It should also be noted that it is improper for the employer to send a list of names of patients seen by the occupational medical practitioner to the medical aid each month in order to recover some of the expenses of a medical department. This is regarded as "farming out" the occupational medical practitioner's services.
- In special circumstances, such as when an employer runs a hospital for its workers and perhaps their families, the occupational medical practitioner will have to negotiate pertinent remuneration for medical care at such hospital with the employing organisation.
- It would be advisable to have a clause incorporated in the contract or letter of appointment stating that remuneration will be reviewed annually.

The Appendix contains a specimen contract for an Occupational Medical Practitioner in industry and can be suitably adapted for use by a specific organisation.

6. Ethical Guidelines

Occupational medical practitioners must refer to the SASOM "*Guidelines on Ethical and Professional Conduct for Occupational Health Practitioners*" as well as the Health Professions Council rules in this regard.

The three following paragraphs summarise the ICOH principles of ethics and values on which is based the International Code of Ethics for Occupational Health Professionals.:

- The purpose of occupational health is to serve the health and social well-being of workers individually and collectively. Occupational health practice must be performed according to the highest professional standards and ethical principles. Occupational health professionals must contribute to environmental and community health.
- The duties of occupational health professionals include protecting the life and the health of the worker, respecting human dignity and promoting the highest ethical principles in occupational health policies and programmes. Integrity in professional conduct, impartiality and the protection of the confidentiality of health

data and of privacy of workers are part of these duties.

• Occupational health professionals are experts who must enjoy full professional independence in the execution of their functions. They must acquire and maintain the competence necessary for their duties and require conditions which allow them to carry out their tasks according to good practice and professional ethics.

The occupational medical practitioner fulfils more than one role, as he is a medical adviser with responsibilities to management, to the worker / patient, the workforce as a group, the public, the worker's families and society as a whole. He may thus have to act on these responsibilities in the presence of conflicting interests.

Confidentiality of clinical information:

- The clinical medical records of workers are confidential and only the Occupational Medical Practitioner and his medical staff should have access to them.
- The Occupational Medical Practitioner is responsible for the safekeeping of these records and when he leaves they may only be passed on to his successor. When there is no successor the responsibility remains with him.
- On occasion, the Occupational Medical Practitioner may have to disclose clinical information about a worker, in the best interest of the worker and the safety of others, to the management. Such disclosures should be made with the worker's consent and, if consent cannot be elicited, the worker should be notified that the information will nevertheless be disclosed.
- Certain results of medical surveillance required under legislation may need to be disclosed to other parties, such as the factory inspectorate and management. Further guidance on this may be obtained from the SASOM Guideline: "Medical Records in Industry".

Relations with other medical practitioners

In the following circumstances, where a worker in industry has a practitioner and he consults the Occupational Medical Practitioner at the workplace, the latter should not treat him but refer the worker to his own practitioner:

- If the worker presents with a problem requiring further investigation of a condition not related to his work.
- If the worker is under treatment by his own doctor for a particular problem or illness.
- If the worker presents with a chronic problem that will require continued supervision.
- If the worker requires hospitalisation.

- However, if a worker in industry does not have a practitioner, the occupational medical practitioner may examine him or initiate treatment, and then refer or advise the worker to consult an outside practitioner.
- In an emergency, the occupational medical practitioner may refer the worker direct to a hospital, but should inform the worker's practitioner and next-of-kin.
- An occupational medical practitioner should never use his position to influence a worker as to his choice of family practitioner.
- An occupational medical practitioner should not normally treat members of a worker's family at the worker's place of work, unless it is required in terms of his appointment.
- If important clinical findings are discovered during the course of a routine examination, the occupational medical practitioner should, if the worker consents, inform his doctor of this.
- If a worker is under the treatment of his own practitioner, and provided that the medical facilities at this own place of work are adequate, the occupational medical practitioner may, with the permission of the doctor, continue the worker's treatment.
- From time to time, the occupational medical practitioner may be asked by management to enquire about the health of a worker. The occasion may also arise that management has reason to suspect that a worker may be absent for reasons other than the stated illness. In these cases, the closest possible co-operation with the worker's practitioner should be sought. If this fails, the occupational medical practitioner may examine the worker at the request of management with the informed consent of the worker and he should inform the practitioner concerned of the time and place of his intended examination. Should a difference in medical opinion arise, the opinion of a mutually agreed consultant should be sought.
- An occupational medical practitioner may be asked to advise management about poor sick note certification. It should also be realised that it is management's decision whether to accept a sick note or not. If the need arises for the doctor employed in industry to query a sick certificate, he should consult the doctor who issued the certificate. In no circumstances should he supersede the opinion of another doctor without prior consultation.
- Good relations should be maintained with outside practitioners to ensure free exchange of professional information to the advantage of the worker. In the work situation, the occupational medical practitioner is often in a better position to judge a worker's problems and his knowledge should be communicated to the worker's practitioner.

References

- Standards, Principles and Approaches in Occupational Health Services (Rantanen + Fedotov) Encyclopaedia of Occupational Health and Safety – 4th ed 1998 (ILO) Ch 16
- Guidelines on Occupational Safety and Health Management Systems ILO-OSH 2001 ILO
- SIMRAC Handbook of Occupational Health Practice in the South African Mining Industry (Guild, Ehrlich, Johnson + Ross) SIMRAC 2001
- International Code of Ethics for Occupational Health Professionals International Commission of Occupational Health (updated 2002) (ICOH)
- Guidelines on Ethical and Professional Conduct for Occupational Health Practitioners SASOM
- Integrated Sustainability Reporting (pp91 – 124) King Report on Corporate Governance

SPECIMEN JOB DESCRIPTION AND CONTRACT FOR A PART-TIME OCCUPATIONAL MEDICAL PRACTITIONER

ATTENDANCE

- Clinic attendance at factory premises for ( ) hour ( ) weekly.
- Days and times to be acceptable to both management and doctor.
- Public Holidays are excluded.

DUTIES

1. The medical attendance of employees referred by clinic staff.
2. The referral of certain cases to suitable institutions for further investigation and treatment.
3. To carry out routine pre-employment, periodic and other health examinations requested by Management.
4. To carry out factory visits at least twice yearly in order to be familiar with processes and materials used.
5. Assist the company in conducting occupational health and safety risk assessments.
6. Be conversant with actual and potential health hazards arising from processes and materials.
7. Ensure employee medical records are accurate, up-to-date and in line with normal medical practice.
8. Advise Management of any unsafe, hazardous or unhealthy practices brought to the Occupational Medical Practitioner's notice.
9. Comply with all relevant legislation such as the Medicines and Related Substances Control Act, the Occupational Health and Safety Act, Mine Health and Safety Act, Compensation for Occupational Injuries and Diseases Act and any other specific legislation or regulations that may affect the particular industry.
10. Assist the company with corporate governance requirements for health and safety and HIV/AIDS.

FEES

a. Remuneration will be negotiated between the doctor and local management according to market principles but bearing in mind the guideline recommendations produced annually by the SA Society of Occupational Medicine. The agreed fees should be inclusive of VAT.

b. Fees for employees referred by the clinic to consulting rooms will be paid by the company.

REGISTRATION AND MEDICAL INDEMNITY

It is a requirement of employment that the doctor must carry his/her own medical indemnity and documentary evidence must be produced to show that there is such cover and it will be a requirement of the contract that this is renewed annually.

A copy of the "Certificate to Practise" from the Health Professions Council of SA should also be kept with the contract documents; this is only valid for the year in which it is issued and a new copy should be obtained from the occupational medical practitioner annually.

ABSENCE

The doctor will provide a locum at his expense if he is absent for any reason. This would not apply to the occasional day where the doctor should try to notify the clinic in good time of his absence.

GENERAL

The doctor and clinic staff should liaise to develop mutually acceptable, effective, routine procedures.

