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UAJ9XH - SIENA LAM

Managing safety in the workplace requires a wide range of safety and health subjects to be mastered. Traditionally, this has been achieved by reference to an encompassing text such as Safety at Work - widely acknowledged as the authoritative guide to safety and health in the workplace. Written by a team of specialist contributors under the joint editorship of John Ridley and John Channing, it has been prepared in association with the Institution of Occupational Safety and Health and covers their academic requirements for membership. In order to make elements of this authoritative work available to those who require information on only one of the major aspects of occupational safety and health, the following modular texts, drawn from the fifth edition of Safety at Work, are now available: Safety Law Risk Management Occupational Hygiene Workplace Safety These separate texts include all the latest changes in health, safety, employment and environmental legislation and are essential reading for all who need to have knowledge of the subject. Particular emphasis is placed on the role of the manager and recognises the shift in employment numbers from manufacturing to service industries. Important coverage is given to the influences on health and safety, practical safety management and behavioural techniques and to the management of chemicals, ergonomics and the environment.

Every day, doctors are faced with the challenge of keeping the people they treat safe and free from harm. Patient safety is a relatively new field of study, but the field is expanding and there is now better understanding of what is needed to measure and achieve safety for patients. The Handbook of Patient Safety will empower doctors, nurses and other professionals to be able to develop safe clinical processes that allow proactive management and minimisation of risk, so that people are not harmed when they receive clinical care. It gives the ra-

tionale for patient safety, the theories behind the science of patient safety and then the practical methods that frontline staff can use on a daily basis to decrease harm. Pocket sized and practical, this handbook is the ideal guide to support frontline staff and trainees, as well as all allied professionals in the name of patient safety. It reflects the World Health Organization's Patient Safety Curriculum and is written by international experts in their field who have specialist interests and direct expertise in dealing with patient safety issues. This book will demystify what is often seen as a complex topic, helping doctors understand the methods needed to provide safe care.

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)." - online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk/

This handbook provides detailed instructions for guideline developers on the following topics: application of high quality methodology for guideline development using systematic search strategies, synthesis and quality assessment of the best available evidence to support the recommendations; appropriate collection and management of experts' declared conflict of interest; expert group composition including content experts, methodologists, target users, policy makers, with gender and geographical balance; instructions for the management of group process to achieve consensus among experts; standards for a transparent decision-making process, taking into consideration potential harms and benefits, end users values and preferences; developing plans for implementing and adapting guidelines; and minimum standards for reporting.--Publisher description.

This report describes the current situation with regard to universal health coverage and global quality of care, and outlines the steps governments, health services and their workers, together with citizens and patients need to urgently take. As societies grow more complex and people are increasingly bombarded with health information and misinformation, health literacy becomes essential. People with strong health literacy skills enjoy better health and well-being, while those with weaker skills tend to engage in riskier behavior and have poorer health. With evidence from the recent European Health Literacy Survey, this report identifies practical and effective ways public health and other sector authorities and advocates can strengthen health literacy in a variety of settings, including educational settings, workplaces, marketplaces, health systems, new and traditional media and political arenas. The report can be used as a tool for spreading awareness, stimulating debate and research and, above all, for informing policy development and action.

This is one of the first books to draw together information and views about international control of food safety from around the world. Demands for safe food, against a background of increasing trade, are making international controls

on food safety essential. Agreements on how to control the safety of food to meet these needs are now in place among the major trading blocks, particularly in Europe and in the USA, and more recently, in Australia. This book also describes progress in areas such as systematically reviewing risk from food; developing national infrastructures to enforce standards; and growing input from consumer groups and others, including economists, to the debate on how to set international food standards. Discussed in depth is the effort to achieve global standards for food safety under the auspices of the Codex Alimentarius Commission. There are chapters from world-leading experts on Codex, international control of radiological contamination, pesticides and veterinary drugs, and other chemical contaminants.

The Patient safety tool kit describes the practical steps and actions needed to build a comprehensive patient safety improvement programme in hospitals and other health facilities. It is intended to provide practical guidance to health care professionals in implementing such programmes outlining a systematic approach to identifying the what and the how of patient safety. The tool kit is a component of the WHO patient safety friendly hospital initiative and complements the Patient safety assessment manual also published by WHO Regional Office for the Eastern Mediterranean.

