Dear Reader,

This is the second issue of GOHNET that refers to the WHO Global Plan of Action on Workers’ Health, which was endorsed by the World Health Assembly this year. The previous issues (number 13 - http://www.who.int/occupational_health/publications/newsletter/gohnet13_26nov07.pdf) referred to the first objective of the Global Plan, which is “To devise and implement policies on workers’ health”.

This issue of GOHNET relates to the second objective of the Plan, which states ‘Promoting and Protecting Health at the Workplace’. We asked for input on practical country examples with reference to:

- assessment and management of health risks at the workplace
- development and enforcement of regulations and a basic set of occupational health standards
- building capacities for primary prevention of occupational hazards, diseases and injuries
- health promotion and prevention of chronic and communicable diseases.

We gathered input and examples from most WHO regions, which cover a variety of subjects from workplace health promotion in general to issues of primary prevention of occupational hazards, national registers, knowledge and education, ergonomics, and many more.

Consecutive GOHNET issues will deal with the remaining objectives of the WHO Global Plan of Action on Workers’ Health, which are:

- to improve the performance of and access to occupational health services;
- to provide and communicate evidence for action and practice;
- to incorporate workers’ health into other policies.

The Global Plan of Action can be accessed here: www.who.int/gb/ebwha/pdf_files/WHA60/A60_R26-en.pdf

We would be pleased to learn about any examples on the improvement of performance of and access to occupational health services to be published in the next issue of GOHNET.

Enjoy your reading!
Evelyn Kortum, Editor

Promoting and Protecting Health at the Workplace

Protecting and promoting health at the workplace

Ivan D. Ivanov
Occupational Health, World Health Organization
ivanovi@who.int, kortume@who.int, wilburns@who.int
World Health Organization, Department for Public Health and Environment

Introduction

Despite the existence of effective interventions to prevent occupational diseases and injuries there are still major gaps in the health status of workers between and within countries. Therefore, the 60th...
World Health Assembly in 2007 endorsed the Global Plan of Action on Workers’ Health 2008-2017 to provide a political framework for development of policies, infrastructure, technologies and partnerships for achieving a basic level of health protection in all workplaces throughout the world. The Global Plan addresses all aspects of workers' health, including primary prevention of occupational hazards, protection and promotion of health at work, employment conditions, and improving the response of health systems to workers' health. In such a way it links occupational health to public health. The objectives of WHO's Global Plan of Action on Workers’ Health are: (1) to devise and implement policy instruments on workers’ health; (2) to protect and promote health at the workplace; (3) to improve the performance of and access to occupational health services; (4) to provide and communicate evidence for action and practice; and (5) to incorporate workers’ health into other policies.

The previous issue of GOHNET (No.13) was devoted to articles that treated objective number 1. The current issue focuses on objective number 2 of the Global Plan, and discusses diverse initiatives that protect and promote health at the workplace.

The workplace as a setting for health interventions

The Global Plan stipulates that the workplace should not be detrimental to health and well-being. Furthermore, the workplace can serve as a setting for delivery of other essential public health interventions, and for health promotion.

A healthy workplace should not present any avoidable risk to the physical, psychological and social well-being of the workers and should allow them to strengthen and promote their health. Improving the health of workers requires a comprehensive approach to the protection and promotion of health at work including control of occupational hazards, development of an enabling physical, psychological and social working environment as well as promoting healthy behaviour.

The healthy workplace approach provides an opportunity to resolve basic health problems by creating synergies between occupational health, health protection and promotion, human resources management, sustainable human development, and environmental protection. In this approach the workplace is regarded as a setting for protecting and promoting health. This requires planning to deliver and evaluate health interventions within the context of the worksite organization, its specific culture with formal and informal networks, and in interaction with the surrounding environment and local communities, including the workers families (see fig. 1).

With this approach, the prevention of occupational hazards, as already mentioned, is accorded highest priority. Another key element of the healthy workplace approach is the improvement of the psychological and social working environment through the creation of work settings that foster mental and social well-being and the empowerment of individuals and work communities.