The factory clinic facilities and its resources for the performance of the occupational medical practitioner's duties shall be made available at the factory's expense.

Medicines prescribed must be those kept in stock as permitted under current clinic registration. Medication outside that allowed under the legislation should be the responsibility of the doctor and the keys for the necessary separate locked facility should be under his/her control.

Employer/employee relationships are often sensitive. The doctor must deliver a totally non-biased and professional service and the doctor would be well advised to be familiar with either the contents of the SAMA "Guide to the Maintenance of Ethical Standards" – section on doctors in industry and the SASOM "Guidelines on Ethical and Professional Conduct for Occupational Health Practitioners".

The doctor should communicate with the Managing Director of the company regarding any workplace problems or suggestions.

TERMINATION OF CONTRACT

One month's notice in writing by either party is required to terminate this contract.

ACCEPTANCE OF CONTRACT

Both management and doctor should sign the contract and each keep a copy for record purposes.

....

EMPLOYER'S SIGNATURE DOCTOR'S SIGNATURE

DATE: .....

SASOM guideline for an occupational health audit

(Occupational medicine and occupational hygiene)

Andre Kotze (Dr), MBChB, DOH, Group Medical Adviser AECI Ltd
Frank Fox (Dr), MBChB, DOH, AFOM Group Medical Officer, Mondi Ltd
Mary H Ross (Prof), BSc(Hons), MBChB, DOH, FFCH(SA), MFOM(UK), MFPHM(UK), Occupational Health Programme Manager Safety in Mines Research Advisory Committee and Honorary Associate Professor School of Public Health, University of the Witwatersrand
Hans van der Merwe (Dr), Occupational Medical Practitioner, SASOL

1. Introduction

1.1 There are many facets of industry that are audited such as safety by the NOSA MBO system, product quality by the SABS, the financial side of business by appointed auditors and so on. Added to this, occupational health in industry tends to be a little peripheral and specialised and seldom is there close scrutiny by management, trade unions or the authorities. As a result, an audit procedure has been drawn up by SASOM.

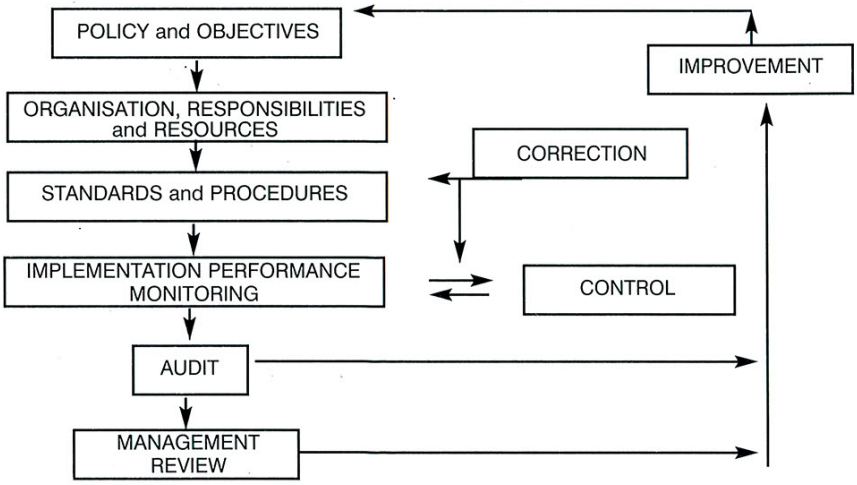
1.2. Apart from the OSHAS 18002 and the voluntary BS 8800 we are not aware of any other similar initiatives. There are also numerous clinics and companies that do not wish to go down the road of certification but would nevertheless like their clinic and systems audited against a professional standard. Our guideline would serve to introduce some uniformity into the process as there is nothing else to guide the occupational medicine practitioner who has been requested to audit a clinic or occupational health service.

1.3 Audit is an essential part of the quality management of health and safety. It recommends a system:-

- "which secures involvement and participation at all levels";
- "is committed to continuous improvement"; and uses audit:
- "to identify areas where performance standards are absent or inadequate";
- "to determine the level of compliance against set performance standards".

Audit and quality management systems demonstrate the competencies of an occupational health department.

1.4. Systems audit approach



1.5. Audit

If used appropriately, it can provide the impetus to raise standards or it can sustain best practice performance standards. Furthermore it helps ensuring legal compliance and employee well-being.

1.6. Practical utilization of this audit document :

1.6.1 This will be of use to occupational health personnel to ensure that they are performing the correct tasks required by them and that the audit can be performed by the occupational health staff themselves, by management or by outside agencies.

1.6.2. It is important to note that the format chosen for this audit is not a points scoring system but rather a compliance rating of acknowledged best practices.

1.7. Disclaimer

It must be emphasised that this audit is aimed at auditing systems and only gives an auditors opinion of whether procedures and systems are in place and functioning. It is not intended as a benchmarking aid and it does not assess clinical audit or the competence of staff. The latter aspect falls under peer review and is outside the scope of this guideline. **SASOM cannot be held responsible for any interpretation or actions based on the findings of such an audit being performed.**

2. LOGISTICS OF THE AUDIT

2.1. Service provider: _____

2.2. Site: _____

2.3. Companies to whom service is provided: _____

2.4. Number of employees: _____

Manpower / staff complement

		Part time	Full time	Total
2.5.1	Occupational medicine practitioner			
2.5.2	Occupational health practitioner			
2.5.3	Employee Assistance Resources (social workers)			
2.5.4	Other (specify)			
2.5.5	Occupational hygiene resources			
TOTAL				

2.6. MEDICAL INCAPACITY

CONDITIONS / ILLNESSES	DATE	PENSION FUND	PROVIDENT FUND
TOTAL			

3. OCCUPATIONAL HEALTH AUDIT DOCUMENT

Key to rating:

1. Unacceptable
2. Needs improvement
3. Required standard

1	2	3

3.1. POLICY AND OBJECTIVES

3.1.1. A formal (written) SHE policy including occupational health elements is available and is distributed to all employees which embodies the Company's commitment, objectives, standards and assigns responsibilities.

3.2. ORGANISATION AND RESOURCES

3.2.1. Line management

- Line managers are assigned in writing of their and SHE responsibilities.
- OH staff have readily access to all management levels.

3.2.2. Occupational Hygienist

A trained appointed Occupational Hygienist is available or an accredited external service provider is resourced for this purpose.

	1	2	3
3.2.3. Occupational Medicine Practitioner			
• A doctor has been appointed.			
• The doctor has a postgraduate qualification in Occupational Medicine.			
• The above is familiar with the workplace and occupational health hazards.			
• There is 1 hour doctor's time / week / 100 employees (SASOM guideline – This might differ dependent on the risk profile of the workplace and the nature of the service provision).			
3.2.4. Occupational Health Practitioner			
• A suitably qualified and trained OH nurse is appointed.			
• The OH nurses is familiar with the workplace and occupational health hazards.			
• There is 1 hour OH nurses time / day / 100 employees (SASOM guideline – This might differ dependent on the risk profile of the workplace and the nature of the service provision).			
3.2.5. First aiders			
• Trained first aiders are available at all times.			
• First aiders get additional training in the handling of pertinent injuries featuring in the workplace.			
• Follow-up review training is done and includes simulation exercises.			
• There is legal compliance on the First Aid requirements to the OHSAct (no 85 of 1993) and COID Act (no 130 of 1993).			
3.2.6. Continuing education			
• OH staff receive on-going education and maintain contact with professional bodies, government and other similar industries.			
• OH staff have access to occupational medicine / nursing and occupational hygiene reference literature.			
3.3. LEGISLATION			
• OH staff have access to updated legislation.			
• Management and employees know their legal responsibilities.			
3.4. RISK IDENTIFICATION AND ASSESSMENT			
• An inventory is available of all raw materials, intermediates, products and other chemicals present in the workplace.			
• A procedure is available to ensure that the inventory is complete and current.			
• All areas, including waste disposal and new processes are surveyed by a competent person for physical, chemical, biological, ergonomic and other health hazards.			
• Procedures and systems are available to identify and assess all health risks.			
• The results of risk assessments are formally documented.			

