

GOHNET NEWSLETTER NO. 22

November 2013 Edition

IMPROVING WORKERS' HEALTH WORLDWIDE:

Implementing the WHO Global Plan of Action on Workers' Health

Dear Reader,

Welcome to issue 22 of the e-GOHNET newsletter, in which you will find a rich array of articles on workers' health. For your information, we have included the activities of the Global Master Plan, which is the work plan of the WHO collaborating centres for occupational health until 2017. In 2018, we need to report to the World Health Assembly on the implementation of this plan and our aims are ambitious but achievable together with our partners.

As you may know, we have developed an electronic mailing list to facilitate the exchange of information - as well as encourage discussions about - GOHNET topics and occupational health topics in general. If you would like to join this mailing list please send an email, with the Subject line "Add me to the list", to E-GOHNET@LISTSERV.WHO.INT

Enjoy your reading.

Evelyn Kortum
Editor

ochmail.who.int

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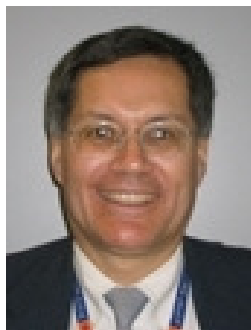
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Workers' health and social determinants of health – new opportunities in WHO Headquarters



As of 1 November 2013 the Unit on Social Determinants of Health joined the Public Health and Environment Department at WHO Headquarters. The department is now called Public Health, Environmental and Social Determinants of Health under the directorship of Dr Maria Neira. This provides renewed opportunities for linking action on workers' health to social determinants, in particular employment and occupation. Dr Eugenio Villar, a medical doctor from Peru, is the coordinator for social determinants of health.

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Globalization often results in sub-standard, or precarious employment, hazardous work and, international or domestic labour migration. In most cases, these forms of work are also associated with exposure to occupational hazards, physical and mental abuse, and long working hours. Therefore, in 2008, the Commission on Social Determinants of Health - set up by WHO - called for full and fair employment as a shared objective of development and a condition for achieving health equity and improving workers' health. The work of the knowledge network on employment conditions (EMCONET) provided a rigorous analysis on how employment relations affect different population groups, and how this knowledge may help identify and promote worldwide effective policies and institutional changes to reduce health inequalities derived from these employment relations.

Following the 2011 World Conference on Social Determinants of Health in Rio, WHO is developing strong partnerships with key institutions, including the collaborating centres. An electronic discussion platform was created to stimulate debate and share experiences of improving health equity through addressing the social determinants of health. We invite you to join this debate at www.actionsdh.org

Links: EMCONET report: http://www.who.int/social_determinants/resources/articles/emconet_who_report.pdf

For full information on WHO action regarding social determinants of health visit http://www.who.int/social_determinants/en/

The Global Master Plan for workers' health

2012-2017

Dr Maria Neira, WHO Director for Public Health, Environment and Social Determinants of Health, approved the global work plan of the collaborating centres for occupational health (CCs), which is called the Global Master Plan (GMP). The GMP was adopted by the 9th Meeting of the global network of WHO CCs in Cancun, March 2012, and will be updated by the 10th Meeting of the Global Network of WHO CCs in 2015. It provides a framework for joint work between the WHO Secretariat (Headquarters and the Regional Offices) and WHO CCs and nongovernmental organizations (NGOs) in official relations with WHO and other partners, to implement WHO-mandated work under the Global Plan of

Action on Workers' Health (2008-2017), the Mid-Term Strategic Plan, and the WHO Programme Budget for 2012-2013 in the area of workers' health.

The work will be achieved through working groups that will develop the products listed in the GMP (see table below) in the following areas:

- Regional and national programmes on occupational noncommunicable diseases (NCDs) with a focus on cancer, silica and asbestos-related diseases.
- National programmes and good practices for occupational health and safety of health workers.
- Tools, standards and capacities for healthy workplaces.
- Strengthening health systems, governance, capacities and service delivery for workers' health.
- Occupational health aspects of emerging technologies.
- Classification, diagnostic and exposure criteria for occupational diseases.
- Occupational health and safety for vulnerable groups and high risk sectors.

Each working group will submit a progress report to the WHO focal point by 31 January of each year and contributions made by the individual CCs and NGOs will be included in their annual reports to WHO. Successful achievements will be featuring in GOHNET newsletters, as well as be disseminated through social media.

The GMP (with its priorities, products and major activities) can be found at: http://www.who.int/occupational_health/network/en/

Global Working Groups active as of November 2013

Working Group	WHO focal point	Chair	Subgroups and leaders (if applicable)
GMP3: Healthy Workplaces	Evelyn Kortum	n/a	Tools and Training for healthy workplaces Standards for workplace health protection
GMP4: Services, capacities and governance for workers' health	Ivan Ivanov	Leslie Nickels	Interventions for workers' health in primary care Capacity-building for basic occupational health National policies and action plans for workers' health
GMP5.1: Workers' Health in Adaptation to Climate Change	Ivan Ivanov	n/a (ad hoc working group)	n/a
GMP5.2: WHO NANO H guidelines	Evelyn Kortum	Vladimir Murashov	WHO guidelines development group
GMP6: Occupational diseases	Ivan Ivanov (in collaboration with Shengli Niu, ILO)	Anil Adisesh	Global working group on occupational health in ICD11 (Anil Adisesh) Diagnostic criteria for occupational diseases (Shengli Niu/Claudio Colosio)

Nanotechnology and human health

Nanotechnology (the development and use of matter at a scale below 100 nanometres) is bringing about important societal benefits in many domains of human life, improving quality of life, wellbeing and health, through a variety of applications, existing and projected. Research and commercial applications for nanotechnology are already widespread and more will be coming into

existence in everyday life, including medicines, fabrics, cosmetics, food additives, and many consumer products.

As it is often the case for new technologies, there are also concerns about the unwanted – and possibly adverse - effects of nanomaterials, notably on human health. Little is known, however, about the extent of human exposure to different kinds of nanomaterials and the possible risks and health effects, some of which may only become apparent after long latency periods.

Health issues: Current evidence on the biological effects of nanomaterials is inconclusive. Traditional toxicology and risk assessment methodologies have limitations, and innovative models and frameworks for risk governance are needed to inform policy¹.

Available evidence, however, suggests that a cautionary approach may be appropriate for several reasons: (i) humans have limited evolutionary experience of nanomaterials - a possible reason for the diminishing ability of cells to interact with particles as their size decreases to nanoscale; (ii) nanoparticles can enter the body with relative ease through multiple pathways and are very mobile once inside the body; occupational and consumer exposure to nanomaterials can occur through inhalation (the main source of intake), ingestion and consequent gastro-intestinal assimilation, and skin absorption; (iii) several chemical-physical mechanisms resulting in cell damage have been reported; (iv) effects are often dependent on particle size, with a tendency to become more active as the particle size decreases; (v) population exposure to nanomaterials is not well known, but may be or become high, for example through cosmetics or food additives; (vi) potential adverse effects include a broad spectrum of adverse effects, specific and a-specific. The need for caution is reinforced by the reported asbestos-like action of carbon nanotubes in animal models and acute exposure episodes, including in workers.

The way forward: Since the use of nanotechnology in many domains of human activity is expected to grow substantially, it is important that the health implications are periodically assessed and that evidence is carefully evaluated as soon as it becomes available. Health implications for groups that may be more biologically vulnerable to harm, such as children and elderly people, are an area of particular concern.

The role of occupational exposures (currently being evaluated by WHO) is of great importance in order to make progress in the understanding of the possible health implications of nanomaterials. As for other physical-chemical agents, workers may represent a population with higher-than-average, measurable and specific exposures, allowing an assessment of health effects, and the generation of research hypotheses.

Given the complexity of the issue, the importance of carefully balancing risks and benefits, and the many different interests surrounding nanotechnology, needs open and transparent consultation processes to ensure the development of fair and health-friendly policies and regulations.