The workplace can also be a setting to implement public health interventions, for example the prevention and treatment of diseases such as HIV/AIDS, tuberculosis, malaria and other major health threats, and provision of immunizations, particularly in low income settings. It can be used for the integrated prevention of non-communicable diseases, including cardiovascular diseases, cancer, diabetes, respiratory diseases and to promote mental health.
Health protection and health promotion at the workplace

Health protection at work is based on primary prevention of occupational health hazards. In the planning and delivery of health interventions in the workplace, priority should be given to meeting basic health requirements. Occupational hazards should be systematically assessed and measures should be taken for their elimination or reduction based on the principles of primary prevention and the hierarchy of interventions.

The hierarchy of preventive measures in occupational health and safety

When addressing the hazards in the workplace there is a logical order to prioritize action, based on effectiveness:

1. Eliminating hazards and controlling risks at the source are the most effective preventive interventions for the protection of workers health;
2. Dangerous substances, processes and machines should be systematically replaced by less hazardous ones;
3. When this is not feasible, the exposure to occupational hazards should be properly controlled through engineering measures designed to reduce exposure;
4. Administrative controls such as policies on staff assignments and rotation, and work practice controls are the next level of control; and
5. Personal protective equipment shall be used only as a last resort to protect workers from exposure to hazards that cannot be controlled otherwise.

Primary prevention and meeting the basic standards for workers health are the basis for developing and implementing healthy workplace programmes. Investing in primary prevention of occupational hazards is more cost-beneficial than taking measures for secondary and tertiary prevention of occupational and work-related diseases and accidents. It also saves unnecessary human suffering and loss off the potential for earning income. Therefore, resources should be allocated for primary prevention as a priority over measures for secondary and tertiary prevention.

Workers, process engineers and line managers should be provided with proper information and training in recognizing occupational hazards and in applying the measures for their primary prevention.

In addition, the workplace provides suitable circumstances for health promotion and the prevention and control of communicable and non-communicable diseases. The workplace can enable and stimulate individuals to make healthy choices, for example, with regards to physical activity, diet and tobacco use. Workplace–based programmes to promote healthy lifestyles, such as employee assistance, wellness, and drug screening, should be provided in addition to and not at the expense of measures for primary prevention of occupational hazards. Protecting occupational health and ensuring safety is the primary responsibility of the employer.

Workplace health promotion includes joint measures taken by employers, workers and workplace organizations, such as health and safety committees to promote health and support the work ability and functioning capabilities of all workers at every stage of their career. It empowers workers to increase control over their health and its determinants and creates a physical, psychological, and social working environment that enables people to make healthy choices.

Actions by countries

The Global Plan of Action on Workers Health calls upon countries to develop national plans and strategies for its implementation. Actions from the Global Plan are to be considered and adapted by countries according to their national priorities and specific circumstances to achieve the specific global objectives.

Protecting and promoting health at the workplace requires a number of actions to be taken by national authorities and by enterprises. Such actions need to be conceived, implemented and evaluated with the
participation of employers, and worker representatives. It also requires a multi-disciplinary approach involving experts in the relevant domains, such as occupational and environmental health and safety, chemical safety, communicable and non-communicable diseases, health promotion, and others.

The assessment and management of health risks at the workplace should be improved by defining essential interventions for prevention and control of mechanical, physical, chemical, biological and psychosocial risks in the working environment. Such measures also include integrated management of chemicals at the workplace, elimination of second-hand tobacco smoke from all indoor workplaces, improved occupational safety, and health-impact assessment of new technologies, work processes and products at the design stage.

Protecting health at the workplace also requires enacting regulations and adopting a basic set of occupational health standards to make certain that all workplaces comply with minimum requirements for health and safety protection. It is very important to ensure an appropriate level of enforcement, to strengthen workplace health inspection, and to scale up the collaboration between the competent regulatory agencies according to specific national circumstances.