	1	2	3
• Up to date information on workplace health risks or acknowledged expert resources are available.			
3.5. RISK COMMUNICATION			
• Training / education of employees and customers on potential hazards, safe handling, personal protection, precautionary measures and emergency information is done and documented.			
• Material safety data sheets are readily available in the workplace.			
• Training is documented.			
• All materials and products are clearly labelled with health hazard information.			
3.6. RISK MANAGEMENT IN THE WORKING ENVIRONMENT			
• Effective engineering control measures are implemented wherever reasonably practicable.			
• The effectiveness of control measures is routinely measured and recorded.			
• A scheduled inspection and maintenance programme of such measures exists.			
• The use of PPE is regarded as a temporary control measure until appropriate engineering controls are implemented.			
• Formal procedures are established and training given in the selection, use, storage, fit, testing and maintenance of PPE.			
• PPE medical fitness medical examinations are done, where applicable.			
• Routine job observations are performed and documented.			
3.7. OCCUPATIONAL HYGIENE PROGRAMME AND STANDARDS			
• A formal annual review of workplace hygiene control measures and procedures to establish:			
- Compliance with control measures, procedures and work practices.			
- The on-going effectiveness of existing control measures, procedures and work practices			
• Occupational hygiene assessments are formally documented. Areas requiring improvement are prioritised.			
• A formal occupational hygiene improvement plan is produced annually and the actions are agreed by management.			
• Evidence that actions are adequately completed.			
• An accredited / delegated appointee does the hygiene monitoring.			
• A trained occupational hygienist is available to interpret the monitoring results.			
• Accredited analysis facilities are used.			

	1	2	3
• Appropriate limits for workplace exposure are established for relevant materials and physical agents.			
• A system is available to ensure legal and acknowledged compliance to current occupational exposure limits (OEL's).			
• Formal procedures are in place to ensure that the OEL's are correct and current.			
3.8. OCCUPATIONAL MEDICINE FACILITIES AND SERVICES			
• Adequately sized medical facilities available, i.e. waiting, consultation and first aid rooms.			
• Facilities are secure and have sufficient privacy.			
• Essential equipment and drugs are readily available.			
• Documented systems on the maintenance and calibration of equipment are available.			
• These facilities have emergency showers and eye baths, if necessary.			
• A written protocol for the safe disposal of medical waste is available.			
• Adequate storage space is available.			
• A valid medicine permit issued by the Department of Health is available for stocked medicines with maintained drug registers and records, if applicable.			
• An emergency action plan is available for the immediate treatment and referral of work related injury cases, as necessary.			
• The referral hospital has been informed beforehand and can handle all referred medical emergency cases, if necessary.			
• Pre-employment / pre-placement / exit medicals are performed on all workers; and			
• A documented medical surveillance and biological monitoring procedure is available for the early detection and prevention of any occupational disease.			
• A recall system is in place for job leavers who require follow-up medical review examinations.			
• Arrangements / procedures at or near the workplace for treatment of non work related injuries and ailments (primary health care) are available.			
• Arrangements / procedures are in place for the rehabilitation of ill or injured employees.			
• COID administration processing is undertaken and the process is monitored.			
• Health education and health promotion programme is in place.			
3.9. EMERGENCY PLANNING			
• A written emergency plan is available.			

	1	2	3
• The emergency plan is regularly reviewed and rehearsed.			
• Responsibilities are assigned in writing, communicated and understood			
3.10 RECORDS			
• A suitable manual / electronic record-keeping system is available for medical, risk assessment and occupational hygiene data.			
• Registers i.e. drug registers, notification of disease are kept, as required.			
• Records are stored in a secure retrievable form.			
• Data / information of individual and employee groups are easily retrievable.			
• Confidentiality of medical records are ensured.			
• All medical records are archived upon retirement or when an employee terminates service and a responsible person (custodian) is appointed for this purpose.			
3.11. AMENITIES AND SANITARY FACILITIES			
• Adequately facilities are available, for changing and storage of personal clothing and PPE.			
• Designated eating and drinking facilities, separated from the work areas are available.			
• There's a written policy available on no eating, drinking or smoking in the workplace.			
• Adequate washing / showering facilities.			
• Adequate toilet facilities provided.			
• Amenity areas routinely cleaned and inspected.			
• Appropriate skin cleaners, soap and towels are available at all wash places.			
3.12. PERFORMANCE MONITORING			
• All occupational illness and injury is immediately reported to management.			
• A formal incident investigation is conducted in all cases.			
3.13. AUDIT AND REVIEW			
• An audit procedure is available to demonstrate legal and in-house standards compliance.			
• The audit is followed with improvement plans and corrective actions.			

4. SUMMARY FINDINGS

Main non-conformances

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

g) _____

5. RECOMMENDATIONS

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

g) _____

6. AUDIT TEAM MEMBERS:-

NAME	TITLE	SIGNED
NAME	TITLE	SIGNED
NAME	TITLE	SIGNED

SASOM says "GOOD BYE and THANK YOU" to DEHLIA MULLER

SASOM says farewell to their administrative assistant of 7 years

SASOM was established in 1948 and has grown considerably as a society over the years. In 1994 it was obvious that an administrative assistant was necessary and Dehlia Muller was appointed early in 1995. Another growth phase has now occurred, which has necessitated strategic rethinking. One of the results of this rethink, which incorporated the financial sustainability of SASOM, has been to change the operation of the National Office. As it became evident that many of Dehlia's duties have slowly required more and more professional input, it was decided to reassign these duties to members of the "day-to-day" committee.

So it was that Dehlia Muller left the National Office at the end of August after seven years of service. She has now established her own company, known as "Ezee 4U", and is also a lifestyle improvement consultant on a part-time basis.

History of the National Office

The National Office was officially inaugurated on 16 August 1994 at the Johnson and Johnson Health Management Institute's building in Centurion. Dehlia was appointed as the administrative assistant in 1995. The National Office later moved to premises in Doringkloof.

There have been many successes since the launch of the National Office:

- Almost a 100% growth in paid-up members
- The implementation of sustaining members
- The hosting of regular conferences and seminars
- The country-wide COIDA training project
- The establishment of scientific committees (e.g. Dermatitis, Transport, Pesticides, etc.), from which new guidelines were developed.
- Closer liaison with other professional societies - SASOHN, SAIOH, MMOA and SASTM
- Improved administrative services.

Dehlia was intimately involved with all these initiatives.

A farewell message from Dehlia

"When I look back on my years with SASOM, it is with a sense of satisfaction. A lot has been accomplished in the 7 years that I worked as administrator for the National Office. I can still remember the advert in the paper to which I replied, the interview with Terry Geddes and landing the job. It was everything I wished for.

I started on the 5th February 1995. Originally I was appointed on a part-time basis for 3 hours a day and a small office space was secured in the Lifestyle Management Building. In the beginning I had a borrowed desk, borrowed computer and a bit of stationery. The telephone/answering machine, and my first desk were bought at Makro and in 1996 the first computer was bought. Cupboards followed until the office was fully equipped. We moved to our own offices in Doringkloof during 1998. The membership grew from ±50 to ±430. Originally, I was appointed to do general administration and secretarial duties, but responsibilities expanded day by day, e.g. budgets, meetings with governmental departments, etc. These were exciting times.