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDSâ€"three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequenceâ€"but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agendaâ€"with state and local implicationsâ€"for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errorsâ€"which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health careâ€"it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health

care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocatesâ€"as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

Antibiotics have revolutionized the treatment of infectious diseases. But their use and misuse have resulted in the development and spread of antibiotic resistance. This is now a significant health problem: each year in the European Union alone, over 25 000 people die from infections caused by antibiotic-resistant bacteria. Antibiotic resistance is also a food safety problem: antibiotic use in food animals -for treatment, disease prevention or growth promotion - allows resistant bacteria and resistance genes to spread from food animals to humans through the food-chain. This publication explores the options for prevention and containment of antibiotic resistance in the food-chain through national coordination and international cooperation, including the regulation and reduction of antibiotic use in food animals, training and capacity building, surveillance of resistance trends and antibiotic usage, promotion of knowledge and research, and advocacy and communication to raise awareness of the issues. This publication is primarily intended for policy-makers and authorities working in the public health, agriculture, food production and veterinary sectors, and offers them ways to take a holistic, intersect oral, multifaceted approach to this growing problem.

The World health statistics 2020 report is the latest annual compilation of health statistics for 194 Member States. It summarizes trends in life expectancy and causes of death and reports on progress towards the health and health related Sustainable Development Goals (SDGs) and associated targets. Four indicators of emerging public health importance relating to poliomyelitis, hypertension and obesity in adults and school age children have been included. These are part of the WHO's Thirteenth General Programme of Work 2019-2023 (GPW13), which the 71st World Health Assembly approved in May 2018. The GPW13 is largely based on the SDGs and sets out WHO's strategic direction until 2023

The WHO Guidelines on Hand Hygiene in Health Care provide health-care workers (HCWs), hospital administrators and health authorities with a thorough review of evidence on hand hygiene in health care and specific recommendations to improve practices and reduce transmission of pathogenic microorganisms to patients and HCWs. The present Guidelines are intended to be implemented in any situation in which health care is delivered either to a patient or to a specific group in a population. Therefore, this concept applies to all settings where health care is permanently or occasionally performed, such as home care by birth attendants. Definitions of health-care settings are proposed in Appendix 1. These Guidelines and the associated WHO Multimodal Hand Hygiene Improvement Strategy and an Implementation Toolkit (http://www.who.int/gpsc/en/) are designed to offer health-care facilities in Member States a conceptual framework and practical tools for the application of recommendations in practice at the bedside. While ensuring consistency with the

Guidelines recommendations, individual adaptation according to local regulations, settings, needs, and resources is desirable. This extensive review includes in one document sufficient technical information to support training materials and help plan implementation strategies. The document comprises six parts.

This guide covers psychological first aid which involves humane, supportive and practical help to fellow human beings suffering serious crisis events. It is written for people in a position to help others who have experienced an extremely distressing event.

Foodborne diseases takes a major toll on health. Thousands of millions of people fall ill and many die as a result of eating unsafe food. Deeply concerned by this a resolution was adopted by WHO and its Member States to recognize fod safety as an essential public health function and to develop a Global Strategy for reducing the burden of foodborne diseases.

Topics covered include child labour, occupational health, occupational safety, developed country, developing country.

The Global status report on road safety 2018 launched by WHO in December 2018 highlights that the number of annual road traffic deaths has reached 1.35 million. Road traffic injuries are now the leading killer of people aged 5-29 years.The burden is disproportionately borne by pedestrians cyclists and motorcyclists in particular those living in developing countries. The report suggests that the price paid for mobility is too high especially because proven measures exist. Drastic action is needed to put these measures in place to meet any future global target that might be set and save lives.

This book presents WHO guidelines for the protection of public health from risks due to a number of chemicals commonly present in indoor air. The substances considered in this review, i.e. benzene, carbon monoxide, formaldehyde, naphthalene, nitrogen dioxide, polycyclic aromatic hydrocarbons (especially benzo[a]pyrene), radon, trichloroethylene and tetrachloroethylene, have indoor sources, are known in respect of their hazardousness to health and are often found indoors in concentrations of health concern. The guidelines are targeted at public health professionals involved in preventing health risks of environmental exposures, as well as specialists and authorities involved in the design and use of buildings, indoor materials and products. They provide a scientific basis for legally enforceable standards.

The purpose of this document is to present the case for the importance of pharmacovigilance, to record its growth and potential as a significant discipline within medical science, and to describe its impact on patient welfare and public health.