Primary prevention of occupational hazards, diseases and injuries requires adequate human, methodological and technological resources as well as training of workers and employers. Countries are expected to stimulate the introduction of healthy work practices and work organization, and to develop a culture of health and prevention at the workplace. In particular, it is necessary to establish appropriate national schemes to stimulate the development of healthy workplaces, including consultation with, and participation of workers and employers.

Health promotion and prevention of non-communicable diseases can be further stimulated in the workplace. Since sedentary work styles and obesity have become very widespread among certain groups of workers. Therefore, it is important that such workers have access to programmes for healthy diet and physical activity. It is also necessary to promote mental and family health at work. Global health threats, such as tuberculosis, HIV/AIDS, malaria and avian influenza, can also be prevented and controlled at the workplace.

Actions by WHO

Through the endorsement of the Global Plan of Action by the WHO Member States, WHO has been requested to take a number of actions to supporting countries in achieving the objective of protecting and promoting health. These include creating practical tools for assessment and management of occupational risks, recommending minimum requirements for health protection at the workplace, providing guidance on development of healthy workplaces, and on promoting health at the workplace. WHO also strives towards incorporating workplace actions in international programmes dealing with global health threats.

A number of initiatives have already been undertaken by the WHO separately or in partnership with other agencies and the Collaborating Centres for Occupational Health to support countries in protecting and promoting health at the workplace. Below are some examples of such initiatives.

Psychosocial Risk Management Toolkit

As part of the Global Workplan of the Collaborating Centres in Occupational Health, the Institute of Work, Health and Organizations, a WHO Collaborating Centre for Occupational Health, has been leading the development of the Psychosocial Risk Management Toolkit through an international consortium including experts from WHO and the ILO. The project places special emphasis on high-risk worker groups and occupational sectors and addresses relevant gender issues and key issues relating to the implementation of best practice in the context of different enterprises and in particular SMEs. In addition, and in line with European policy on corporate social responsibility and social dialogue, the project aims at engaging social partners throughout its implementation and will link the project outcomes to these
principles. At the end of 2008, the results will be disseminated widely with the support of the WHO and the ILO. In addition, the consortium works in synergy with partners in European candidate countries and national regulatory bodies to ensure a wide impact of the project outcomes and the development of an international network of reference centres in psychosocial risk management.

The project objectives include:

- development of existing knowledge in reviewing available methodologies to evaluate the prevalence and impact of psychosocial risks at work and work-related stress;
- identification of appropriate means of collecting sensitive data in relation to these issues;
- development of international standards and indicators on stress and violence at work to promote harmonization in the area of psychosocial risk management and enhance best business practice;
- development of detailed recommendations and evidence-based best-practice guidance on the management of these issues at the workplace to promote clarity and a unified European approach that will enable stakeholders to put these into practice to improve the quality of working life; and
- dissemination of the results of the project to stakeholders and social partners including small and medium-sized enterprises (SMEs) to raise awareness and promote understanding, engagement and best practice in relation to the issues of concern.

The longer term objectives of this initially Europe-focused project include the extension and adaptation of the toolkit to other developed and low- and medium-income countries worldwide. Current research on the nature of psychosocial risks in the latter two is under way, headed by the WHO/HQ.

Guidelines on health services and HIV/AIDS

In 2005, in a tripartite process WHO and ILO developed joint guidelines on health services and HIV/AIDS. The purpose of the guidelines is to promote the sound management of HIV/AIDS in health services, including the prevention of occupational exposure. Furthermore the purpose is to ensure that healthcare workers have decent, safe and healthy working conditions, while ensuring effective care that respects the needs and rights of patients, especially those living with HIV/AIDS.

The guidelines take a rights-based approach as promoted by the Declaration of Commitment and the international community at large, expanding on ILO and WHO HIV-AIDS and occupational safety and instruments with a preventive occupational health approach to hazard identification and risk management. The guidelines include a series of fact sheets and tools in the annex that incorporate healthcare waste management, infection prevention and control, disinfection methods and materials, and occupational health management systems.

