



**RADIATION PROTECTION AUTHORITY OF ZIMBABWE (RPAZ)**

**RADIATION PROTECTION ACT [CHAPTER 15:15]**

**GUIDELINES ON  
IONISING RADIATION DOSE LIMITS AND  
ANNUAL LIMITS ON INTAKE OF  
RADIOACTIVE MATERIAL**

## CONTENTS

1	INTRODUCTION	1
2	DOSE LIMITATION	1
3	OCCUPATIONAL EXPOSURE	2
3.1	Effective Dose Limit	2
3.2	Non-uniform Exposure	2
3.3	Equivalent Dose Limits	2
3.4	Annual Limits on Intake	2
3.5	Rate of Dose Accumulation	3
3.6	Previous exposure unknown	3
3.7	Exposure of women of reproductive capacity	3
3.8	Exposure of pregnant women	3
3.9	Abnormal exposures	3
3.10	Potential Exposures	
4	CLASSIFICATION OF WORKPLACES AND DOSIMETRY	6
4.1	Controlled Areas	6
4.2	Supervised Areas	6
4.3	Personal Dosimetry	6
5	PUBLIC DOSE LIMITS	6
	GLOSSARY	7
	REFERENCES	8

## 1 INTRODUCTION

### Statement on Tissue Reactions

Approved by the Commission on April 21, 2011

(i) The Commission issued new recommendations on radiological protection in 2007 (ICRP, 2007), which formally replaced the Commission's 1990 Recommendations (ICRP, 1991a). The revised recommendations included consideration of the detriment arising from non-cancer effects of radiation on health. These effects, previously called deterministic effects, are now referred to as tissue reactions because it is increasingly recognised that some of these effects are not determined solely at the time of irradiation but can be modified after radiation exposure. Previously, the Commission had reviewed various aspects of non-cancer health effects of low linear-energy-transfer (LET) ionising radiation in *Publication 41* (ICRP, 1984), high LET radiation in *Publication 58* (ICRP, 1990), the skin in *Publication 59* (ICRP, 1991b), and the skin and the eye in *Publication 85* (ICRP, 2000).

(ii) The Commission has now reviewed recent epidemiological evidence suggesting that there are some tissue reaction effects, particularly those with very late manifestation, where threshold doses are or might be lower than previously considered. For the lens of the eye, the threshold in absorbed dose is now considered to be 0.5 Gy.

(ii) For occupational exposure in planned exposure situations the Commission now recommends an equivalent dose limit for the lens of the eye of 20 mSv in a year, averaged over defined periods of 5 years, with no single year exceeding 50 mSv.

(iii) Although uncertainty remains, medical practitioners should be made aware that the absorbed dose threshold for circulatory disease may be as low as 0.5 Gy to the heart or brain. Doses to patients of this magnitude could be reached during some complex interventional procedures, and therefore particular emphasis should be placed on optimisation in these circumstances.

(iv) The Commission continues to recommend that optimisation of protection be applied in all exposure situations and for all categories of exposure. With the recent evidence, the Commission further emphasises that protection should be optimised not only for whole body exposures, but also for exposures to specific tissues, particularly the lens of the eye, and to the heart and the cerebrovascular system.

## 2 DOSE LIMITATION

2.1 A system of dose limitation is laid down whereby:

- (a) no practice involving exposures to radiation shall be adopted or continued unless it produces sufficient benefit to the exposed individuals or to society to offset the radiation detriment it causes;
- (b) all exposures shall be kept as low as reasonably achievable, economic and social factors being taken into account. This procedure shall be constrained by appropriate restrictions on the doses to individuals; and
- (c) the doses to individuals shall not exceed the limits laid down in this directive. The dose limits represent the upper bounds of acceptability and should not necessarily be interpreted as allowable limits.

With regard to (b) above, it should be noted that the requirement of keeping doses as low as is reasonably achievable (optimisation of protection) is particularly important and

Dose Limits that individual exposures, even below the level of the dose limits, are not necessarily acceptable, if judged in the light of this requirement. Source related individual dose constraints (below the dose limits) must be applied, in order to ensure adequate protection of the individual. Continued exposure of workers at or near the dose limits will only be acceptable if a careful analysis has shown that the associated risk is justifiable.

- 2.2 Doses resulting from natural background and from *medical exposures* are generally excluded from the dose limits referred to in paragraph 2.1(c) unless RPAZ deems it necessary, in any particular case, to include exposure from natural radioactivity in a workplace.
- 2.3 The dose limits cover two categories of exposed individuals:
  - (a) occupationally exposed individuals (i.e. adults exposed in the course of their work), and
  - (b) members of the public.