This edited volume of original chapters brings together researchers from around the world who are exploring the facets of health care organization and delivery that are sometimes marginal to mainstream patient safety theories and methodologies but offer important insights into the socio-cultural and organizational context of patient safety. By examining these critical insights or perspectives and drawing upon theories and methodologies often neglected by mainstream safety researchers, this collection shows we can learn more about not only the barriers and drivers to implementing patient safety programmes, but also about the more fundamental issues that shape notions of safety, alternate strategies for enhancing safety, and the wider

implications of the safety agenda on the future of health care delivery. In so doing, A Socio-cultural Perspective on Patient Safety challenges the taken-for--granted assumptions around fundamental philosophical and political issues upon which mainstream orthodoxy relies. The book draws upon a range of theoretical and empirical approaches from across the social sciences to investigate and question the patient safety movement. Each chapter takes as its focus and question a particular aspect of the patient safety reforms, from its policy context and theoretical foundations to its practical application and manifestation in clinical practice, whilst also considering the wider implications for the organization and delivery of health care services. Accordingly, the chapters each draw upon a distinct theoretical or methodological approach to critically explore specific dimensions of the patient safety agenda. Taken as a whole, the collection advances a strong, coherent argument that is much needed to counter some of the uncritical assumptions that need to be described and analyzed if patient safety is indeed to be achieved.

Antibiotic resistance development is a natural process of adaption leading to a limited lifespan of antibiotics. Unnecessary and inappropriate use of antibiotics favours the emergence and spread of resistant bacteria. A crisis has been building up over decades, so that today common and life-threatening infections are becoming difficult or even impossible to treat. It is time to take much stronger action worldwide to avert an ever increasing health and economic burden. A new WHO publication "The evolving threat of antimicrobial resistance--Options for action" describes examples of policy activities that have addressed AMR in different parts of the world. The aim is to raise awareness and to stimulate further coordinated efforts.

Safety has traditionally been defined as a condition where the number of adverse outcomes was as low as possible (Safety-I). From a Safety-I perspective, the purpose of safety management is to make sure that the number of accidents and incidents is kept as low as possible, or as low as is reasonably practicable. This means that safety management must start from the manifestations of the absence of safety and that - paradoxically - safety is measured by counting the number of cases where it fails rather than by the number of cases where it succeeds. This unavoidably leads to a reactive approach based on responding to what goes wrong or what is identified as a risk - as something that could go wrong. Focusing on what goes right, rather than on what goes wrong, changes the definition of safety from ‘avoiding that something goes wrong’ to ‘ensuring that everything goes right’. More precisely, Safety-II is the ability to succeed under varying conditions, so that the number of intended and acceptable outcomes is as high as possible. From a Safety-II perspective, the purpose of safety management is to ensure that as much as possible goes right, in the sense that everyday work achieves its objectives. This means that safety is managed by what it achieves (successes, things that go right), and that likewise it is measured by counting the number of cases where things go right. In order to do this, safety management cannot only be reactive, it must also be proactive. But it must be proactive with regard to how actions succeed, to everyday acceptable performance, rather than with regard to how they can fail, as traditional risk analysis does. This book analy-

ses and explains the principles behind both approaches and uses this to consider the past and future of safety management practices. The analysis makes use of common examples and cases from domains such as aviation, nuclear power production, process management and health care. The final chapters explain the theoretical and practical consequences of the new perspective on the level of day-to-day operations as well as on the level of strategic management (safety culture). Safety-I and Safety-II is written for all professionals responsible for their organisation's safety, from strategic planning on the executive level to day-to-day operations in the field. It presents the detailed and tested arguments for a transformation from protective to productive safety management.

Aimed at practitioners, policymakers and researchers, this volume distills knowledge of environmental health during an emergency or disaster. It draws on results from the International Decade for Natural Disaster Reduction and experience with sustainable development between the two Earth Summits.

This book is the result of the WHO European Working Group on Health Promotion Evaluation which examined the current range of qualitative and quantitative evaluation methods to provide guidance to policy-makers and practitioners. It includes an extensive c

This publication is a derived version of the International Classification of Functioning, Disability and Health (ICF, WHO, 2001) designed to record characteristics of the developing child and the influence of environments surrounding the child . This derived version of the ICF can be used by providers, consumers and all those concerned with the health, education, and well being of children and youth. It provides a common and universal language for clinical, public health, and research applications to facilitate the documentation and measurement of health and disability in child and youth populations.--Publisher's description.