Contributed by: Marco Martuzzi, WHO European Centre for Environment and Health, World Health Organization, Regional Office for Europe, martuzzim@ecehbonn.euro.who.int

Reference

1. Nanotechnology and human health: scientific evidence and risk governance. Copenhagen, WHO Regional Office for Europe, 2013. Available at <http://www.euro.who.int/EH-Nanotechnology-health-evidence-2012>

First meeting of the Guideline Development Group on manufactured nanomaterials

The Guideline Development Group (GDG) - which works towards the development of WHO guidelines on protecting workers from manufactured nanomaterials - had their first face-to-face meeting

in Johannesburg, South Africa, from 30 September to 1 October 2013 by invitation of the National Institute of Occupational Health (NIOH), a WHO collaborating centre for occupational health.

The process to develop these guidelines was initiated in 2011 by WHO. In 2012, the GDG was established and through its experts it reflects the diversity of manufactured nanomaterials and manufacturing processes on the global scale and the cultural differences of workplace safety. The GDG oversees important elements in the guideline development process such as methodological issues, and, drafting guideline text. The GDG also identified ten key questions to be addressed by the guidelines through a Delphi process of consensus seeking. This step is now being followed by the preparation of systematic evidence review papers and guideline recommendations for each of the identified key questions.

The guidelines will provide an urgently needed, authoritative, and globally accepted assessment of nanomaterial hazards and exposures, and recommendations for improving working conditions in nanotechnology workplaces with a focus on workers in low- and medium-income countries.

WHO is still looking for systematic reviewers from the collaborating centres, NGOs and/or other partners. Please contact Evelyn Kortum (kortume@who.int) if you are interested.

Link to the WHO website: http://www.who.int/occupational_health/topics/nanotechnologies/en/

WHO priorities for workers' health in Europe: Overview of the WHO CC meeting of the European region from 21-23 October 2013 at the BAuA in Dortmund

In implementing the Global Plan of Action on Workers' Health (GPA), 2008-2017, WHO is supported by a global network of 57 collaborating centres for occupational health (CCs) working under multi-year work plans. In 2012, WHO agreed with the CC network a Global Master Plan (GMP) of activities to implement the GPA for the period 2012-2017. This work plan includes several specific European products that require coordination of activities of CCs in the region. This was the main purpose of the meeting of the European CCs, organized by the WHO Regional Office for Europe and the German Federal Institute for Occupational Safety and Health (BAuA) from 21 to 23 October in Dortmund, Germany.

During the three-day meeting, 40 participants from the 24 occupational health centres, the WHO European Centre for Environment and Health, and the WHO Global Occupational Health Programme, reviewed the ongoing activities, opportunities, and challenges for implementing the GPA in the region and the further collaboration in the context of major international public health developments such as the European policy for health and well-being (Health 2020), prevention and control of non-communicable diseases (NCDs), and universal health coverage.

The discussion was focused on:

- prevention of NCDs such as, occupational cancer, asthma, chronic obstructive pulmonary, and, cardio-vascular diseases through interventions on occupational risks and workplace health promotion;
- national profiles and programmes for the elimination of asbestos related diseases;
- creating national profiles on structures and organization of occupational health as the initial part of national programmes for improving occupational health services in the European region, and;

- current needs for extending coverage and improving the quality of occupational health services in the European region.

Conclusions: Participants encouraged improved information sharing between WHO and CCs and, in particular, emphasised the increased use of GOHNET for presentation of their work. They expressed the interest to receive feedback on a WHO CC survey performed by WHO more than a year ago on their input to the GMP and called for web publishing of the GMP as the main framework document for their work planning.

In relation to the elimination of asbestos-related diseases, it was agreed to organize and involve smaller groups of CCs to support the WHO European region Member States in developing national programmes for their elimination.

Four existing CCs in South-East Europe (SEE) will serve as the framework support to the SEE Network on workers' health in developing products agreed and defined in the Bucharest Statement for all nine Member States participating in the SEE Network. The opportunity for further networking should be used in WHO European region-wide actions for promoting and protecting workers' health and in particular for collaboration between the SEE Network and the Baltic Sea Network.

The network of CCs will be used as the resource for developing tools and actions on NCD prevention and control at the workplace under the WHO "2008-2013 Action plan for the global strategy for the prevention and control of NCDs" and the WHO Regional Office for Europe "Action plan for implementation of the European Strategy for the Prevention and Control of NCDs, 2012–2016".

Models of good practice for the integration of occupational health into the national health systems - developed as occupational health profiles - should be collected as the first step towards the development of national health programmes relevant to the protection of workers' health. CCs will contribute to the development of most appropriate indicators to measure the progress.

All participants emphasised the need to hold such meetings on a regular basis to develop and maintain closer connections.

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Further Reading

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2008-2013 Action Plan for the global strategy for the prevention and control of noncommunicable diseases.

Adopted by 61st World Health Assembly (WHA), World Health Organization, A61/8, 18 April, 2008. Available at:

http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf

Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016. Adopted by WHO Regional Committee for Europe, EUR/RC61/R3, Baku, Azerbaijan, 15.9.2011, Available at:

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News from WHO collaborating centres and partners

New e-training on psychosocial risk management

An online training platform, PRIMA-eT, for psychosocial risk management has been collaboratively developed by a consortium of WHO collaborating centres for occupational health (Centre for Organizational Health & Development, University of Nottingham, UK; INAIL, Italy; BAuA, Germany; and FIOH, Finland) with financial support from the European Commission's Lifelong



Learning Programme.

PRIMA-eT is part of the work plan of the WHO network of collaborating centres for occupational health. Access is provided to an online platform including nine modules on psychosocial risks, work-related stress, bullying/mobbing and their management, as well as specific advice for employers, employees and their representatives, and occupational health professionals. Materials include case studies, podcasts, guidance, videos, and short quizzes. PRIMA-eT is currently available in 6 languages (English, French, German, Italian, Polish, and Finnish).

The aim of this freely available e-training is to raise awareness on psychosocial risks and their management. The platform is flexible and can be adapted to suit local needs. To use the platform as it is, you can directly access the training through the above link. If you would like to collaborate with the consortium in its WHO work plan by adapting the platform to use it in your country or by providing the e-training in further languages, please get in touch with Dr Stavroula Leka or Dr Aditya Jain.

Links: PRIMA-eT (Psychosocial Risk Management e-training) is accessible through this link: <http://www.prima-ef.org/primaet.html>

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The British Heart Foundation inspires and equips workplaces to improve the health and well-being of their employees

The British Heart Foundation's (BHF) Health at Work programme promotes health in the workplace. The programme aims to provide workplace health coordinators (usually someone in HR, OH or H&S) with the information, tools and motivation they need to introduce and sustain a health at work scheme. The programme also helps employers to make the connection between a healthy active workforce (with increased productivity, morale and inter-organisational communication) and reduced ill-health, sickness absences and staff turnover. Our work is in line with the WHO global model for

healthy workplaces which highlights the importance of promoting health at work to prevent and control non-communicable diseases such as heart disease.

The programme is very much in line with the WHO Five Keys to Healthy Workplaces including providing personal health resources to support and encourage a healthy lifestyle. Organisations signed up to the programme to gain access to a wide range of resources, a telephone helpline, online community, training sessions and a monthly e-newsletter, and a handy toolkit covering heart health- related topics such as, stop smoking, healthy eating, physical activity and mental well-being, including promotional material and detailed information on health impact on employees and the organisations as well. With more than 6,000 organisations registered, the programme has taken a leading role in promoting workplace health in the UK. In the past three years we have reached over 7,000 individual employees through our health and well-being days – our onsite health initiative delivered by heart health practitioners promoting heart health messages in a fun and interactive way. Employees are involved in the management process of the implementation of health initiatives and since 2010, we have trained over 600 workplace health coordinators in how to gain support from senior management, activities easy to implement and run, and supported them to take action, for example, in how to evaluate the programme and make improvements to create sustainability.

Organisations can also find out how to create a healthy workplace and download information, news, fact sheets and health initiatives, from the Health at Work website. The website has received the patient information award by the British Medical Association.

“The BHF Health at Work programme is an excellent initiative – it’s given me insights into what is available and what I can do. I used the website to get guidance on questionnaire design for our survey. It has been invaluable – it’s focused my mind on the issues – it’s like a library I can refer to.” David Johnston, Dept. for Social Development, Northern Ireland.

And yes, we practice what we preach at BHF too. Our dieticians help to plan the menus in the canteen and there are 11 weekly activity classes taking place onsite at lunchtime and after work. We continually look to improve the programme and to expand our resources to include a focus on alcohol, providing activity resources, such as pedometer challenge packs, and also support workplaces in specific industries or with particular difficulties e.g. shift workers.