### 3 OCCUPATIONAL EXPOSURE

#### 3.1 OCCUPATIONAL EXPOSURE

*For occupational exposure of workers over the age of 18 years, the dose limits are:*

- (a) An effective dose of 20 mSv per year averaged over five consecutive years<sup>66</sup> (100 mSv in 5 years), and of 50 mSv in any single year;
- (b) An equivalent dose to the lens of the eye of 150 mSv in a year;
- (c) An equivalent dose to the extremities (hands and feet) or the skin<sup>67</sup> of 500 mSv in a year.

Additional restrictions apply to occupational exposure for a female worker who has notified pregnancy or is breast-feeding.

*For occupational exposure of apprentices of 16 to 18 years of age who are being trained for employment involving radiation and for exposure of students of age 16 to 18 who use sources in the course of their studies, the dose limits are:*

- (a) An effective dose of 6 mSv in a year;
- (b) An equivalent dose to the lens of the eye of 50 mSv in a year;
- (c) An equivalent dose to the extremities (hands and feet) or the skin<sup>67</sup> of 150 mSv in a year.

#### 3.2 PUBLIC EXPOSURE

*For public exposure, the dose limits are:*

- (a) An effective dose of 1 mSv in a year;
- (b) In special circumstances<sup>68</sup>, a higher value of effective dose in a single year could apply, provided that the average effective dose over five consecutive years does not exceed 1mSv per year;
- (c) An equivalent dose to the lens of the eye of 15 mSv in a year;
- (d) An equivalent dose to the skin of 50 mSv in a year.

#### 3.3 Non-uniform Exposure

In the case of non-uniform or partial exposures, account must be taken of the contribution of different organs to the overall stochastic effects on the body. The effective dose  $E$  must then be calculated with the use of tissue weighting factors, representing the contribution from different organs or tissues (see Glossary).

### 3.4 Equivalent Dose Limits

The restriction on effective dose specified in sub-paragraph 3.1 is sufficient to ensure the avoidance of deterministic effects in all body tissues and organs except the skin and the lens of the eye. Additional *equivalent dose limits* are needed for these tissues. The annual limits are 20mSv for the lens of the eye and 500 mSv for the skin averaged over any 1 cm<sup>2</sup>, regardless of the area exposed. The latter limit is also applicable to the hands and feet.

### 3.5 Annual Limits on Intake

Annual limits on intake (ALI's) for a number of radionuclides are given in ICRP Publications 61. These ALI's are based on a committed effective dose of 20 mSv. Estimated intakes may be averaged over a period of 5 years to provide some flexibility. Where necessary, the intake of nuclides must be added to the external exposure, as described on page 1.

The ALI values are frequently used to find derived levels of concentrations of radionuclides for the purpose of implementing control measures in practice. In this way, Derived Air Concentrations (DAC) are found which describe those concentrations of radionuclides in air which, when inhaled during normal working hours for one year, will lead to the annual limit of intake (ALI). In a similar fashion, taking cognisance of the mode of intake, other concentrations can be established in particular situations that could lead to the ALI.

### 3.6 Rate of Dose Accumulation

No further restriction is placed on the instantaneous rate or the rate at which the equivalent dose may be accumulated, except in the case of pregnant women. However, it is advisable that the management of an institution implement such restrictions from the point of view of administrative control.

### 3.7 Previous exposure unknown

If the previous exposure cannot be derived conclusively, it shall be assumed that the worker has received a dose equal to the currently recommended equivalent dose limit (20 mSv) in each year of any given period.

### 3.8 Exposure of women of reproductive capacity

The prescribed dose limits for the control of the occupational exposure of women who are not pregnant are the same as those for men. No special requirements are necessary.

### 3.9 Exposure of pregnant women

When pregnancy has been diagnosed, the conceptus must be protected by applying a supplementary equivalent dose limit to the surface of the woman's abdomen (lower trunk) of 2 mSv for the remainder of the pregnancy and by limiting intakes of radionuclides to less than 1/20 of the ALI. Arrangements should be made to ensure that the pregnant woman performs work which is of a type that does not carry a significant probability of high accidental doses and intakes.

### **3.11 Abnormal exposures**

Doses received under abnormal circumstances should be recorded together with, and clearly distinguished from, normal exposures.

(a) *Emergency exposures*

Exposures in excess of the recommended dose limits are acceptable in operations during or immediately after an emergency, to save a life, to prevent injuries, or to prevent a substantial increase in the scale of the incident. Such exposures are voluntary and should not exceed 0.5 Sv, except for life-saving actions. The equivalent dose to skin should not exceed 5 Sv, again except for life-saving actions. Once the emergency is under control, remedial work must be treated as normal occupational exposure.

(b) *Accidental exposures*

Accidental exposures in excess of the limits recommended for normal practice differ from emergency exposures in that they are unavoidable and unforeseen. For this reason no dose limits are set for such exposures. Levels must be limited by equipment design, protective features and the provision of emergency procedures.

If a dose or intake of radioactive material exceeds twice the annual limit, the situation should be reviewed by the appointed doctor.