Smoke free workplaces

The WHO Framework convention on tobacco control requires parties to adopt and implement effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. To facilitate countries in implementing such measures the Conference of Parties in its second session in Bangkok, 30 June–6 July 2007, adopted guidelines for protection of exposure to tobacco smoke. One of the principles underpinning these guidelines is that all indoor workplaces should be smoke free. It is recommended that “indoor” areas be defined to include “any space covered by a roof or enclosed by one or more walls or sides, regardless of the type of material used for the roof or enclosed by one or more walls or sides, regardless of whether the structure is permanent or temporary”. The guidelines also define workplace broadly as “any place used by people during their employment and work.” This includes also corridors, lifts, stairwells, lobbies and other places commonly use by workers.
The WHO Occupational Health Programme is actively collaborating with the WHO Tobacco Free Initiative to stimulate the development of smoke-free workplaces. Part of this initiative is to raise awareness among occupational health and other health professions about second-hand tobacco smoke as an occupational hazard. WHO also provide support to countries to leverage the measures for tobacco control at the workplace through occupational health and safety legislation, services and inspection. For example, WHO assisted the Ministry of Health of Thailand to develop a programme “Smoke-free Thailand” supported by the Bloomberg Global Initiative. The main emphasis of this project is on smoke-free workplaces and concerted efforts between tobacco control and occupational health programmes.

**Preventing cancer through healthy workplaces**

Establishing synergies between the prevention of non-communicable diseases and prevention of occupational diseases is another area for action on protecting and promoting health at the workplace. For example, with Resolution 58.22 from 2005 on Cancer Prevention and Control, the World Health Assembly urged the Member States to pay special attention to cancers for which avoidable exposure is a factor, particularly exposure to chemicals and tobacco smoke at the workplace and recommended the incorporation of occupational exposures for cancer into national cancer control programmes.

Every year, at least 200,000 people die from cancer related to their workplace. Millions of workers run the risk of developing cancers such as lung cancer and mesothelioma (a malignant cancer of the internal lining of the chest cavity) from inhaling asbestos fibres and from tobacco smoke, or leukemia from exposure to benzene at their workplaces. Yet, the risks for occupational cancer are preventable.

Currently, most cancer deaths caused by occupational risk factors occur in the developed world. This is a result of the wide use of different carcinogenic substances such as blue asbestos, 2-naphthylamine and benzene, 20-30 years ago. Today, there are much tighter controls on these known carcinogens in the workplace in developed countries. However, work processes involving the use of carcinogens such as chrysotile asbestos and pesticides, and those used in tire production and dye manufacturing, are moving to countries with less stringent enforcement of occupational health standards. If the current unregulated use of carcinogens in developing countries continues, a significant increase in occupational cancer can be expected in the coming decades.

To protect workers from occupational cancer, WHO urges governments and industry to ensure that workplaces are equipped with adequate measures to meet health and safety standards and that they be free from dangerous pollutants. Prevention of occupational cancer can be more effective if it is linked to national programmes for cancer control. WHO has prepared a set of modules to assist countries in developing such programmes. The module “Prevention” contains a number of practical recommendations to address the priority risks factors for cancer, including those arising from the workplace.

**The Bangkok charter on health promotion in a globalized world**

The Charter adopted by the 6th Global Conference on Health Promotion in Bangkok, 2005, highlights the changing context of global health and the challenges faced in achieving its aims. It underlines the need to address and harness the health effects of globalization such as widening inequities, rapid urbanization and the degradation of environments. The Charter called upon the corporate sector to make the promotion of health a requirement for good corporate practice.
As a follow up of the Bangkok Charter, the 60th World Health Assembly urged countries to support and foster the active engagement in health promotion of communities, civil society, professional and labour unions as well as businesses and associations.