International organisations can join too and gain access to all our free downloadable resources. Sign up online at bhf.org.uk/healthatwork.

Relevant links: http://www.who.int/occupational_health/healthy_workplaces/en/index.html

Contributed by Ann Liljas, Project Officer, British Heart Foundation, healthatwork@bhf.org.uk

Reducing the underreporting of occupational health problems in Brazil

The labour laws in Brazil have traditionally been modeled on tripartite agreements between the federal government, representatives of employers and workers as advocated by the International Labour Organization (ILO).

Although workers’ rights to health are formally defined in the Federal Constitution, economic interests often prevail over workers’ health since government actions to protect workers are determined by auditing self-declared company documents about their working conditions, with a low capacity for effective inspections by the State. In spite of difficulties with labour inspections and enforcing occupational health and safety standards, important national and regional actions with great social

support have triggered positive processes of change, which are important to reinforce the State's role on safeguarding workers' rights.

To that effect, an important decision was taken by the federal government in 2007, which underpins a historical moment for reducing underreporting of occupational health problems. A new epidemiological criterion was included in the existing system, clarifying the causal link between some work activities and injuries/illnesses for the purpose of granting compensation for work-related problems and disabilities. This new approach to recognize workplace problems helped to create an information system capable of effective monitoring and implementation of preventive actions at the regional and national levels - such as suggested by the fourth priority of the WHO Global Master Plan on Workers' Health that deals with strengthening health systems, governance, capacities, and service delivery for workers' health.

According to Brazilian law, there have been approximately 200 occupational diseases recognized for more than 20 years. Since 2007, the Social Security Agency began to recognize these problems in relation to their statistical significance in the economic branch of activity of the workers' company. This decision to track most underreported occupational health problems resulted in the recognition of thousands of problems such as musculoskeletal injuries and mental health problems - largely unattended health issues in Brazilian workplaces for many years. For example, in 2006, the Social Security granted 125 accident benefits for occupational depressive episodes and in 2007 already granted 3,584. The number further increased, as in 2008 there were 5,117, in 2009 there were 4,714 and 4,048 accident benefits in 2010. Although the decrease from 2009 deserves to be carefully studied, many work organizational issues were associated with episodes of depression which might have created some incentives for companies to pay greater attention in improving their work organization systems.

Another possibility may be that companies might have developed new management mechanisms to hinder the actual cases of occupational injuries/illness in which they need to pay their share on Social Security insurance premiums. The inclusion of an epidemiological criterion in the evaluation of benefit claims represents a significant advance that will facilitate to target specific economic sectors and which will hopefully lead to improve working conditions and the wider coverage for sick workers in Brazil.

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A Croatian national occupational health programme for health workers: 2013-2020

The Republic of Croatia, which is a post-communist transitional developing country, has recently undergone fundamental structural changes. Even though the health sector has educated health workers, they may be reluctant to remain in their jobs and the health workers shortage is one of the most pressing and serious issues. However, during the tourist seasons, some hospitals suffer from additional health worker shortage due to an increased number of patients. According to the Croatian Medical Chamber and the Croatian Nursing Council, in 2011 the estimated shortage of healthcare workers included 4,300 medical doctors, while the estimates for nurses vary from 3,000 to 6,000 and even to 13 000¹.

Consequently, the Ministry of Health decided to develop the *National Occupational Health Programme for Health Workers 2013-2020*. At this very moment the Programme is ready to be accepted by the Croatian Parliament. The Programme was developed in cooperation with the WHO

collaborating centre of Croatia, the Ministry of Labour and Pension System, the Croatian Institute for Health Insurance, the National Council for Occupational Safety, the Croatian Institute for Health Protection and Safety at Work, the National Committee for Prevention and Control of Healthcare-Associated Infections, the Croatian Medical Chamber, the Croatian Chamber of Nurses, the Croatian Medical Association, the Croatian Nurses Association, the Croatian Society for Occupational Medicine, four trade unions in the health sector, and other relevant institutions responsible for the protection and promotion of health worker health and safety in the private as well as public sector.

The overall objective of the Programme is to provide an approach on how to improve productivity and quality of life of health workers as a strategic goal to support the health system to cope with the shortage of future health workforce. The keys to achieve this are to promote psychosocial and psychobiological sustainability of hospital health workers over the whole working life and to accomplish a specific management approach. To get human sustainable performance at their workplaces it is necessary to create and implement cultural, structural and personal measures.

This work also blends in with the global work plan of the WHO collaborating centres for occupational health who were asked to work on a *WHO/ILO global framework and guidance for the development of national occupational health programmes for health workers*. The Croatian collaborating centre will coordinate the *South East European network for collaboration on occupational health and safety of health workers*^{2,3}.

Contributed by: Professor Jadranka Mustajbegovic, MD, PhD, University of Zagreb, School of Medicine, Andrija Stampar School of Public Health, a WHO collaborating centre for occupational health

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2. http://www.who.int/occupational_health/publications/newsletter/newsletter_17_global_issues/en/index.html
3. <http://www.cdc.gov/niosh/ccc/CCCnewsV2N6.html>

Injury prevention, occupational rehabilitation and compensation: towards a more integrated approach to ensure workers' health in Brazil

After many years of social deliberations, the Brazilian government enacted two important legal provisions in relation to the National Policy for Workers' Health: enactment n° 7.602 signed by the President and three government agencies (the Ministries of Labour, Health, and Social Security); and resolution n° 1.823 signed by the Ministry of Health in the context of their mandate to oversee the Brazilian Unified Healthcare System. In summary, these new regulations prescribe that all actions related to prevention of accidents/diseases, workplace surveillance and occupational rehabilitation, are de facto components in a comprehensive approach to caring for workers' health. Vocational rehabilitation and compensation are legal responsibilities of the Social Security Agency. However, actions in these spheres must now be integrated with the efforts mentioned above.

Despite these directives, many challenges lie ahead to assure that operational arrangements are made so that workers' health is addressed comprehensively as agreed by all governmental agencies, and as recommended by the WHO Global Plan of Action on Workers' Health (2008-2017). A particular preoccupation in emerging economies such as Brazil concerns the fact that once a worker is injured in his/her job, there is as yet no systematic approach that can support early return-to-work as

advocated by international best practices¹. In the current context, effective work reintegration depends on how prevention is done at all levels, i.e. injury occurrence, aggravation of an existing medical condition, and the progression to work disability. The quality and accessibility of occupational health, rehabilitation and compensation services – which varies widely across the country – are also important determinants of whether it is possible for injured workers to return early to productive work-life.

Since 2007, a group called the “Brazilian Network for Social Support and Research on Prevention and Rehabilitation of Work Incapacity” - in partnership with several governmental organizations (in particular FUNDACENTRO, the research agency of the Ministry of Work and Labour) - began to advocate around these issues, raising awareness among local communities on best practices in occupational rehabilitation and incentivizing programs for prevention of work incapacity linked with workplace surveillance. This Network has organized several workshops, conferences and training with the intention to engage local and regional communities in order to assist them with their everyday challenges in the occupational rehabilitation sphere. Pilot projects led by a few Workers’ Reference Centers have been developed aiming to test the possibility of integrating workplace surveillance and other occupational health services actions in parallel with operating a return-to-work system with coordinated efforts and use of evidence-informed practices. Thus far, the consensus is that a more customized framework for actions that connect healthcare, prevention, and compensation must be developed considering the major intra-national socioeconomic differences that exist in Brazil, particularly when it comes to the regional profile of companies.

This ongoing Network is committed to expand its reach and continue in the direction of the development of a formal Community of Practices where new knowledge and solutions can be created and operationalized in different levels from the local (municipalities) to the national level, with the long-term aim of facilitating implementation of an integrated system for healthcare and social protection for the Brazilian workforce.