This book helps the next generation of doctors understand how to contribute to making healthcare safer. Patient safety is increasingly important in medical practice today and is becoming a core part of training for medical students and foundation doctors. This book will enable the student or junior doctor to challenge and innovate in practice to improve patient safety and care. It takes a practical approach and explores what patient safety is, why it is important, how to involve patients, the role of education, technology and resources, how to be an innovative practitioner and measuring the impact of patient safety initiatives.

Implementing safety practices in healthcare saves lives and improves the quality of care: it is therefore vital to apply good clinical practices, such as the WHO surgical checklist, to adopt the most appropriate measures for the prevention of assistance-related risks, and to identify the potential ones using tools such as reporting & learning systems. The culture of safety in the care environment and of human factors influencing it should be developed from the beginning of medical studies and in the first years of professional practice, in order to have the maximum impact on clinicians' and nurses' behavior. Medical errors tend to vary with the level of proficiency and experience, and this must be taken into account in adverse events prevention. Human factors assume a decisive importance in resilient organizations, and an understanding of risk control and containment is fundamental for all medical and surgical specialties. This open access

book offers recommendations and examples of how to improve patient safety by changing practices, introducing organizational and technological innovations, and creating effective, patient-centered, timely, efficient, and equitable care systems, in order to spread the quality and patient safety culture among the new generation of healthcare professionals, and is intended for residents and young professionals in different clinical specialties.

"The Global status report on road safety 2015, reflecting information from 180 countries, indicates that worldwide the total number of road traffic deaths has plateaued at 1.25 million per year, with the highest road traffic fatality rates in low-income countries. In the last three years, 17 countries have aligned at least one of their laws with best practice on seat-belts, drink-driving, speed, motorcycle helmets or child restraints. While there has been progress towards improving road safety legislation and in making vehicles safer, the report shows that the pace of change is too slow. Urgent action is needed to achieve the ambitious target for road safety reflected in the newly adopted 2030 Agenda for Sustainable Development: halving the global number of deaths and injuries from road traffic crashes by 2020. Made possible through funding from Bloomberg Philanthropies, this report is the third in the series, and provides a snapshot of the road safety situation globally, highlighting the gaps and the measures needed to best drive progress."--Publisher's description.

This guide provides a step-by-step explanation of how to use the Safe Hospitals Checklist, and how the evaluation can be used to obtain a rating of the structural and nonstructural safety, and the emergency and disaster management capacity, of the hospital. The results of the evaluation enable hospital's own safety index to be calculated. The Hospital Safety Index tool may be applied to individual hospitals or to many hospitals in a public or private hospital network, or in an administrative or geographical area. In some countries, such as Moldova, all government hospitals have been evaluated using the Hospital Safety Index. In this respect, the Hospital Safety Index provides a useful method of comparing the relative safety of hospitals across a country or region, showing which hospitals need investment of resources to improve the functioning of the health system. The purpose of this Guide for Evaluators is to provide guidance to evaluators on applying the checklist, rating a hospital's safety and calculating the hospital's safety index. The evaluation will facilitate the determination of the hospital's capacity to continue providing services following an adverse event, and will guide the actions necessary to increase the hospital's safety and preparedness for response and recovery in case of emergencies and disasters. Throughout this document, the terms "safe" or "safety" cover structural and nonstructural safety and the emergency and disaster management capacity of the hospital. The Hospital Safety Index is a tool that is used to assess hospitals' safety and vulnerabilities, make recommendations on necessary actions, and promote low-cost/high-impact measures for improving safety and strengthening emergency preparedness. The evaluation provides direction on how to optimize the available resources to increase safety and ensure the functioning of hospitals in emergencies and disasters. The results of the evaluation will assist hospital managers and staff, as well as health system managers and decision-makers in other relevant ministries or organizations in prioritizing and allocating limited resources to strengthen

the safety of hospitals in a complex network of health services. It is a tool to guide national authorities and international cooperation partners in their planning and resource allocation to support improvement of hospital safety and delivery of health services after emergencies and disasters. Over the past three years, the expert advice of policy-makers and practitioners from disciplines, such as engineering, architecture and emergency medicine, has been compiled, reviewed and incorporated into this second edition of the Guide. Global and regional workshops and virtual consultations have enabled technical and policy experts to contribute to the revision of Hospital Safety Index until consensus was reached on the content for its publication and distribution. Further comments and observations are certain to arise as the Hospital Safety Index continues to be applied across the world and these experiences will enable us to improve future editions. The rapid diagnostic application of the Hospital Safety Index provides, as a comparison, an out-of-focus snapshot of a hospital: it shows enough of the basic features to allow evaluators to confirm or disprove the presence of genuine risks to the safety of the hospital, and the hospital's level of preparedness for the emergencies and disasters to which it will be expected to provide health services in the emergency response. The Hospital Safety Index also takes into account the hospital's environment and the health services network to which it belongs. This second version of the second edition was released in December 2016.