For further information
Psychosocial Risk Management Toolkit
Psychosocial Risk Management – European Framework (PRIMA-EF)
http://prima-ef.org/default.aspx

Smoke free workplaces
FCTC COP Guidelines on protection from exposure to tobacco smoke http://www.who.int/gb/fctc/PDF/cop2/FCTC_COP2_7-en.pdf

HIV/AIDS

Occupational Cancer

Health promotion
The Bangkok Charter for Health Promotion in a Globalized World
http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/index.html

Acknowledgements: The authors would like to acknowledge the support and active assistance in protecting and promoting health at the workplace of the following WHO colleagues: Ms Sandra Black (HIV/AIDS), Dr Luminita Sanda (Tobacco Free Initiative), Dr Andreas Ullrich (Cancer Alliances), Dr Kwok Cho Tang (Health Promotion), and Ms Carolyn Vickers (Chemical Safety)
The Occupational Risk Management Toolbox - Update on development and use

Gerry Eijkemans
Occupational Health
WHO, Mexico

People worldwide face occupational health and safety hazards on a daily basis. Over the years, many efforts have been made to improve the health and safety of workers, in all parts of the world. The development of occupational health programmes and tools that can be applied in developing countries, as well as in small and medium enterprises, where resources and technical expertise are often scarce, remain the largest challenge.

The Occupational Risk Management Toolbox (the Toolbox), is a creative solution to meet this challenge. The Toolbox contains a variety of toolkits, which are semi-quantitative risk management tools; each designed to address a specific occupational hazard. The first toolkit is the International Chemical Control Toolkit (Chemical Toolkit), which was developed for the International Labour Organization (ILO) by the International Occupational Hygiene Association (IOHA) as a contribution to the International Programme on Chemical Safety. Another toolkit is the “silica essentials”, or Dust Control Toolkit. Other toolkits under development are on Psychosocial Risk Management (PRIMA), ergonomics, safety and biological hazards.

The underlying concept of the toolkits is commonly called “control banding.” It is an occupational risk assessment and management instrument for use without on-site technical experts and expensive exposure measurements. The control banding concept has been used to address chemical hazards by many organizations: governmental, corporate and non-governmental.

Because of the success of control banding of chemicals, particularly COSHH Essentials, a tool designed by the Health and Safety Executive (HSE) of the United Kingdom (UK), the Chemical Toolkit was developed. The global occupational health and safety community recognized that the control banding concept could revolutionize workplace health and safety worldwide. This concept could be applied to a range of hazards – physical, biological, psychosocial and ergonomic.

Control Banding Toolkits are user-friendly, simple matrices that provide the user with guidance for controlling exposures to hazards. If adequate training is provided, people who have little or no occupational hygiene experience, like the employer of a small company, can implement the hazard assessment process and understand the sound occupational hygiene advice given in the form of guidance sheets. The simplicity of the Toolkits is the outcome of extensive, complex work carried out by experts behind the scenes who analyze the hazard, develop a predictive model for exposure, determine the best methods for exposure control and develop guidance documents.

Toolkits provide guidance for the more routine occupational hygiene problems. Because they do not use on-site experts to conduct exposure monitoring, the focus of risk management shifts from measurement to on-site exposure control. Yet, Toolkits do not replace the need for experts. In fact, the method itself recommends that some situations be dealt with only by experts on the subject. Moreover, whenever experts are scarce, this approach allows them to have more time to concentrate on the more complicated risk assessment and management processes.

Toolkits offer opportunities to overcome the scarcity of technical expertise in developing nations and help leverage resources in developed nations. Employers can save money on hazard assessment and therefore, have more to spend on workers’ protection. The international occupational health and safety community anticipates that this easy-to-use system will result in higher levels of workers’ protection around the world and will reduce the number of occupational accidents and illnesses.

Toolkits are user-friendly when they are interactive, allowing the user to enter specific worksite information to obtain exposure control guidance for a specific problem. For example, when using the
Chemical Toolkit, the user finds the correct chemical hazard group by looking at the label or the Safety Data Sheet from the chemical supplier; then, determines how the chemical will be used, and in what quantity. This leads to the tool’s guidelines or exposure control recommendations.