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A New Zealand (Aotearoa) perspective of ‘Healthy Workplaces’ and Te Whare Tapa Wha

In 2010 I commenced a journey of engaging with hundreds of staff in their teams, of a large multi-disciplinary healthcare service in New Zealand, as part of my Masters of Health Science. At that time WHO defined their view of a ‘Healthy Workplace’ and the ‘model for action’. This was excellent timing, as it gave me a basis to start discussion on what made a healthy workplace from a ground level

¹ Many examples of successful return-to-work systems can be found in Scandinavian countries, Germany, the United Kingdom and Canada. They basically appoint to the need to avoid long work absences and propose a coordinated and progressive return-to-work after injury/illness.

perspective. In addition, WHO and a Māori definition of health, *Te Whare Tapa Wha* (Durie, 1982), was added as part of the foundation for discussion.

Health: “A state of complete physical, mental and social well-being and not merely the absence of disease”¹.

Te Whare Tapa Wha (four cornerstones of health): The concept of a Māori health model was first identified in the early 1980’s from a survey of women’s health with the Māori Women’s Welfare League. *Te Whare Tapa Wha* was noted as an anchor for the survey, a holistic approach, appealing widely with acknowledgement of the importance of spirituality. With previous approaches based on



disease rates and impacts, this model was said to make “...sense to Māori, it was possible for Māori communities to experience a sense of ownership and to balance medical and professional dominance with community involvement and local leadership”².

Te Whare Tapa Wha is a “system of health, based on Māori epistemologies where health is comprised of four main areas or pillars: *te taha wairua* (spiritual health), *te taha hinengaro* (psychological health), *te taha tinana* (physical health) and *te taha whanau* (social/family health)”³. With a focus on equal sides and strong foundations, it identifies that if one part is missing or damaged, this will

lead to an individual becoming unwell or not balanced, with the essential elements of well-being out of alignment⁴. Many years on, the model is used in numerous areas from policy, health, education and endorsed as a framework in mental health⁵.

‘Healthy Workplaces’ and *Te Whare Tapa Wha*:

It became very evident early on that the staff immediately engaged with this model of health, and many have worked with and use this model in everyday practices. The synergies with the WHO ‘Healthy Workplaces’ definition in the four areas, was quickly identified. This led to a more engaged interaction with many of the team members: it made sense; they could relate to it; it was familiar and they liked its holistic viewpoint. When working with the cultural teams, Māori and Pacifica, it was obvious that they aligned with it quickly, as this is the way that they practice - it is part of their culture and values. As many of the staff related to *Te Whare Tapa Wha*, maybe it is time to recognize that a holistic view is far more

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beneficial and acceptable to the majority and that the WHO Healthy Workplace model will achieve more success as a quality improvement because of this alignment.

“He aha te mea nui te ao?”

**He tāngata
He tāngata
He tāngata**

“What is the greatest treasure in the world?”

It is people. It is people. It is people
(Māori proverb)

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- 1 World Health Organization, (WHO). 1948. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. <http://www.who.int/about/definition/en/print.html>
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Do we need to redefine occupational health terminology?

In many countries, occupational diseases (OD) and Work-Related Diseases (WRD) are either not diagnosed or are not reported correctly and, therefore, they are significantly underestimated. For this reason, in 2013, the International Labour Organization (ILO) declared occupational diseases as a "hidden epidemic"¹. According to the data published in GOHNET issue12, in Latin American countries, only 1-5% of the occupational diseases are reported². The ILO, this year, also declared that the estimated number of non-fatal occupational diseases around the world should be around 160 million per year¹. However, in reality, only few of these cases are diagnosed and reported correctly.

We think that the number of cases that are diagnosed and reported correctly is only about 1 million worldwide. For example, given the fact that 1/4th-1/5th of the world's population lives in China, the number of annually reported cases should be around 30-40 million. However, according to the 2013 ILO report, the number of reported cases in China in 2010¹ was only 27,420. Similarly, according to the data from a survey completed in European Union (EU) countries, 8.6% of the working population between 15 to 64 reported suffering from at least one work-related health problem³. Considering the number of the working population in all of the EU countries, the number of reported WRD cases should have been about 23 million³. However, in reality, the number of reported OD cases was less than 140,000⁴. The picture is not much different in Turkey, and, a recent study shows that about 3.7% of the working population suffer from WRDs⁵. Again, considering the number of workers is about 11 million, the number of reported OD cases should have been about 400,000. The reality is that the number of annual reported OD cases in Turkey is most of the time less than 1,000.

Although there are many reasons why ODs are underdiagnosed, underreported, and underestimated, we believe the first step would be to correctly define and discuss the terminology of this "hidden epidemic", because:

1. the medical OD term is an etiologic definition. As discussed in a recent issue of GOHNET², about 300 years ago, Ramazzini - considered "the father of occupational medicine" - urged his colleagues to always ask their patients about their occupation. Unfortunately, even today, not all physicians ask this key question². We believe that not only must we ask our patients what their occupation is, but, we must also ask them about the types of exposures in their workplace/environment.

2. all ODs are not legal ODs (definition used by insurance companies, not a medical term). However, all ODs are medical ODs. All legal ODs require compensation and disability benefits. In medicine, OD is defined in very general terms. Medical ODs include WRDs, work aggravated diseases, ODs, and legal ODs.
3. if diagnosed at an early stage, the effect from OD/WRDs can be reversible. Since legal ODs fall into a different category, we believe it is more appropriate to define them as “quaternary prevention”. At this stage, persons diagnosed with legal ODs require disability benefits and/or compensation, based on the degree of disability.

In conclusion, ODs/WRDs are underestimated worldwide. This problem needs to be addressed and solved together, and, to do this correctly, we first need to define the terminology correctly to change the paradigm. For this purpose, we first must discuss and redefine the following terms: medical ODs, legal ODs, etiologic definition, tertiary-quaternary prevention, and disability-compensation.

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Promoting health equity by addressing the needs of health workers: a collaborative international initiative

Health workers globally face difficult working conditions. Moreover, the occupational risk of tuberculosis (TB) now includes multiple and extreme-drug resistant (MDR and XDR-TB)¹. The 5-year collaborative research programme described here was conceived to address gaps identified in these WHO-ILO-UNAIDS guidelines to improve health worker access to HIV and TB prevention, treatment, and support², and to expand knowledge on promoting health equity through improving working conditions for health workers. This initiative addresses three objectives of the *Global Plan of Action for Workers Health*: objective 2- to protect and promote health at the workplace; objective 3- to improve the performance of and access to occupational health services; and objective 4- to provide and communicate evidence for action and practice³.

The projects we are conducting in South Africa follow on from our earlier multi-stakeholder capacity-building work^{4 5 6 7}, and include a cluster randomised controlled trial in 27 hospitals in Free State province to strengthen occupational health and infection control and to improve access to HIV and TB services in the workplace. All hospitals are offering, 1) regular workplace assessments and targeted incident-based infection control assessments, 2) voluntary confidential TB screening and testing, as well as HIV counselling and testing, 3) TB prophylaxis for HIV-positive staff, and

4) TB treatment. Fourteen randomly chosen hospitals will also offer workplace access to, 5) HIV treatment and, 6) a stigma reduction campaign. We are developing, piloting and implementing the data collection instruments to evaluate success of all these various interventions.

At a hospital in Gauteng province we are also studying the implementation of infection control, conducting environmental sampling to quantitatively assess the degree of risk from TB in different hospital locations. Additionally, we are continuing to study the implementation of the web-based Occupational Health and Safety Information System (OHASIS) in several hospitals in Free State and across the country in over 250 sites of the National Health Laboratory System⁸.

Meanwhile, building on our previous work^{9 10} with the Ecuadorean Ministry of Health and the Pan American Health Organization, we are organizing an intervention study to improve working conditions for health workers in ten hospitals across Ecuador.

Finally, we are also exploring the extent to which globalization paradigms are impacting health systems, effecting working conditions and health system capacities to control infections.

This multi-country multi-component program of interventions and evaluations will help address some of the priorities identified in the *Global Plan of Action* and build capacity for ongoing progress in future.