Patient Safety and Healthcare Improvement at a Glance isa timely and thorough overview of healthcare quality writtenspecifically for students and junior doctors and healthcareprofessionals. It bridges the gap between the practical and thetheoretical to ensure the safety and wellbeing of patients.Featuring essential step-by-step guides to interpreting andmanaging risk, quality improvement within clinical specialties, andpractice development, this highly visual textbook offers the bestpreparation for the increased emphasis on patient safety andquality-driven focus in today’s healthcare environment. Healthcare Improvement and Safety at a Glance: • Maps out and follows the World Health OrganizationPatient Safety curriculum • Draws upon the quality improvement work of theInstitute for Healthcare Improvement This practical guide, covering a vital topic of increasingimportance in healthcare, provides the first genuine introductionto patient safety and quality improvement grounded in clinicalpractice.

Regular physical activity is proven to help prevent and treat noncommunicable diseases (NCDs) such as heart disease stroke diabetes and breast and colon cancer. It also helps to prevent hypertension overweight and obesity and can improve mental health quality of life and well-being. In addition to the multiple health benefits of physical activity societies that are more active can generate additional returns on investment including a reduced use of fossil fuels cleaner air and less congested safer roads. These outcomes are interconnected with achieving the shared goals political priorities and ambition of the Sustainable Development Agenda 2030. The new WHO global action plan to promote physical activity responds to the requests by countries for updated guidance and a framework of effective and feasible policy actions to increase physical activity at all levels. It also responds to requests for global leadership and stronger regional and national coordina-

tion and the need for a whole-of-society response to achieve a paradigm shift in both supporting and valuing all people being regularly active according to ability and across the life course. The action plan was developed through a worldwide consultation process involving governments and key stakeholders across multiple sectors including health sports transport urban design civil society academia and the private sector.

In 2015, building on the advances of the Millennium Development Goals, the United Nations adopted Sustainable Development Goals that include an explicit commitment to achieve universal health coverage by 2030. However, enormous gaps remain between what is achievable in human health and where global health stands today, and progress has been both incomplete and unevenly distributed. In order to meet this goal, a deliberate and comprehensive effort is needed to improve the quality of health care services globally. Crossing the Global Quality Chasm: Improving Health Care Worldwide focuses on one particular shortfall in health care affecting global populations: defects in the quality of care. This study reviews the available evidence on the quality of care worldwide and makes recommendations to improve health care quality globally while expanding access to preventive and therapeutic services, with a focus in low-resource areas. Crossing the Global Quality Chasm emphasizes the organization and delivery of safe and effective care at the patient/provider interface. This study explores issues of access to services and commodities, effectiveness, safety, efficiency, and equity. Focusing on front line service delivery that can directly impact health outcomes for individuals and populations, this book will be an essential guide for key stakeholders, governments, donors, health systems, and others involved in health care.

This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

Confronted with worldwide evidence of substantial public health harm due to inadequate patient safety, the World Health Assembly (WHA) in 2002 adopted a resolution (WHA55.18) urging countries to strengthen the safety of health care and monitoring systems. The resolution also requested that WHO take a lead in setting global norms and standards and supporting country efforts in preparing patient safety policies and practices. In May 2004, the WHA approved the creation of an international alliance to improve patient safety globally; WHO Patient Safety was launched the following October. For the first time, heads of agencies, policy-makers and patient groups from around the world came together to advance attainment of the goal of "First, do no harm" and to reduce the adverse consequences of unsafe health care. The purpose of WHO Patient Safety is to facilitate patient safety policy and practice. It is concentrating its actions on focused safety campaigns called Global Patient Safety Challenges, coordinating Patients for Patient Safety, developing a standard taxonomy, designing tools for research policy and assessment, identifying solutions for patient safety, and de-