However, a toolkit can also be too complicated for use directly by the owner of a small company. In many instances it will be necessary for organizations, or intermediaries, such as local governments, health and labour departments, academic institutions, NGOs or others, to assist in the implementation of the control measures.

**Next steps**

**Chemical Toolkit**

Under the auspices of the International Programme on Chemical Safety (IPCS), an International Technical Group (ITG) has been established to further develop and implement the Chemical Toolkit through the Occupational Risk Management Toolbox. Partners in this international effort include: ILO, WHO, UNITAR, IOHA, UK HSE, US NIOSH, Germany’s GTZ, Dutch ArboUnie and others.

A Global Implementation Strategy developed by the ITG provides key strategy elements that include a) development of new control guidance sheets based on country experience to meet the needs of developing countries in particular, b) translation into different languages and development of training plans, c) establishment of new partnerships and influencing national decision-makers, and d) elaboration of detailed workplans by the stakeholders, to effect local implementation.

Most advances towards the implementation stage have been made with the Chemical and Silica Toolkits. Some examples are described here.

- The Ministry of Health in Chile, with the support of NIOSH and PAHO, started work on use of the silica essentials, and is constructing a National Plan on the Elimination of Silicosis. PAHO and WHO, in coordination with ILO and NIOSH are supporting the development and implementation of a Regional Plan of Action on the elimination of silicosis, including the use of the Silica Toolkit.

- WHO has supported the implementation the Chemical Toolkit in pilot projects in Brazil, Chile, India and South Africa. Important advances have been made in all these projects. Use is also starting in China.

- The Ministry of Manpower in Singapore assessed the use of the international Chemical Toolkit and found the toolkit to be adequately assessing exposure. In the few where cases discrepancies existed, the Toolkit was more conservative, which means more protective for workers. KOSHA (the Korean Occupational Safety and Health Agency) is also implementing the Chemical Toolkit.

**Other toolkits**

- The IEA, in coordination with ICOH and IOHA, is starting the development of control banding and ergonomics. This will be closely linked to the ILO work on Ergonomic Checkpoints.

- The TU in Delft in the Netherlands, together with IOHA is developing the methodology of control banding for occupational safety.

- The development of a Psychosocial Risk Management Toolkit (PRIMAT) is in process headed by the Institute of Work, Health and Organizations.

**Work has been carried out to influence international and national decision-makers, including through:**

- The inclusion of the concept of occupational risk management tools in the WHO Global Plan of Action on Workers Health, which was endorsed by the World Health Assembly in May 2007. This gives a strong political support for the further development and implementation of the toolkits in all countries.
ILO-CIS Network, ILO and WHO offices, the European Union.

Promotion at international and national Occupational Safety and Health/Industrial Hygiene Conferences. The Silica Toolkit was discussed in the ICORD meeting in Beijing in April 2005.

Holding annual or bi-annual international Control Banding workshops (1st workshop was held in November 2002, the 2nd workshop was held in March 2004, the 3rd workshop in September 2005 was held in the IOHA 6th International Scientific Conference (South Africa). Additionally, training on silicosis and control banding was carried out in and around the IOHA Conference.

Control banding has been extensively discussed in the WHO Collaborating Centres in Occupational Health Network meeting (Milan, June 2006). One of the 6 Activity Areas in the WHO Global Workplan of Collaborating Centres for 2006-2010 is on the development and implementation of control banding.

The principle of control banding was introduced by WHO and discussed in meetings in China and in the Arab States on “Basic Occupational Health Services” (BOHS), and is considered an important component for the implementation of BOHS.

An international Control Banding Workshop for Asia was held in November 2007 in Chennai, India. The meeting brought together approximately 35 experts from Ministries of Labour, Ministries of Health, WHO Collaborating Centres, and WHO (country, regional and global level), as well as NIOSH and GTZ.