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New strategies to measure the health effects of nanoparticles to ensure worker protection

The Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST) and NanoQuébec will jointly fund three new research projects on worker exposure to engineered nanoparticles. While developments of new applications of nanotechnologies are growing, the results of many scientific studies raise important questions on the actual effects of nanoparticles, mainly on health and the environment. Since the conventional risk assessment procedures may not be sufficient to quantify nanoparticle exposure, the IRSST and NanoQuébec believe that new strategies are required to measure exposure as well as to ensure appropriate protection for workers. Following a joint call for proposals in 2012, these three projects will address the following topics:

- Measuring the Effectiveness of Protective Gloves for Working with Nanoparticles in Conditions Simulating their Use in the Workplace;
- Development and Validation of Methods for Sampling and Characterizing Engineered Nanomaterials in Air and on Workplace Surfaces;
- Development and Validation of Universal NanoBadge prototypes (u-Nanobadge) for Evaluating Pulmonary and Cutaneous Exposure to Engineered Nanoparticles.

These projects involve collaborators from various research institutions, as well as students. This is the second time that the IRSST and NanoQuébec have worked as partners in funding initiatives on exposure to nanoparticles. The first call of proposals launched in 2008 resulted in the funding of four research projects addressing two themes:

- Characterization of nanoparticles and, in particular, the exposure of individuals to different types of nanoparticles (respiratory, cutaneous, etc.).
- Evaluation of the effectiveness of means of control aimed at ensuring protection against the health effects related to exposure to different types of nanoparticles.

By the end of 2013, the final reports of these projects will be made available to download from IRSST's Web site at www.irsst.qc.ca.

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Delivery Models of Basic Occupational Health Services in Shanghai, China

China is experiencing a health reform which emphasizes universal coverage of essential healthcare, public health, and especially essential public health services. In the GOHNET newsletter No.18, Dr Ivan D. Ivanov asked how to deal with the health of workers in the health reform, how to provide basic occupational health services while moving towards universal coverage, what would be the role of specialized occupational health services in an integrated primary health care (PHC), and how are national and local health systems performing to protect and promote the health of the workforce? With these questions in mind, we conducted a survey of a delivery model of occupational health services in Shanghai. Our preliminary results showed that there are four models of healthcare provided in workplaces:

1. The healthcare separation model in which the PHC is provided by a community healthcare centre nearby employees' residential areas, while the governmental occupational health institutes are in charge of their occupational healthcare. This is the traditional and most popular model demonstrating a very limited coverage of employees.
2. The integrated model of PHC and basic occupational health services where the family practitioners' team from the community healthcare centres close to workplace provides a full package of services to employees with the help of organizers from workplaces including occupational and PHC such as non-communicable diseases management, health promotion and so on. This model has gradually caught great attention by Chinese government because of its high coverage of small and middle enterprises and informal employees and sustainable continuation of healthcare.
3. The private healthcare model entitles those with high income, good health consciousness and high requirement for healthcare to purchasing health services from private providers.
4. Intra-services model in large enterprises are led by healthcare institutes within a few large enterprises with occupational and PHC.

There are large differences of health services utilization for employees among these four models. The integrated PHC model and the basic occupational health services, and the intra-services model in large enterprises both showed a great advantage over healthcare utilization compared with the other models. However, the generalization of the integrated model of PHC and basic occupational health services needs further collaboration and involvement of multi-stakeholders. Policy implications from the study address that the governments should clarify how to fund and what kind of services are to be provided based on a universal health information ecosystem in a city. Also, governmental departments should provide a bridge between community healthcare centers and employers. As for community healthcare centres, the biggest obstacle lies in lack of capacity, especially human resources. Currently, the implementing policy of the family practitioners team is just on its first stage in Shanghai. According to key opinion leaders interviewed, qualified healthcare services meeting employees' needs are essential to the development of this model. However, it is crucial to advocate employers to be involved in, and give essential support, to coordinate family practitioner teams and employees. Most importantly, empowerment of employees plays a key role in this model. It is very important for them to reflect on their healthcare needs.

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Dissemination of higher education in environmental and occupational health in Central Asia: the CANERIEH Tempus Project

The relevant environmental and occupational health problems that exist in Central Asia are universally known to be environmental pollution and depletion, radioactivity, and occupational diseases and accidents. In particular, in the most risky sectors (agriculture, mining and the building trades) there are problems that need to be faced and overcome in the process of transition of these countries. This process must involve several sectors of the society, but must start from the higher education institutions, which are the ones able to train human resources for research, innovation, and creation of a new generation of environmental and occupational health personnel equipped with the skills necessary to face the complexity of the existing situation.

Having in mind these major needs, two institutions linked with the WHO CC network, the International Centre for Rural Health of Milano (Italy), and the International School of Medicine of Bishkek (Kyrgyzstan), have developed the project *Central Asian Network for Education, Research and Innovation in Environmental Health* (CANERIEH) within the frame of the European Union TEMPUS action: "Higher Education and Society". The project, which involves six Universities, two public environmental health centres and two NGOs of Kazakhstan, Kyrgyzstan and Tajikistan, as well as three EU Universities from Tartu (Estonia), Gothenburg (Sweden) and Milan (Italy), has been granted by the European Education, Audiovisual & Culture Executive Agency (EACEA). It is now running, under the coordination of Prof. Claudio Colosio, with the support of Prof Kenesh Dzhusupov, acting as the coordinator of the Central Asian activities.

The project's wider aims are to support capacity-building of the participant institutions in education, research & innovation in occupational and environmental health, to enhance the quality of education and research in this area, and to improve international cooperation.

Among the planned activities, there are:

- Training of trainers, including provision to the Central Asian partners, of specific skills in English language;
- Establishment of Centres for Education, Research & Innovation in Environmental Health capable to deliver training and to promote and perform innovative research;
- Development of PhD programmes in Environmental Health together with courses on research methods;
- Establishment of a web-based Central Asian network & forum.



Picture: The Environmental and Health Centre created by the project in Almaty (Kazakhstan)

No fewer than 12 students will be recruited for the PhD programme (which contains six approved courses on research methods) and 60 students will be trained on research methods in a summer school in Kyrgyzstan in 2014. At the end of this three-year project, the Centres for Education, Research & Innovation in Environmental Health will be actively building capacity and knowledge in each of the participant countries, as well as creating a new generation of technicians, environmental and occupational health experts.

After the end of the three-year grant there will be the possibility of applying for different sources of funding to perform specific research projects, and to promote continuous mobility of teachers and students among the institutions. Moreover, the possibility of involving other Central Asian partners is under evaluation, which would enable the network to reach other existing networks dealing with different aspects of occupational and environmental health and safety.

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Implementing the WHO Global Plan of Action on Workers' Health in Brunei Darussalam

Brunei is a sultanate situated in the north-west of Borneo and with a population of 414 400 (2011). It has a working population of 198 800 (2010).

Occupational Health Services: The Occupational Health Division (OHD) of the Ministry of Health (MoH) provides occupational health services at national level to workers in both government and private sectors. The services are based on the ILO OSH Convention No.161 and Recommendation No.171 (1985), and comprises workers' health surveillance, surveillance of the working environment, health education and health promotion, investigation of complaints, workplace accidents, and occupational and work-related diseases. Services also include ongoing training, collaborative activities with other agencies, and research on OHS.

Vulnerable groups - Healthcare workers are required to undergo health surveillance (pre-employment and periodic checks). Greater emphasis is given with regard to the hepatitis B (HBV) status during these screening checks. Those non-immune to HBV are given immunisation and currently over 80% of healthcare workers are protected against HBV. Additionally, they are subject to mandatory periodic tuberculin skin tests as a precautionary measure of TB, and receive education on safe work practices and prevention of workplace hazards through induction courses and continuing medical and nursing education sessions.

Health protection and promotion at the workplace: The OHD conducts regular workplace health and safety inspections, audits, and risk assessments to monitor work environments. Employers are subsequently informed of corrective and preventive measures with regard to hazards in their workplaces. The OHD provides health education on OHS to employers, employees, and the general public. Activities include workplace health talks, seminars, workshops, discussions during workplace visits, production of pamphlets, fact sheets, quizzes, interactive audio-visual media, and guides. The OHD also promotes its activities through an exhibition booth at the Health Promotion Centre (part of the MoH) and the MoH's website which includes downloadable guides and pamphlets.

Coverage of occupational health services: Currently 12-15% of the working population are covered by occupational health services provided by the OHD at national level. The OHD expects to strengthen and increase the coverage of occupational health services through a primary healthcare

approach and has prepared an “Occupational Health Strategic Plan (2008-2017)” which targets basic coverage for 51% of the working population in Brunei by 2017.