veloping reporting and learning initiatives aimed at producing 'best practice' guidelines. Together these efforts could save millions of lives by improving basic health care and halting the diversion of resources from other productive uses. The Global Patient Safety Challenge, brings together the expertise of specialists to improve the safety of care. The area chosen for the first Challenge in 2005-2006, was infection associated with health care. This campaign established simple, clear standards for hand hygiene, an educational campaign and WHO's first Guidelines on Hand Hygiene in Health Care. The problem area selected for the second Global Patient Safety Challenge, in 2007-2008, was the safety of surgical care. Preparation of these Guidelines for Safe Surgery followed the steps recommended by WHO. The groundwork for the project began in autumn 2006 and included an international consultation meeting held in January 2007 attended by experts from around the world. Following this meeting, expert working groups were created to systematically review the available scientific evidence, to write the guidelines document and to facilitate discussion among the working group members in order to formulate the recommendations. A steering group consisting of the Programme Lead, project team members and the chairs of the four working groups, signed off on the content and recommendations in the guidelines document. Nearly 100 international experts contributed to the document (see end). The guidelines were pilot tested in each of the six WHO regions--an essential part of the Challenge--to obtain local information on the resources required to comply with the recommendations and information on the feasibility, validity, reliability and cost-effectiveness of the interventions.

"Hypoxaemia is a major contributor to child deaths that occur worldwide each year; for a child with pneumonia hypoxaemia increases the risk of death by up to 5 times. Despite its importance in virtually all types of acute severe illness, hypoxaemia is often not well recognized or well managed, more so in settings where resources are limited. Oxygen therapy remains an inaccessible luxury for a large proportion of severely ill children admitted to hospitals in developing countries. This is particularly true for patients in small district hospitals, where, even if some facility for delivering oxygen is available, supplies are often unreliable and the benefits of treatment may be diminished by poorly maintained, inappropriate equipment or poorly trained staff with inadequate guidelines. Increasing awareness of these problems is likely to have considerable clinical and public health benefits in the care of severely ill children. Health workers should be able to know the clinical signs that suggest the presence of hypoxaemia and have more reliable means of detection of hypoxeamia. This can be achieved through more widespread use of pulse oximetry, which is a non-invasive measure of arterial oxygen saturation. At the same time oxygen therapy must be more widely available; in many remote settings, this can be achieved by use of oxygen concentrators, which can run on regular or alternative sources of power. Having effective systems for the detection and management of hypoxaemia are vital in reducing mortality from pneumonia and other severe acute illnesses. Oxygen therapy is essential to counter hypoxaemia and many times is the difference between life and death. This manual focuses on the availability and clinical use of oxygen therapy in children in health facilities by providing the practical aspects

for health workers, biomedical engineers, and administrators. It addresses the need for appropriate detection of hypoxaemia, use of pulse oximetry, clinical use of oxygen and delivery systems and monitoring of patients on oxygen therapy. In addition, the manual addresses practical use of pulse oximetry, and oxygen concentrators and cylinders in an effort to improve oxygen systems worldwide."--Publisher's description.

A practical guide to basic principles and practices aimed at reducing the incidence of foodborne illness at both family and community levels. Addressed to health workers and their trainers, the book responds to the magnitude of health problems caused by foodborne illness, particularly in young children, the elderly, and other vulnerable groups. Although all components of food safety are covered, particular emphasis is placed on the hazards posed by the presence of pathogenic microorganisms in food. The book has seven chapters. The first introduces the problem of foodborne illness, discusses its health and economic consequences, and explains the concepts of infection intoxication and infectious dose. Chapter two focuses on foodborne hazards, gives a detailed account of the many biological, chemical, and physical hazards that can compromise food safety. Against this background, chapter three explains the processes of microbial contamination, growth, and survival as the main causes of outbreaks of foodborne illness. Particular attention is given to factors such as hygiene, temperature, time, nutrient and oxygen requirements, storage, and packaging that carry lessons relevant to safe food preparation and processing. Hazards associated with different foods are considered in the next chapter, which provides a guide to the risks posed by meat and poultry, eggs, milk and dairy products, fish and shellfish, fruits and vegetables, cereals, and bottled waters. Chapter five considers both traditional and modern industrial technologies that can prevent contamination, control microbial growth or remove or kill microorganisms in food. The remaining chapters outline the principles of good hygiene in family food preparation and mass catering, and discuss what health workers can do to alleviate the problem of foodborne illness, particularly in young children. The book concludes with an extensive table setting out basic facts about the epidemiology of over 30 foodborne illnesses.

These guidelines have been prepared by the International Labour Office in order to assist employers and national organisations with practical advice on implementing and improving occupational safety and health (OSH) management systems, in order to reduce work-related injuries, occupational ill health and diseases and unsafe working conditions. The guidelines may be applied on two levels: they provide a national OSH framework for legal and voluntary regulatory standards; and encourage the integration of OSH management principles with overall policy management at the organisational level.