I have recently celebrated my 41st birthday and am not ashamed to admit that it felt great! I can look back and know that I have accomplished many things, have overcome a lot of problems, helped a lot of people in distress, made good friends and always tried to enjoy life to its fullest. On the 15th December this year, I will have been married to the same hubby, Johan, for 23 years. I have two great kids, Dewald, who turned 14 in January and Jeanine, who turned 18 in September. At the moment I am worrying full-time to get her through matric and to have everything ready for the matric dance in October.

My biggest passion is music and dancing, including gospel dancing. Jeanine and I enrolled in freestyle and rock-a-roll dancing last year. In the exams I received highly commended results for both.

I believe that a person should learn as many skills as possible to diversify

yourself and I qualified as a Reflexologist in 1994. To date, I can still use this skill, especially to the advantage of my family. Through SASOM, I was able to obtain skills in Access database, Pastel, budgets and conference co-ordination.

I have always been interested in herbs and in how to enjoy a healthy lifestyle. I have recently joined a company called "Lifestyle International" and am now a lifestyle improvement consultant on a part-time basis. One of the main focuses of this company is health and wellness, primarily through weight loss management. Enhancement of lifestyle is also achieved through the career opportunities that are offered.

After my retrenchment, I decided to give it a go working for myself. The name of my company is: "Ezee 4U" and entails making your administration easier for companies. To work for myself is quite an unnerving, but exciting experience and I look forward to this new challenge.

It is with sadness that I had to say goodbye to SASOM and everyone I worked with, but everything in life cannot go on forever. Thank you to everyone who made my life interesting while working for SASOM. Everything in life happens for a reason and although I still feel saddened by decisions made, I also realize, it is time to move on… I can be contacted on either 012 - 654 6941 or 083 442 5752."

A message of thanks from SASOM

Without a doubt Dehlia's input and dedication have been instrumental in the success of SASOM as a member-friendly society. She was always willing to help, as any member who telephoned for assistance will verify. Dehlia, the society says a huge "Thank You" for your years of toil and wishes you all the very best in your new endeavours.

SASOM's future

The national executive committee wishes to reassure SASOM members that the society is on sound financial footing, and to ensure sustainability, is constantly looking for new and appropriate initiatives to ensure that it continues to go from strength to strength.

The day-to-day committee members' responsibilities are as follows:

Daan Kocks (Chairman)	Membership, chapters, liaison and general correspondence.
Murray Coombs (Vice-chairman)	Scientific sub-committees, guidelines and control of SASOM assets on the premises
Jim Murphy (Secretary)	Executive bi-monthly meetings and general correspondence
Danie Ungerer (Treasurer)	Finances and budget
Fiona Robinson	Journal and ASOSH

Michelle Shelby will continue to be involved in the limited remaining day-to-day administrative running of the National Office.

Product News

The importance of a Hearing Screening Program

The prevention of noise-induced hearing loss should be of concern to all employees both at work and at home. This is best achieved by means of a hearing conservation program (HCP). Screening audiometry is typically used as an on-site audit of the effectiveness of the HCP, and provides early warning of hearing losses that may be occuring.

Audiometry is the technique for testing the acuity level of a person's hearing ability. This is achieved by using an audiometer which is calibrated to produce a wide range of frequencies (250 – 8000 Hz). It is imperative to ensure that your audiometer has been calibrated recently. The employee responds to these sounds and the lowest level of sound perceived is called the threshold level. This is recorded as a pure tone audiogram.

According to regulation 171, all employees must have had a baseline test completed before 16 November 2003, whereafter regular monitoring audiograms are required.
Audiometric screening employs basic air conduction testing to record baseline, periodic screening, monitoring and exit audiograms. Record keeping is very important, and audiometric records should be kept for a period of 40 years.

In complex cases, or where permanent disability is likely, the employee can be referred by the Occupational Health Practitioner for diagnostic audiometry.

Screening audiometers should be at least a Type 4 intrument (IEC 60645-1), and should have a valid calibration certificate. On-site calibrations must be performed annually in accordance with SABS 0154: 1996.

The GSI 66 audiometer, distributed by H.A.S.S Medical and the Ear Institute is a Type 4 screening audiometer, testing 125 – 8000 Hz. It also boasts a 50 test memory, automatic testing capabilities and can link to a computer with popular software programs. Operational training is included following purchase.

For more information on this or other audiometric options offered by H.A.S.S. Medical in conjunction with the Ear Institute, please contact Christine Fourie on 012 – 333 3130 or 082 378 2928 .

Noise induced hearing loss: Instruction 171 and Supplement

Dr Mmuso Ramantsi, Chief Medical Officer, Compensation Fund, Department of Labour

Noise is one of the most common of all occupational hazards. Audiometric evaluation of an employee's hearing is crucial to the success of a hearing conservation program. It is the only way to be certain that occupational hearing loss is being prevented. The laws governing noise in the workplace are primarily the Occupational Health and Safety Act (OHSA), No 85 of 1993, Mine Health Safety Act (MHSA), No 29 of 1996 SA and SABS Code of Practice (083).

An occupational disease due to excessive noise in industry, and an occupational injury due to factors other than excessive industrial noise are compensable diseases under Compensation for Occupational Injury and Diseases Act (COIDA), No 130 of 1993. The aim of this article is to explain the new policy regarding compensation for noise induced hearing loss in terms of Instruction 171 and Instruction 171 Supplement.

History

The Compensation Commissioner relies on Internal Circular Instructions to determine permanent disablement. These Circular Instructions are administrative devices which detail the procedures for processing claims, and ensuring standardised decision-making, within the shortest period of time possible. Most instructions have not been successful as they were developed and implemented unilaterally by the Compensation Office. Instruction No. 171 was developed after consultation amongst the three stakeholders, namely, State, employers and organised labour.

The Policy on Noise-Induced Hearing Loss, Circular Instruction No. 63, was first introduced on the 04 February 1969 and replaced on 12 January 1995 by Instruction No. 168. On the 16 May 2001, Instruction No. 171 replaced Instruction No. 168 after the tripartite consultation mentioned above. As there were problems experienced with the implementation of Instruction No. 171, Instruction No. 171 Supplement was published on 16 November 2001 to ensure the proper management and implementation of Instruction No. 171, as well as a smooth transition from the repealed Instruction No. 168 to the new Instruction No. 171.

Objectives of Circular Instruction No. 171 and supplement

The purpose of these instructions is to clarify the process of referral, impairment assessment and permanent disablement calculation for cases of hearing impairment resulting from occupational disease or injury

Who should have a baseline audiogram done (who should be "baselined")?

Both OHSA and MHSA require that on all employees working in a noise zone must have a statutory (for his total working career) baseline audiogram. That is, a baseline audiogram must be conducted on all employees in any working place where the equivalent continuous A – weighted sound pressure level, normalised to an eight hour working day or a forty hour working week, is equal to or exceeds 85 decibels A (dB(A)). They recommend that the employers must provide baseline audiograms to all workers, at no cost, as a way of measuring the overall effectiveness of the hearing conservation program.

Conducting and recording of a baseline audiogram:

A baseline audiogram must be conducted on every current employee exposed to noise by 16 November 2003. Every new employee must have a baseline audiogram done within 30 days of commencement of employment in a noise zone. The baseline of an employee must be con-

ducted in terms of Instruction 171.An employee's baseline must be recorded and this record must be kept for 40 years.

The baseline audiogram is a screening audiometric testing conducted by an audiometrist; using only **air-conduction** techniques. The baseline audiogram must be done 16 hours after an employee has been removed from the noise zone. The use of hearing protection devices to effect this attenuation will not be acceptable. The baseline audiogram is the better of the two audiograms performed on the same day and that do not differ from each other by more than 10 dB for any of the following measured test frequencies: 0.5, 1, 2, 3, and 4 kilohertz (kHz). If it is impossible to obtain two audiograms that comply with the above requirements of a baseline, the employee must be referred to a competent person to establish baseline-hearing levels by using any reasonable and acceptable techniques.