Development of human resources: The MoH is in the process of training medical officers and nurses in occupational health, in addition to the current trained staff. The OHD provides training support for the module on “Occupational Health” of the Master of Public Health programme conducted by University of Brunei Darussalam. Additionally, doctors (both local and overseas) and allied health professionals and related officers, are trained through short-term attachments, delivering lectures, conducting workshops and seminars. The OHD has received post graduate students for training from, Sri Lanka, Myanmar, China (through University of Brunei Darussalam), the USA, and Bosnia Herzegovina.

Research activities: The OHD completed a research study on musculoskeletal disorders among dental personnel in Brunei. At present, medical officers of the division are conducting a study on noise induced hearing loss among police personnel. Future research topics may include the prevalence of hepatitis B in healthcare workers in Brunei, heat-related disorders among construction workers, obesity and other health risk factors of fire-fighters.

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Conference Reports

1st Latin American Summit on Healthy Workplaces took place in Brazil

The 1st Latin American Summit on Healthy Workplaces was organized within the XIII Brazilian Congress on Life Quality, by the International Association for Worksite Health Promotion (IAWHP) and the Brazilian Association on Health Quality (ABQV), in Sao Paulo, Brazil, on 29 September 2013.

Close to 60 persons gathered to share, listen and learn about workplace innovations and health promotion initiatives, responding to the growing desire to improve health through the workplace and to create healthy workplaces. PAHO/WHO was present, with Dr Julietta Rodriguez Guzman, Regional Advisor on Workers' Health, who, during the opening session, gave a brief message emphasizing the challenges imposed by noncommunicable diseases (NCDs) and other occupational diseases in the regional workforce of Latin America. She also mentioned that the WHO Healthy Workplace approach aims to controlling and preventing deleterious effects in workers, and for shifting towards a happy, healthy and productive workforce. Professor Rene Mendes' keynote addressed the key elements in the construction of the Healthy Workplaces. Dr Rodríguez-Guzman followed with a presentation on “How to

create a healthy Workplace according to the WHO Framework” which was prepared with the support of Dr Evelyn Kortum, WHO Technical Officer. It addressed WHO mandates in the global context and its Global Action Plan on workers’ health; the fundamentals of workers’ health promotion creating the healthy workplace model; the 5 keys to healthy workplaces; and practical applications of the model.

Particularly, three pilots currently ongoing in Peru, Chile and Colombia were presented by the WHO Consultant Dr Manuel Parra, showing their preliminary results and different approaches to implement them in SMEs. Mr Wolf Kirsten presented the global trends in workplace health through a survey conducted with more than 35 000 employers globally, showing their commitment and involvement for the initiative. However, workers satisfaction surveys were missing to have a complete panorama of the situation.

The Global Healthy Workplace Award was awarded to: 1) Telefonica, Brazil, who showed an integrated management model in which a “club of well connected with life partners” had high levels of satisfaction in terms of usage metrics, volume of consultations and dashboard use; and, 2) American Express Argentina, with the “Healthy living – life in balance” as a capital plan for human resources covering 1,500 workers in a call center, aimed at talent acquisition and management, employer resources, leadership compliance, smoking cessation, individual medical check-ups, and work-life balance. Other good practices in SMEs were presented by Chile and Uruguay and several multinationals. Mental health and work issues were a common concern for all.

Finally, contacts with the Brazilian and Argentinian Associations for Quality of Life were made, and initial exchanges to support new developments for attaining NCD & occupational disease prevention in workplace were discussed. Steps towards establishing new alliances with these two professional associations are expected to follow.

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ICOH JOINT CONFERENCE

São Paulo - Brazil
September, 22-26, 2013

ICOH Joint Conference on Healthcare Workers

A joint conference on healthcare workers was organized by the International Commission on Occupational Health (ICOH) - a nongovernmental organization in official relations with WHO - in Sao Paulo, Brazil, during 22-26 September 2013. It was jointly organized by four scientific committees (healthcare workers, development and occupational health, infectious agents and nursing).

Dr Julietta Rodríguez Guzman, Regional Advisor on Workers' Health at the Pan-American Health Organization (PAHO/WHO) gave a brief message, in the opening session, highlighted the importance and need to protect the Health of Healthcare Workers (HCW), to improving their working and employment conditions, and to sharing and exchanging successful experiences and knowledge in this field. This is a priority sector for PAHO's workers' health program.

Dr Rodriguez also delivered a keynote speech addressing the "*Global crisis of healthcare worker shortage*", that was jointly prepared with Ms Susan Wilburn, WHO Technical Officer with the Interventions for Healthy Environments unit. The deficit of HCW around the world and in the region, and its evolution since WHO called for attention on this issue in 2006, still needs to involve more personnel in the sector. Working and employment conditions challenge service delivery. Next steps aim to improve the situation facing the panorama of the regional human resources for health and the PAHO/WHO human resources development framework. Expected results from the coming 3rd *Global Forum on Human Resources for Health* were mentioned for improving the critical situation described. Other topics addressed included the needs and the problems of the health workforce such as violence in the HCW workplace comprising brief descriptions of the different types of violence experienced and effects on their physical, emotional and mental health.

PAHO also organized a workshop on their initiative to protect the health of HCW, and a presentation on *PAHO's experience protecting the Healthcare HC Workforce in Latin American countries* introduced the workshop. Dr Ahmed Gomaa made a presentation on the educational activities carried out in the region/world by National Institute of Occupational Safety and Health (NIOSH), showing the results achieved so far.

A final presentation and video on selection of retractable devices was given by Ms Rosa Orriols Ramos from Spain. The audience exchanged and shared several experiences from other institutions from Brazil, Spain and other Latin American countries, and steps to advance and expand the initiative to other countries were proposed. Another important issue was to address chemical hazardous exposures. Dr Melissa MacDiarmid, Director of the WHO collaborating centre for occupational health in the University of Maryland, made a presentation on *Antineoplastic Agents and hazards and handling*, a new area being addressed by PAHO's initiative to protect HCW from chemical and dangerous exposures.

The upcoming launch of the monograph to be e-published by PAHO was announced. Finally, acknowledgements for ICOH's efforts having put together this joint conference were made. Expectations as to the next steps to support PAHO/WHO activities in joint efforts with ICOH were also discussed.

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Link: ICOH Joint Conference on HCW www.healthcareworkers2013.com

Toward OHS prevention in the dairy sector: the International Dairy Research Consortium

Agriculture is one of the most hazardous sectors, and dairy farming is associated with high risk of injury and occupational diseases in all the corners of the world. Most of the injuries are caused by heavy equipment, in particular, in cow milking but, also, manure and livestock handling represent a source of hazard for the workers. As for human health, heavy workload and repetitive motions bring

about a relevant risk of musculoskeletal disorders. Other significant risks are zoonoses, respiratory diseases related to organic dusts inhalation, and exposure to biogases. Despite these important health and safety risks, and the significant presence of vulnerable population subgroups (migrant and seasonal workers), preventive interventions are often lacking and these workers have poor or no access to occupational health surveillance.

With the aim to promote a better and harmonized preventive approach in the sector, the International Dairy Research Consortium (IDRC) was founded in 2011, in collaboration with other key colleagues and institutions. The promoting institution was the Colorado State University (Fort Collins, USA) and its centre of excellence, the High Plains Center For Agricultural Health and Safety (HICAS). Among the participants of the Consortium is the International Centre for Rural Health of Milano, Italy, a WHO collaborating centre for occupational health. The main objectives of the Consortium are increasing research capacity, sharing best practices, and optimizing resources to improve worker health and productivity in the global dairy industry.

After a first meeting held in July 2011, a second meeting was organized in July 2013, with the attendance of researchers and dairy industry representatives from seven different countries from Europe, North America and Australasia. Since the initial meeting in Colorado in July 2011, the consortium has experienced significant growth and is now engaged in the development of specific projects addressed at the major gaps in dairy health and safety research and practice, as pointed out in previous meetings and highlighted in the recently published special issue of the Journal of Agromedicine (Vol 18, No 3) "Global Perspective on Modern Dairy: Occupational Health and Safety Challenges and Opportunities". It is worth remembering that, in the dairy industry - as well as in the whole agricultural sector - occupational health and safety (OHS) strongly overlaps with food quality and environmental protection, making the impact of any OHS intervention quite broad.