### **3.12 Potential Exposures**

Dose limits do not apply directly to potential exposures. For potential exposures, risk limits (which take account of both the probability of incurring a dose and the detriment associated with that dose), rather than dose limits, should be applied. In addition, the detriment associated with possible intervention (should the event occur) should be taken into account. ICRP 60 should be consulted in this regard.

## **4 CLASSIFICATION OF WORKPLACES AND DOSIMETRY**

In order to facilitate the control of occupational exposure, workplaces containing sources of radiation must be formally designated as controlled or supervised areas, the aim being to ensure that anyone outside the designated areas need not be regarded as occupationally exposed. The designation should be based on operational experience and judgement, and must take account of the expected level and likely variations of doses and intakes, as well as the potential for accidents.

### **4.1 Controlled Areas**

A controlled area is one in which normal working conditions, including the possible occurrence of minor mishaps, require the workers to follow well-established procedures and practices aimed specifically at controlling radiation exposures.

### **4.2 Supervised Areas**

A supervised area is one in which the working conditions are kept under review, but special procedures are not normally needed.

### **4.3 Personal Dosimetry**

All occupationally exposed workers should be subject to individual monitoring for external radiation unless it is clear that their doses will be consistently low or, as in the case of air crew, it is clear that the circumstances prevent the doses from exceeding an identified value.

Individual monitoring for intakes of radioactive material is usually much more difficult, and should be used routinely only for workers who are employed in areas that are designated as controlled areas specifically in relation to the control of contamination and in which there are grounds for expecting significant intakes.

## 5 PUBLIC DOSE LIMITS

- 5.1 The scope of dose limits for public exposure is confined to the doses incurred as a result of practices. Situations which can only be influenced by intervention (e.g. radon in dwellings and in the open air, radioactive materials, natural or artificial, already in the environment, and other natural sources) are thus excluded. See Section 3.2 for values.

### SUMMARY OF DOSE LIMITS

APPLICATION	OCCUPATIONAL DOSE LIMIT	PUBLIC DOSE LIMIT
Effective Dose	* 20 mSv per year, averaged over 5 years, and not more than 50 mSv in any 1 year.	** 1 mSv per year
Annual Equivalent Dose to lens of the eye skin hands and feet	20 mSv 500 mSv 150 mSv	1 mSv 5 mSv 1 mSv

\* Additional restrictions apply to the exposure of pregnant women (see paragraph 3.8)

\*\* In exceptional cases, this may be exceeded provided that the average over 5 years is less than 1mSv per year.

## GLOSSARY

*Deterministic effects* (previously termed non-stochastic effects) are those for which the severity of the effect varies with the dose, and for which a threshold may therefore occur, for example, lens opacification, or loss of function of other organs.

*Effective dose* in Sievert (Sv) (previously termed the effective dose equivalent) is the sum of the weighted equivalent doses in all the tissues and organs of the body. The weighting factor to be used is the tissue weighting factor,  $w_T$ . A uniform equivalent dose to the whole body gives an effective dose numerically equal to that uniform equivalent dose. If the equivalent dose to an organ with weighting factor  $w_T$  is  $H_T$ , the effective dose is given by:

$$E_T = w_T \cdot H_T \dots \dots \dots Eq1$$

Gonads	0.2
Red bonemarrow	0.1
Colon	0.1
Lung	0.1
Stomach	0.1
Bladder	0.0
Breast	0.0
Liver	0.0
Oesophagus	0.0
Thyroid	0.0
Skin	0.0
Bone surface	0.0
Remainder	0.0

For further details of calculations consult ICRP publication 60 (ref. 1). *Equivalent Dose* in Sievert (Sv) is the absorbed dose (in gray) averaged over a tissue or organ and weighted for the relevant radiation quality. The **equivalent** dose in tissue T is given by the expression

$$H_{T,R} = w_R \cdot D_{T,R} \dots \dots \dots Eq2$$

where  $D_{T,R}$  is the absorbed dose average over the tissue or organ T, due to radiation R and  $w_R$  is the radiation weighting factor (previously called quality factor).

Values of  $w_R$  are given in the following Table 2:

Photons (e.g. Gamma and X-radiation):	1
Muons and Electrons (e.g. Beta Radiation):	1
Neutrons less than 10 keV:	5
Neutrons 10keV-100 keV:	10
Neutrons more than 100keV-2 MeV:	20
Neutrons more than 2 MeV-20MeV:	10
Neutrons more than 20 MeV:	5
Protons, other than recoil protons, energy >	5
Alpha Particles, fission fragments, heavy nuclei:	20

*Medical exposure* refers to the exposure of patients in the course of medical procedures and not to the exposure of the personnel conducting or incidentally associated with such procedures.

*Stochastic effects* are those for which the probability of an effect occurring, rather than its severity, is regarded as a function of dose. Stochastic effects include somatic effects (such as fatal or non-fatal cancers occurring in exposed individuals) as well as hereditary effects (effects transmitted to future generations).



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