What should happen when hearing loss is discovered during baselining of new and currently exposed employees?

All "new employees"(with occupational history of exposure to excessive noise but new to the current employer) and all employees currently employed in a noise zone, who are found to be compensatable according to Instruction 168, should be referred for a diagnostic audiogram.

Diagnostic audiograms

Diagnostic audiograms are two audiograms conducted by the diagnostic audiologist and should be performed after at least 16-24 hours have elapsed since the last exposure to excessive noise. The audiograms may be done on the same day but at different sittings. The audiograms must not differ by more than 10 dB at any frequency. The better diagnostic audiogram will be used to calculate the percentage loss of hearing (PLH) for compensation purposes. If required, a third audiogram shall be performed. If this is still not within the 10dB limit then the assessment shall be delayed for a period of 6 months. If audiograms of the required quality are still not obtained after 6 months then the employee must be referred to an ear, nose and throat (ENT) specialist in order to determine hearing loss. The audiologist performing the audiogram should attest in writing to the employee's identity

Who should be referred for compensation

All new employees **without** occupational history of exposure to excessive noise should be baselined and **not** be submitted for compensation until PLH has deteriorated by more than 10% PLH from the baseline audiogram. All "new employees", (with occupational history of exposure to excessive noise but new to the current employer) and those employees currently employed in a noise zone who are found to be compensatable according to Instruction 168, must be referred to the Compensation Commissioner (or to the applicable Mutual Association), for compensation consideration. If the employee was exposed to excessive noise from different previous employers, the last employer shall carry the financial responsibility of all accepted noise induced hearing loss (NIHL) of the "new employees".

All "new employees", (with occupational history of exposure to excessive noise but new to the current employer) and those employees currently employed in a noise zone who are **not** compensatable according to Instruction 168, should be submitted for compensation consideration when the PLH has deteriorated by more than 10% PLH from the baseline audiogram.

A medical opinion

Medical opinion must be provided by an ENT-specialist if the case is complicated or the degree of disablement is expected to exceed 15% (PLH > 30 % from baseline) and by an Occupational Medical Practitioner if the case is uncomplicated and the degree of disablement is expected to be 15% or less (PLH 30% from baseline).

Claim reporting

Once a diagnosis of noise induced hearing loss is made, the following documentation should be forwarded to the Compensation Commissioner or to the Mutual Association as applicable:

- Employer's report for an occupational disease/injury (W.Cl.1/2)
- Notice of an Occupational Disease/Injury and Claim for Compensation (W Cl.14/3)
- First medical report in respect of an occupational disease /accident (W.CL.22/4)
- Final/Progress medical report in respect of an occupational disease / accident (W.CL.26/5)
- Two diagnostic audiograms conducted by the audiologist
- A copy of the baseline audiogram (and calculated PLH)
- Claimant's service record - confirm in writing exposure to excessive occupational noise. The intensity and duration of exposure should be commensurate with the hearing impairment.
- Proof of the employee's identity is to be verified by the audiologist performing the audiogram
- Medical opinion (where applicable) – this should state that the hearing loss is compatible with noise induced hearing impairment. In atypical cases an appropriate explanation should be provided.

Conclusion

Baselining of all employees currently employed in a noise zone must be done by the 16 November 2003 because after that period permanent disablement of all non baselined acceptable NIHL claims will calculated using Instruction 171.

Checklists

This NetPage (seventeenth) provides a listing of sites providing Health and Safety Checklists. Further links are included on the Checklists page of ASOSH.org (World Links> Topics > Control > Checklists and Audits) and its new mirror site ASOSH.SHEAfrica.info. If you are aware of additional online checklists please notify the author.

Audit
Inspections, Checklists & Procedure Audits (http://www.safetyline.wa.gov.au/institute/level1/course13/lecture37/index.asp) WorkSafe Western Australia. Online course
Occupational health auditing (1): occupational hygiene (http://www.concawe.be/Download/Reports/Rpt_99-58.pdf) CONCAWE, Belgium. Includes model answers
Public-Audit Templates and Guidelines (http://notesweb.dme.wa.gov.au/MODAMS/MDWebAnalysisReps.nsf/) Mining Operations Division Audit Management System (MODAMS), Department of Mineral and Petroleum Resources (MPR), Western Australia
Construction
eLCOSH (http://www.cdc.gov/niosh/elcosh/docs/other/checklists.html) NIOSH, USA
WorkSafe Victoria (http://www.workcover.vic.gov.au/vwa/alerts.nsf/SafetyInter?OpenView&Expand=1) Australia
Workplace Housekeeping (http://www.ccohs.ca/oshanswers/hsprograms/cklstcon.html) CCOHS, Canada
Contractors
Contractor Safety Checklists (http://www.maqohsc.sa.gov.au/Documents/ContractChecklists.pdf) Mining and Quarrying Occupational Health and Safety Committee (MQOHSC), Australia
Contractors' Health & Safety Information Kit (http://www.nelsoncitycouncil.co.nz/jobs/downloads/docs/ContractorsKit.pdf) Nelson City Council, New Zealand
Education/Schools
Hazard Assessment Guide for education sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/educationguide.pdf) Workers Health & Safety Centre (WHSC), Ontario, Canada
Health & Safety Checklists (http://www.shopaustralia.org/htfhs/tfhs_checklists.htm) Tools for Healthy Schools, Australia
Nursery Equipment Safety Checklists (http://www.safetyalerts.com/t/ch/nck.htm) SafetyAlerts, USA
Playground Safety Checklist (http://www.safetyrules.health.wa.gov.au/others/checklists/playgroundcheck.htm) Safety Rules OK!, Western Australia
Safety Checklists (http://www.edmontonsport.com/Facilities/checklists.html) Edmonton Sport Council, Canada
Safety Checklists: Classrooms, Chemical, Electrical, and Refrigerators (http://www.mdk12.org/practices/support_success/mspap/activities/safety/appendix_d.html) School Improvement in Maryland, USA
Safety Inspection Checklists (http://www.pvusd.net/html/safety_checklists.html) Pajaro Valley Unified School District, USA
Ergonomics
Computer Workstation Self-Audit Checklist (http://www.safetyservices.uaf.edu/codesweb/Ergonomics/checklist.htm) University of Alaska Fairbanks, USA
Construction Ergonomics Checklist (http://www.cpwr.com/kcheck.PDF) The Center to Protect Workers' Rights, USA
Office Ergonomics Checklist (http://www.3m.com/market/omc/om_html/cws_html/ergochk.html) 3M, USA
Farm
Farm Safety – a checklist (http://www.farmsafewa.org/downloads/FarmSafetychecklist.doc) Farmsafe WA, Australia
Farm Safety Checklist (http://www.safetyrules.health.wa.gov.au/others/checklists/farmcheck.htm) Safety Rules OK!, Western Australia
The Farm Health & Safety Checklist (http://enterprise.newcomm.net/agricult/check.htm) Atlantic Environmental Farm Plan (EFP) , Canada
The Farm Safety Checklist (http://www.agric.gov.ab.ca/ruraldev/safefarm/audit.html) Alberta Agriculture Web Site, Canada