The outcome of this recent workshop was the identification of 8 projects addressing gaps in global dairy health research and practice:

- Speakers Bureau;
- Training/Scholarships;
- ATV/Quadbikes;
- (Immigrant) Workforce;
- Zoonotic diseases;
- Interdisciplinary Masters Project/Status of Safety Culture and Management;
- Development and Evaluation of Management/Safety Culture Programs; and
- Precision Agriculture.

As the IDRC continues to grow and seek support, developing a more formal structure would provide potential benefits. This approach is currently under evaluation and the Consortium is looking forward to new collaborators with the aim of creating a unique reference point for the worldwide dairy sector.

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Presentation of the Indian Association of Occupational Health (IAOH)

The Indian Association of Occupational Health (IAOH) is a group of occupational health practitioners of India. It is committed to enable occupational health professionals to make India's workplaces healthy, safe and green, and free from the ill effects of hazards, by evolving effective solutions; to be the nodal nongovernmental organization committed to attend highest standards of health in India by enabling stakeholders, influencing policy makers, and creating community consciousness.

To disseminate the knowledge and awareness on 'Basic Occupational Health Services', it has launched another initiative by putting up BOHS presentations on the IAOH website (www.iaohindia.com). Eminent experienced and specialist subject experts have developed modules on

- 1) Overview of Occupational Health,
- 2) Chemical Hazards,
- 3) Physical Hazards,
- 4) Occupational Health in Agriculture Sector,
- 5) Occupational Health in Construction Sector,
- 6) Occupational Health in Mining, and
- 7) Ergonomics.

The objective is to utilise these presentations and hold seminars for various stakeholders of occupational health. This should include medical officers of primary healthcare centres in various districts, the medical fraternity practising in industrial zones, safety engineers in industries both large and small, Industrial Associations, and other interested parties.

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Forthcoming conferences

WHO WPRO and SEARO collaborating centre meeting

The WHO Regional Office for the Western Pacific (WPRO) and the WHO South-East Asian Region (SEARO) will be co-organizing a meeting for the WHO collaborating centres for occupational health in the Asia-Pacific region on 13 November 2013, in Manila, the Philippines. This meeting is the side-event of the Asian Asbestos Initiative, 6th International Seminar (AAI6). The objectives of the meeting are to:

1. share and update the work plans and activities/projects of the individual WHO Collaborating Centres in relation to the priorities and products included in the Global Master Plan;

2. assess the progress made in implementing the regional strategy/action plan for occupational health for SEARO and WPRO (i.e. the regional framework for action for occupational health in the Western Pacific Region), and identify emerging issues that need to be included in the future regional strategies and plans; and
3. recommend potential areas and activities of future collaboration among the Asia-Pacific regional network members (i.e. the WHO Collaborating Centres and WHO Secretariat).

6th Asian Asbestos Initiative International Seminar:

Strategic approaches towards the elimination of asbestos-related diseases

14-15 November 2013

The Asian Asbestos Initiative (AAI) for the elimination of asbestos-related diseases (ARDs) aims at developing a platform on which public health specialists, researchers, administrators, academics and civil society groups from different countries can share relevant knowledge, core technologies and strategic approaches. The ultimate goal of the AAI is consistent with the efforts of the WHO and the International Labour Organization to eliminate ARDs.

Proponents agree that the most effective means to prevent ARDs is to eliminate the future use of asbestos and proper management of asbestos currently in place. However, they acknowledge the unique societal situation for each country in the Asian region, and that national actions will require a gradual transition involving progressive steps.

The AAI considers the traditional public health approach as the central pillar on which to develop intervention strategies as this model addresses all three levels of prevention. Thus, clinical technologies (including the diagnosis and treatment of ARDs) are as important as technologies at the primary level of prevention (i.e. reducing or eliminating exposure). These efforts will focus on Asian countries, while attempting to formulate a regional model from which other parts of the world may benefit.

With such efforts, the following AAI international seminars had been conducted focusing on specific themes:

- 1-3 October, 2008, Japan: Application of Japan technology in cooperation with Asia;
- 21-23 December 2009, Thailand: Preventive technologies with emphasis on economic consideration and current situation of asbestos use in countries;
- 2-4 November 2010, Japan: Local adaptation of preventive technologies;
- 16-18 November 2011, Republic of Korea: Enhancing cooperative mechanism among sectors;
- 6-8 November 2012, Republic of Korea: Applying science to practice.

Drawing upon the achievements and lessons learned from the first five international seminars, the 6th AAI Seminar will assess the progress made so far on the strategic approaches towards the elimination of ARDs through:

1. presenting updates of national asbestos profiles of participating countries;
2. sharing legislative approaches towards addressing the elimination of asbestos-related diseases;
3. presenting and discussing current technologies for handling asbestos in various settings and in diagnosing and treating ARDs; and

4. presenting and discussing 3-year country action plans (2014-2016) towards the elimination of ARDs.

Attendees will be country delegates from agencies with responsibilities in addressing asbestos issues (e.g. Ministry of Environment, Health and Labour), academic institutions with an interest in asbestos, other development partners, and invited resource persons. There will be 80 international and 100 local participants.

XX World Congress on Safety and Health at Work 2014

The XX World Congress on Safety and Health at Work 2014 will take place 24-27 August 2014, in Frankfurt, Germany. WHO was invited, together with ILO, to organize symposium 2.3 "Health strategies: prevention, promotion and care for all workers". The symposium will highlight key developments in workers' health worldwide in the context of major global health initiatives, such as universal health coverage and non-communicable diseases.

If you attend the Congress and would like to contribute to the WHO symposium, we would welcome presentations that cover any of the following:

- access of workers to preventive health services in the context of universal health coverage;
- prevention and control of occupational cancer and chronic respiratory diseases;
- development of healthy workplaces in the context of low-resourced work settings, precarious employment, and informal sector.

Abstract requirements: Your abstract must be in English and should be structured using the following headings: Objectives, Methods, Results, Conclusion. The abstract must be a minimum of 2,000 and a maximum of 3,000 characters in length (including spaces).

Abstracts for symposium 2.3 must be **submitted online by 30 November 2013**. Visit:

https://www.safety2014germany.com/en/registrierung/call_for_papers/submit_now/submit_now.html

Congress link: https://www.safety2014germany.com/en/home_1/index.html

Making the case for well-being at work conference in Copenhagen, 26-28 May 2014

www.nrcwe.dk/waw2014

8th Annual HSE Excellence Europe Forum in Vienna, 20-22 May 2014

<http://hse.flemingeurope.com/hse-excellence-europe-forum>

XII International congress on prevention of occupational risks (ORP 2014) in Zaragoza, 21-23 May 2014

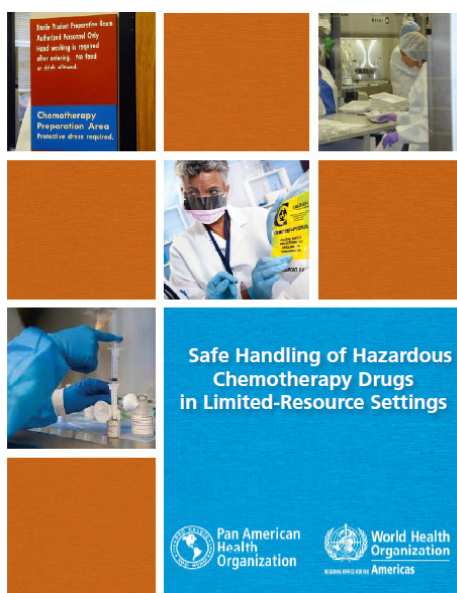
Prevention in the XXI century business: a key factor for competitiveness

<http://www.preencionintegral.com/en/congresos/orp-2014/home>

New publications

PAHO/WHO and the University of Maryland promote the safe handling of hazardous drugs

The collaborating centre at the University Of Maryland School Of Medicine in Baltimore has had a long interest in the hazards of healthcare workers and has worked with PAHO/WHO and other regions in training and other capacity-building activities that promote health and safety protections for these workers. One aspect of our Terms of Reference in supporting the Global Master Plan for Workers' Health in the area of Cancer Prevention has been focused on the safe handling of anti-cancer chemotherapy drugs.