Forest Products
Hazard Assessment Guide for forest products sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/forestguide.pdf) WHSC, Canada
General
Checklists.com (http://www.checklists.com/) USA
Checklists for General Industry (http://www2.wku.edu/www/stuorgs/ihsa/checklist/beginning.html) Western Kentucky University Industrial Hygiene Student Association, USA
Compliance Checklists (http://www.setonresourcecenter.com/safety/checklists/comply.htm) Seton, USA
Hazard Assessment Guide for general sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/generalguide.pdf) WHSC, Canada
Inspection Checklists - General Information (http://www.ccohs.ca/oshanswers/hsprograms/list_gen.html) CCOHS, Canada
Occupational and Industrial Safety Resources (http://www.khake.com/page59.html) Vocational Information Center, USA
Safety Forms (http://www.safetyinfo.com/safetyinfo/html/aa-g-index.htm) SafetyInfo, USA
Safety Self Audit Forms (http://www.sullivancurtismonroe.com/html/customer/SelfAudit.htm) SullivanCurtisMonroe, USA
Self-Inspection Checklists (http://www.osha-slc.gov/SLTC/smallbusiness/chklist.html) OSHA, USA Module 3: Conducting a Safety & Health Checkup (http://www.osha-slc.gov/SLTC/safetyhealth_ecat/mod3.htm)
Self-Inspection Checklists Table of Contents (http://www.safety.ambest.com/checklist/) Best's Safety & Security Directory
Small Business (http://www.workcover.vic.gov.au/dir090/vwa/home.nsf/) WorkSafe Victoria, Australia
Starting Your Business (http://www.hse.gov.uk/pubns/indg324.pdf) HSE, UK
Worksite Inspections: Union Representatives as Detectives (http://www.afscme.org/health/faq-insp.htm) American Federation of State, County and Municipal Employees (AFSCME)
Hazardous Substances
General Checklists and sample registers, lists and worksheets for hazardous substances (http://www.workcover.vic.gov.au/vwa/home.nsf/pages/so_haz_subs_checklists) WorkSafe Victoria, Australia
COSHH Essentials (http://www.coshh-essentials.org.uk/) HSE, UK. Provides online advice on controlling the use of chemicals for a range of common tasks, e.g. mixing, or drying. Includes Control Guidance Sheets with checklists
Health
Hazard Assessment Guide for health care & social services sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/healthguide.pdf) WHSC, Canada
Radiation Protection - Guides and Checklists (http://www.healthservices.gov.bc.ca/rpteb/forms.html) Radiation Protection Branch , Ministry of Health Services, British Columbia, Canada
Templates - Forms, Procedures (http://www.health.vic.gov.au/ohs/tmplte.htm) Victorian State Government, Australia
Home
Checklists (http://www.allaboutmoms.com/tools.htm) All About Moms, USA
Child Safety (http://www.babycenter.com/safety/) BabyCenter, USA
Emergency Disaster Plan Checklist (http://www.disaster-emergencymgt.com/ema4b.html) Mahoning County Emergency Management Agency, USA
Home Safety Checklist (http://www.cdc.gov/ncipc/falls/FallPrev4.pdf) CDC, USA. Fall safety program for seniors
Home Safety Checklist (http://www.safetyrules.health.wa.gov.au/others/checklists/homecheck.htm) Safety Rules OK!, Western Australia
Safety Checklist (http://www.childsafety.co.nz/) Child Safety Foundation, New Zealand
Safety Checklists (http://www.extension.iastate.edu/housing/safety/safety.html) Iowa State University Extension, USA

NET Page

Informal Sector
Improving Safety, Health and the Working Environment in the Informal Sector (http://www.ilo.org/public/english/protection/safework/sectors/informal/patris/patristrg.htm) ILO
Laboratory
Checklists (http://www.labsafety.org/cheklists.htm) The Laboratory Safety Institute (LSI), USA
Cornell Laboratory Safety Inspection Resources and Policies (http://www.ehs.cornell.edu/lrs/inspections/inspection.splash.htm) Cornell University, USA
General Laboratory Safety Checklist (http://www.stanford.edu/dept/EHS/prod/training/checklist/labcheck.pdf) Stanford University, USA
Online Safety Library: Laboratory and Chemical Safety (http://www.pp.okstate.edu/ehs/links/labchem.htm) Oklahoma State University, USA
Laboratory Environmental Safety Audit (http://esf.uvm.edu/uvmemp/audit_info.pdf) University of Vermont, USA
Laboratory Safety Checklist HELPER (http://www.uwm.edu/Dept/EHSRM/GENINFO/LabChecklist.pdf) EHS&RM, University of Wisconsin-Milwaukee, USA
Lab Safety (http://www.ab.ust.hk/sepo/check_list/) Hong Kong University of Science and Technology, China
Lighting
Lighting in the Workplace (http://www.ilo.org/public/english/protection/safework/hazardwk/ergono/lighting.pdf) ILO
Manufacturing
Hazard Assessment Guide for manufacturing & fabricating sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/manufacturingguide.pdf) WHSC, Canada
Inspection Checklists - Sample Checklist for Manufacturing Facilities (http://www.ccohs.ca/oshanswers/hsprograms/list_mft.html) CCOHS, Canada
Military
Afloat Checklists (http://www.safetycenter.navy.mil/afloat/checklists/default.htm) United States Navel Safety Center Safety Checklists (http://www.safetycenter.navy.mil/services/checklists.htm)
Checklists (http://safety.army.mil/pages/sbo/workplace/checklists.html) United Sates Army Safety Program
OO-ALC Ground Safety Checklists (http://www.hill.af.mil/safety/chklists/ChecklistIndex.htm) Hill Air Force Base, Utah, USA
Safety Checklists (http://www-benning.army.mil/dps/safety/ibsoweb/checklists.htm) Infantry Branch Safety Office (IBSO), Fort Benning, Georgia, USA
Safety Inspection Checklists (http://www.wood.army.mil/safety/Checklists/checklists.htm) Safety Office, Maneuver Support Center (MANSCEN), Fort Leonard Wood, USA
Safety Inspection Checklists for Equipment and Activities (http://www.nws.usace.army.mil/SafetyOffice/checklists.html) U.S. Army Corps of Engineers, Seattle District
Mining
Checklists and Guidelines (http://www.masha.on.ca/conchecklist.htm) Mines and Aggregates Safety and Health Association (MASHA), Canada. Includes Conveyor Safety and Post Blast Clearance
Hazard Assessment Guide for mining sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/miningguide.pdf) WHSC, Canada
Moving to the new way of measuring OHS performance (http://www.nswmin.com.au/ohs/ohs-performance.pdf) NSW Minerals Council, Australia
Public-Audit Templates and Guidelines (http://notesweb.dme.wa.gov.au/MODAMS/MDWebAnalysisReps.nsf/) MODAMS, MPR, Western Australia
Office
Hazard Assessment Guide for office and professional sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/officeguide.pdf) WHSC, Canada
Office Safety Checklist (http://www.uwm.edu/Dept/EHSRM/GENINFO/OfficeSafety.pdf) EHS&RM, University of Wisconsin-Milwaukee, USA
Office Safety Checklist Guide (http://www.ab.ust.hk/sepo/check_list/) Hong Kong University of Science and Technology, China

NET Page

Printing

Hazard Assessment Guide for printing sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/printingguide.pdf) WHSC, Canada

Pulp and Paper

Hazard Assessment Guide for pulp and paper sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/pulpguide.pdf) WHSC, Canada

Public Sector

Hazard Assessment Guide for public sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/publicguide.pdf) WHSC, Canada

Retail

Hazard Assessment Guide for retail sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/retailguide.pdf) WHSC, Canada

Tourism

Hazard Assessment Guide for tourism & hospitality sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/tourismguide.pdf) WHSC, Canada

Transport

Best Practices and Checklists (http://www.flighttestsafety.org/bestprac.htm) Flight Test Safety Committee, USA

Checklists For Fun & Safety Gear (http://4wheeldrive.about.com/cs/checklists/) 4-Wheel Drive/SUVs, About.com, USA

Hazard Assessment Guide for transportation sector workplaces (http://www.whsc.on.ca/HazardGuidesPDF/transportguide.pdf) WHSC, Canada

University

Administrative Documentation Checklist Guide (http://www.ab.ust.hk/sepo/check_list/) Hong Kong University of Science and Technology, China

Audit Checklist Menu (http://bioengr.ag.utk.edu/safety/checklists/menu.htm) Safety Office, Institute of Agriculture, University of Tennessee, USA

Checklists and Referral Forms (http://www.ad.ic.ac.uk/occ_health/forms.htm) Occupational Health Service, Imperial College of Science, Technology and Medicine, UK

Departmental Self-Inspection Checklists etc: (http://www.safety.ed.ac.uk/safenet/self_inspec/index.html) Health & Safety, University of Edinburgh, UK
Risk Assessment Forms & Notes: (http://www.safety.ed.ac.uk/safenet/risk_assess/index.html)

DOHS Forms (http://www.udel.edu/OHS/formindex.html) OHS, University of Delaware, USA

Email Requests, Health and Safety Plans, Manuals, & Forms (http://www.ehs.washington.edu/forms/Index.htm) University of Washington, USA
Safety Inspections and Sample Safety Inspection Checklists (http://www.engr.washington.edu/facilities/Workplace_A.PDF) College of Engineering

Forms (http://www.ncsu.edu/ehs/forms.htm) EHS, North Carolina State University, USA

Forms and Checklists (http://www.riskman.unsw.edu.au/ohs/forms.shtml) University of New South Wales, Australia

How to Use the Self-Audit Checklists (http://www.princeton.edu/~ehs/Checklst/selfadit.htm) EHS, Princeton University, USA

IIPP Safety Checklists (http://www.csus.edu/fmgt/eh&s/eh&s(IIPPsafetycheaklist).htm) California State University, Sacramento, USA

Safety Training Checklist and Forms (http://www.stanford.edu/dept/EHS/prod/training/checklist/index.html) EHS, Stanford University, USA

Sample Safety Review Checklists (http://pie.che.ufl.edu/guides/safety_health/) University of Florida, USA

Self-inspection Checklists (http://engineering.tamu.edu/safety/checklists.shtml) Engineering Safety Office, Texas A&M University System, USA

Contact the author at the following address:
David W. Stanton - davidws@asosh.org

Mine Medical & Other Health Care Professionals Association Newsletter

Harmony and Freegold health care services

Dr Tony De Coito, Manager: Health Services, Harmony Gold Mining Company

In this newsletter, Dr de Coito outlines the opportunities afforded by the Free State consolidation of mines, and indicates how the resulting rationalization of medical facilities has brought about cost savings. He also describes the two hospitals which will be used by the companies.

Freegold, a 50:50 joint venture between Harmony Gold Mining Company and ARMgold, has gone about purchasing a number of mines previously owned by different companies. This has enabled access to an increased number of gold deposits at a lower cost and has the potential to prolong the life of some of the Free State shafts to a planned life of up to 25 years. Harmony's gold mining production has increased 5 fold over the last 7 years and the company is worth 50 times more than it was 6 years ago. The Free State consolidation has also created other opportunities in that it has been possible to greatly reduce costs and improve health care sustainability into the future.

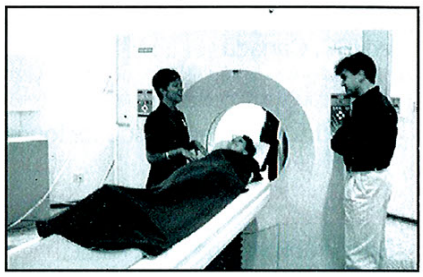
Provision of clinical medical care is an important aspect of the range of services offered to mining companies by the occupational medical practitioners in their employ. Ernest Oppenheimer Hospital in Welkom is perfectly situated to play a dominant role in private health care provision for the Free State Goldfields. Apart from medical, surgical, orthopaedic, spinal and paediatric wards, the hospital offers a 24 hour casualty service, a maternity unit, an occupational health center, a well equipped theatre complex, a 9-bed intensive care unit, and a specialized radiology unit (including a spiral CT scanner and angiography facilities). The rehabilitation center includes physiotherapy,

The entrance to the Ernest Oppenheimer Hospital, situated in Welkom

occupational therapy and biokinetics, with the three disciplines working together as a team. The primary emergency response is contracted to Netcare 911, thus ensuring the highest quality standards. There is also an on-call resuscitation team of medical doctors, ICU nurses and casualty staff.

Serving the West Rand area (Randfontein and Carletonville), is Sir Albert Medical Center. This private hospital has recently passed a 2-year Council for Health Service Accreditation of Southern Africa (COHSASA) accreditation process. This accreditation reaffirms the quality of care at this health care center, where facilities include medical, surgical, orthopaedic and maternity wards, a well equipped theatre complex, a day ward, a 5-bed intensive care unit, a 24-hour casualty unit, an occupational health center, physiotherapy and other services. Specialized surgery, including arthroplasties are done in this unit. A CT scan is a recent "high tech" addition. Netcare 911 also provides the ambulance service for this facility.

Dr de Coito feels that it is wrong to see their hospitals as "just another private hospital". In fact, they are premium quality centers and need to be positioned as top of the range private health care centers! Their cost focus and experience at running model health maintenance organizations enables them to provide top quality private health care at about half the cost of the traditional private health care market. The cost leadership and quality leadership strategies benefit their mine employees and private patients on medical schemes. Specialized referrals from other mining groups who can benefit from their expertise and cost leadership, are welcomed.



The CT scanner in the radiology department of Ernest Oppenheimer Hospital. (Posed photograpgh).

If you are wondering how all this is possible, the answer lies in their vision: "Quality Care by the World Class Team". It is their *exceptional*, empowered and motivated staff that provides *exceptional* customer service and value. Indeed, Dr de Coito believes that they hold the key to how private health care should be managed in this country and throughout the world. He adds that it is also great fun to work for dynamic growing companies.

Report on Barcelona Aids Conference July 2002

Gill Harrower, Co-ordinator HIV/AIDS Unilever SA/Africa

The 14th International AIDS Conference was held in the beautiful Mediterranean city, Barcelona, from 7 – 12 July 2002, and was attended by approximately 15000 delegates from all over the world. South Africa was extremely well represented by both the private and public sectors.

The theme of the conference was "Knowledge and Commitment for Action". This action to be focused across all aspects of HIV and to include all infected and affected groups. People need to understand how to prevent HIV and to have empathy for those with it.

Aids reaches into every corner of society, affecting parents, children and youth, teachers and health workers, rich and poor. Since the XIII International Aids Conference held in Durban two years ago, under the theme "Breaking the Silence", tremendous progress has been seen in improved treatment options, vaccine development and an understanding of HIV transmission dynamics.

Since its emergence in the 80s, HIV/AIDS has spread rapidly throughout the world. No community has been excluded from this pandemic. The continuous rise in the number of new HIV infections proves that prevention policies have not been sufficient or efficient enough. The economic impact of the epidemic was a common theme underlying much of the formal discussions of the conference, and emphasis was placed on increasing access to treatment for HIV infected individuals in developing countries.

We are now moving to an era where AIDS has become a top global issue in politics, as HIV/AIDS emerges as the leading cause of death in Africa. It was stressed that business can act faster and more effectively than any other source. In many countries workplace awareness and prevention programmes are the only sources of accurate information employees will have about HIV/AIDS. The generalized invisibility of HIV+ people shows that certain attitudes and policies, which tend to stigmatize and exclude the HIV+ population still exist. So far the necessary social and political changes to face this crisis have not come about.

Amid global tragedy, a preventive vaccine for AIDS offers the best hope of ending the pandemic. However, no AIDS vaccine is yet available. An AIDS vaccine must be safe and effective as well as practical for where it is needed most. AIDS therapy has advanced by leaps and bounds in the past ten years, but researchers are continually seeking new weapons in the arsenal of HIV drugs, since resistant strains of the virus emerge rapidly and many of today's medicines have serious side effects. Treatment certainly has enormous potential and prevention benefits. However, combination therapy is expensive and out of the price range of people in developing countries, where 95% of those infected by the virus live.