Protocols for safely handling these highly toxic medications - some of which, themselves, cause cancer - have been crafted by many occupational health government agencies including US OSHA and NIOSH, and also by professional organizations of cancer pharmacists and nurses in the United States and internationally. These safe handling guidelines generally follow the traditional hierarchy of hazard controls including: 1) engineering solutions in the form of biologic safety cabinet use for drug aerosol containment during drug preparation, 2) administrative controls restricting personnel access to drug compounding areas and requiring training and medical surveillance of involved workers, 3) work practices which minimize drug aerosol contamination and, 4) the use of personal protective equipment (PPE) whilst preparing and administering drugs to patients.

The adoption of these safety guidelines by countries in development, and in other limited-resource settings, are challenged by the expense of the engineering controls, such as biologic safety cabinets. However, other elements of a comprehensive safety approach to handling these drugs can still mitigate exposure and risk to health workers.

Using this approach, members of the University of Maryland, Dr Melissa McDiarmid and occupational health nurse, Marc Oliver, together with other partners from NIOSH and the United States hospital pharmacy and oncology nursing organizations, turned the hierarchy of controls upside down, to emphasize administrative strategies, work practices and PPE use, in order to design a 'good' (if not 'ideal') approach to safely handling these hazardous medications. PAHO/WHO colleagues, Dr Julietta Rodriguez-Guzman and Ms Janet Khoddami, worked closely with the University of Maryland team to develop a monograph containing this approach entitled: *Safe Handling of Hazardous Chemotherapy Drugs in Limited- Resource Settings*. The monograph is expected to be available in Autumn 2013.

As the global health agenda enlarges to include a more comprehensive address of chronic disease, the importance of cancer prevention, treatment and control, will also grow. This monograph describes protections for health workers as they provide these life-saving, but highly toxic medications to their patients.

Contributed by: Melissa A. McDiarmid MD, MPH, DABT; Professor of Medicine and Director, Occupational Health Program, a WHO collaborating centre for occupational health, University of Maryland School of Medicine, Baltimore, Maryland, USA, mmcdiarm@medicine.umaryland.edu

Creating a Safe and Healthy Workplace

A Guide to Occupational Health and Safety
for Entrepreneurs, Owners and Managers



International Commission on Occupational Health

Scientific Committee on Occupational Health and Development

The International Commission on Occupational Health (ICOH) Scientific Committee on Occupational Health and Development (SCOHDev) has developed an outreach tool for educating and raising awareness of occupational health protection among the owners and managers of small and medium enterprises in developing and middle-income countries.

The instrument is entitled “Creating a Safe and Healthy Workplace”. It is a short (less than 70 pages), easy-to-understand guide to occupational health protection, emphasizing the benefits to employers, workers, and the community. The guide is written to avoid confrontational language and to encourage employers to achieve a safer workplace by simple, low-cost efforts, and to be proud of their efforts.

The language of the OH Guide is very simple. It is written to be easy to translate and therefore avoids technical jargon. Translation is encouraged and a glossary is supplied to assist translators. There are many pictures, which can be supplied for use in translated versions.

Although it is comprehensive and very practical, the OH Guide is not intended to be the only resource an employer uses: it is a starting point. Ideally, once the owner or manager reads or skims it and realizes the benefits of occupational health protection, they will obtain the appropriate expertise locally or assign someone in their company to learn more.

The instrument is now ready for dissemination as a work product of the Scientific Committee on behalf of the ICOH. This means distribution as widely as possible by partners who can reach the target readership of small employers, government agencies, occupational health institutes, NGOs, and, especially, trade associations and employer confederations. The ICOH Scientific Committee is particularly interested in promoting use of the OH Guide by large multinational corporations as a hand-out they can give to their contractors, vendors, and suppliers in-country to help them comply with contractual requirements to provide a safe workplace.

Ideally there would also be a mechanism to keep track of how many employers actually receive the OH Guide, who uses it, how effective it is, how it can be improved, and what translations have been made. Unfortunately, the level of control over the document that would be needed to require this is likely to impede its dissemination, so evaluation at present is voluntary.

We thank the IAOH for being such enthusiastic partners!

Link to copy of the guide (copy & paste URL into your browser):

<http://www.iaohindia.com/images/208/ohs%20guide%20SCOHDEV.pdf>

Contributed by: Tee L. Guidotti, on behalf of SCOHDev

New Publication on NCDs: Environmental factors one of the main causes of preventable deaths

Civil Society Groups release, in cooperation with UNEP, first publication about non-communicable diseases (NCDs) and environmental determinants



NCDs are now the leading cause of preventable morbidity and related disability, and thus significantly affect the well-being of many individuals and workers' daily lives. NCDs cause 60 per cent of all deaths worldwide and 18 out of 35 million annual deaths related to NCDs are women. Besides well known risk factors like tobacco smoke, toxic chemicals and radiation are important determinants for NCDs; however they are so far not sufficiently recognized by policy makers.

Link : <http://www.env-health.org/resources/press-releases/article/joint-press-release-new>

First health assessment of the humanitarian workforce!

The United Nations World Food Programme has published its first Global Health Appraisal Survey Report



Increasing productivity by maintaining a healthy workforce is widely recognized and well developed as a business strategy. The first step of building a programme for improving employees' health is to assess the staff's health profile. In large, global organizations like the World Food Programme (WFP), this is a very challenging process.

WFP has nearly 14 000 employees, serving in 80 countries. They often work in the harshest and most difficult places on earth with a range of healthcare systems and medical insurance plans. Staff data is not standardized or centralized; they are recorded in many languages, and are often incomplete. Data on medical risks and lifestyle do not exist at all. In such circumstances, the Medical Service at WFP, in collaboration with the World Bank Group/Fund Health Services Department, developed a global Health Appraisal Survey distributed to all WFP employees in English, French and Spanish.

The overall response rate was 32% (3,901 employees) - a very high rate considering the large and decentralized organization, language barriers across the world, and intermittent access to internet in many remote locations. Local employees were well represented among respondents, ranging from 68%-82%. The high response rate from the local staff is a strong indication of interest in personal health, but also of inadequate healthcare.

The data analysis of the survey results identifies a number of issues, including health risk factors, medical conditions, stress and mood, gaps in medical services and insurance plans, as well as a lack of awareness among staff about prevention and early detection of prevalent and/or costly diseases. The most prevalent medical conditions identified are metabolic syndrome, chronic pain, stress and mental disorders. Numerous occupational health issues are reported, such as; service-incurred injuries; limited access to healthcare; lack of preventive screening; inconsistent sick leave management; poor ergonomics; and insufficient vaccinations. The survey respondents reported various risky behaviours including sedentary lifestyle, poor nutrition, smoking, alcohol/substance abuse, and irregular use of seat belts.

There is a clear need for employee education on health issues. The knowledge gaps revealed by the survey relate to a variety of subjects regarding nutrition, personal, and occupational health. For example, our employees generally do not comply or are or unable to comply with age-appropriate screening and prevention recommendations, resulting in increased risk of non-communicable disease, communicable disease, and certain cancers. Furthermore, 15% of the respondents consider their health to be poor and a significant number do not know what kind of insurance they have. However, an

encouraging 70-90% respondents support occupational health and safety initiatives and are ready to participate in preventive programmes.

The survey and analysis have significantly improved our understanding of WFP's staff health profile. This understanding will be our guide as we prioritize preventive actions and shape our occupational health strategy in the coming years.

Similar health appraisals could be implemented at other UN organizations with a comparatively small effort, now that the basic content and modalities have been developed, something that would open up unprecedented opportunities for benchmarking.

A larger pool of survey responses would also enable mapping of health risks in the international humanitarian workforce, laying the ground for knowledge-based, and coordinated preventive action with shared resources.

Contributed by Dr Yimei CAO and Dr Jasminka GOLDONI LAESTADIUS, The World Bank

For more detailed information contact Dr Yimei CAO, yimei.cao@wfp.org

Copies of the Report available on request

Useful WHO links

WHO Occupational Health website: http://www.who.int/occupational_health/en/

WHO CC website: http://www.who.int/occupational_health/network/en/

WHO publications: http://www.who.int/occupational_health/publications/en/

To join GOHNET: http://www.who.int/occupational_health/publications/newsletter/en/index.html