Every country that has succeeded in reducing the number of new infections has used a combination of prevention approaches. They have all supported targeted prevention interventions, anti-stigma efforts, public awareness campaigns, and the active involvement of every major sector of society in the fight against AIDS. We do still have the opportunity to make a difference, and the sooner we start, the greater that difference will be.

Voluntary counselling and testing is key to the integration of HIV prevention and care. VCT has an independent prevention benefit, especially when coupled with counselling and other intensive interventions. This effect has been most consistent for people who test positive.

South Africa remains big news

Our Department of Health attracted thousands to their stand which reflected a magnificent gallery of photographs of adults and children affected by and infected with HIV/AIDS. It was encouraging to discover a new range of exciting pamphlets on display, under the title "Khomanani – Caring Together", as well as the Government's new Strategic Five Year Plan. Those manning this stand wore traditional outfits with beautiful beadwork, and were certainly in the spotlight as many supporters gathered around to sing Shosholoza and Nkosi Sikelele at both the opening and closing ceremonies. Patriotism was very evident.

Graca Machel had delegates on their feet in a standing ovation as she urged leaders to stop "continual planning" and rather act to fight the AIDS war with much more indignation and aggression. She questioned Government's promise of financial aid five years from now, asking, "How can we sleep at night knowing that thousands are dying"

Judge Edward Cameron stated that South Africa has the framework, the capacity – even the international resolutions – but still needed the political will, commitment and money. Would the Government take heed?

Nelson Mandela claimed that although AIDS was a war against humanity - there is still life after AIDS. He called on all activists to continue their fight to overcome the terrible scourge surrounding us.

Bill Clinton called for everyone to "Stop it – Reverse it – Prevent it." He

urged people not to grow weary in doing good, for in a new season they would reap if they did not lose heart. He pledged to ensure that HIV/AIDS would be on the agenda of every meeting he attended in the future.

Four days was far too short a time to take in such a wealth and variety of information, which included excellent poster presentations. What an unforgettable experience to be amongst so many people from all corners of the globe, gathered together to look for solutions to an epidemic that now infects 40 million people worldwide, more than half of them in Africa.

Dr Peter Piot, executive director of the UNAIDS programme stated "From a historical perspective, we are still in the early days of the epidemic. There are no indications that the AIDS epidemic is leveling off, not even in the most affected countries."

Urgency and speed of delivery are the messages delegates would be taking home from the AIDS summit. In two years from now it will be the turn of the City of Angels, Bangkok, to host the 15th world conference, to take the battle forward.

What a wonderful privilege it was for me to have been given the opportunity, by my company, to attend a conference of this nature. The beautiful city of Barcelona, with 2000 years of history behind it, provided the perfect backdrop for the resolution of so many controversial issues. This was a unique occasion for networking and forging global links, which will undoubtedly prove to be invaluable as we go forward.

Copious notes were taken during the course of the Conference. I wish to acknowledge that many of the facts, figures and statements recorded throughout this report, are to a large extent excerpts from presentations and lectures I attended.

"KNOWING IS NOT ENOUGH

- WE MUST APPLY

CARING IS NOT ENOUGH

- WE MUST DO"

SASOHN honorary life membership

Karen Michell, SASOHN Executive Committee

Honorary life membership to the South African Society of Occupational Health Nursing Practitioners (SASOHN) is not easily achieved. Stringent criteria have been established for the awarding of this honorary status to ensure that those who receive such recognition are truly deserving of the award. At the SASOHN National Conference in November 2001, two very deserving members were awarded this status - Ms Louwna Pretorius and Professor Linda Grainger.

Professor Linda Grainger (left) and Ms Louwna Pretorius (right) were awarded honorary life membership to SASOHN in November 2001.

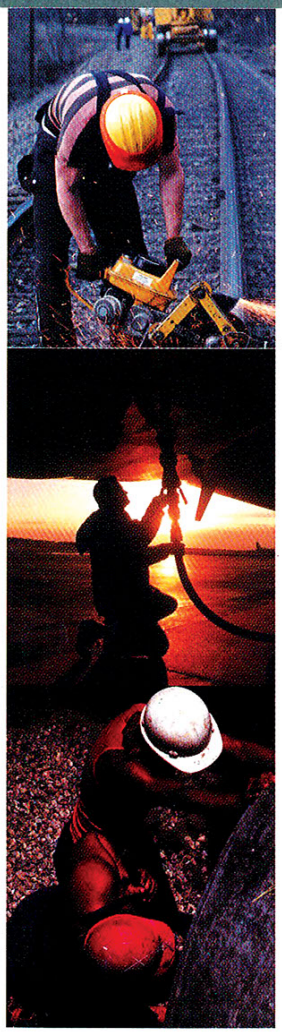
Ms Louwna Pretorius is employed as an Occupational Health Consultant and senior lecturer at NOSA. Louwna started her career in occupational health nursing with South African Breweries in the 1980s and since then has been actively involved in occupational health. Her involvement with SASOHN over the years has been extensive and includes chairmanship of the Pretoria branch for four years and education representative at national level for four years. Currently, Louwna is serving her second term as the SASOHN president. Other involvements in the development of occupational health as a specialisation have included serving on the Standards Generating Body for Occupational Health and Safety, and the Mine Qualifications Authority (MQA) system over the past four years.

Professor Linda Grainger is currently the head of the Department of Community Nursing at Durban Institute of Technology. She has been an active SASOHN member intermittently since 1978 and her portfolios have included Port Natal Executive Committee member, the National Education Representative and Vice President of the national body. Linda is actively involved in occupational health and her areas of interest include the improvement of standards of education in occupational health. These standards have been developed in order to produce practitioners of excellence in the field of occupational health. Linda's focus has been on the meeting of clients' health care needs, the promotion of research and the implementation of health care through a quality management approach. She has published numerous papers and has recently with the assistance of Bachelor of Technology: Nursing (occupational Health) students completed the National Salary Survey for SASOHN.

Both these recipients have committed themselves to the development of occupational health nursing as a profession and have represented South African OHNPs on an international level. Their involvement in the profession is unquestioned and has benefited many occupational health nursing practitioners. To both recipients we say congratulations. SASOHN and all OHNPs thank you for the input you have made to the specialisation and the sacrifices you have made along the way. May the receipt of this award, the highest accolade in occupational health nursing, mark the beginning of yet another era in your lives with SASOHN and most definitely not the end.

Directory of Occupational Health and Hygiene Practitioners

Only Variphone guarantees complete protection with optimum communication in noise.



Why is Variphone the safest and most reliable hearing protector available?

Only Variphone guarantees complete protection with optimum communication:

- The only SABS approved hearing protector in South Africa
- Custom-made for complete wearer comfort
- 100% leak-tight fit in the ear of each user
- Optimum communication in noise (*important safety feature*)
- Protection against noise induced hearing loss up to 120dB(A)
- Fully adjustable valve (*saves time and money*)
- Variphone comprises part of a full Hearing Conservation Program implemented by SABS accredited staff
- Individual training for each user and safety personnel
- Training for Medical staff on request.

Variphone offers guaranteed protection and guaranteed peace of mind!

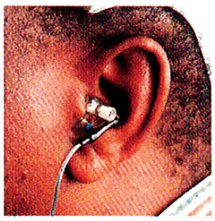
Leading companies implementing the H.A.S.S. Hearing Conservation Programme include

SAB

ISCOR

South African Airways

Anglo Platinum



If you would like more information, a free interactive CD or a demonstration on how Variphone can significantly reduce both noise-induced hearing losses and accidents in the workplace, contact H.A.S.S. Industrial on (012) 333 3130

made in south africa

SABS

www.hassindustrial.co.za

VARIPHONE®

Protect your people. It's a sound investment.

Gentel 35795-V-NS