PRIMA stakeholder workshops in Amsterdam (13-14 June 2008) and Berlin (24-25 January 2008) involving workers, employers and government representatives, including the WHO, ILO and the European Commission participation; as well as a project workshop in Warsaw in 2007.

Conclusion

Although many advances have been made over the past decades in addressing occupational risks, the knowledge-application gap remains. This is particularly important in small workplaces, and in developing countries. The Toolbox is an important step forward in addressing this issue, through simplifying risk assessment and focusing on feasible risk management. The experiences in using the advanced toolkits are extremely positive, both in small enterprises in developed countries and in medium-size workplaces in developing countries. Still a lot of work needs to be done, particularly on implementing the toolkits at a scale that makes impact in a sustainable manner.

We invite you to become a part of this exciting new venture, through actions such as:

- Developing new toolkits for the Toolbox.
- Advocating for the implementation of the existing Toolkits in your country.
- Conducting relevant research.
- Training local small business owners, large employers, union members and line managers on how to use the toolkits.
- Supporting the use of the Toolkits in workplaces, when applicable.

For further reading:
2. [http://www.ioha.net/content/view/14/](http://www.ioha.net/content/view/14/)
3. [http://www.who.int/occupational_health/publications/newsletter/gohnet7e.pdf](http://www.who.int/occupational_health/publications/newsletter/gohnet7e.pdf), background articles
5. [http://prima-ef.org/default.aspx](http://prima-ef.org/default.aspx), on the development of the psychosocial toolkit
A South-African perspective; protecting and promoting health at the workplace: by Hope Mugagga Kiwekete

Hope Mugagga Kiwekete
weketehm@sabs.co.za
The South African Bureau of Standards (SABS) Training Division

Introduction

The International Labour Organization (ILO) theme for 2007 World Health and Safety Day is “Safe and Healthy workplaces - making decent work a reality”. The ILO estimates that about 2 million men and women lose their lives through occupational accidents and work-related diseases each year. It is everyone’s desire to work in a healthy workplace, to feel valued and secure at work. Employers share the same sentiments too; they want employees who are productive and committed to their work. However, this can only be realized in a healthy workplace.

The following discussion highlights some of the efforts in South Africa that propagate safe and conducive work environments.

Actionable Policy Statements

In order to protect and promote health in the workplace, policy statements need to be actionable and emphasized to state the overall health and safety objectives and a commitment to improving health and safety performance within the organizations. The combined commitment and participation of the entire organization is necessary to create and maintain an effective safety culture. Every person in the organization, from the top management of the corporation to the newest employee, is responsible and accountable for preventing injuries. For example, the South African National Standard, SANS 16001:2007, Edition 1: HIV and AIDS management systems — General requirements clause 3.2.1(f) HIV and AIDS policy, requires a policy statement to “include a commitment to the provision of information, education, communication (IEC) and behaviour-change communication (BCC), and to promote the prevention of HIV transmission” (1). Health and safety is a joint effort as the policy statements indicate, the health and safety policy needs to be communicated to all employees such that they are aware of their responsibilities, roles and health and safety obligations.

Responsibilities of Employers

Employers have an overall responsibility for health and safety in the workplace. Roles and responsibilities are critical in the success of health and safety in the workplace. However, some employers have defined health and safety functions, responsibilities and accountability of personnel whose functions may have an effect on the health and safety of the organization’s activities. To ensure an effective management of health and safety at work, organisations must appoint a representative(s) with clear and defined health and safety roles, responsibilities and authority. Some companies have dedicated health and safety personnel on-site. In this case the health and safety functions usually fall under the responsibility of a departmental head as directed by top management.

Hazard identification and assessing of risks

Employees should not only rely on employers to provide a conducive work environment. Employees should participate in the identification of hazards that have the potential to harm and cause injury. In order to propagate the principles of protecting health and safety in the workplace, a process must be established to first and foremost, identify hazards in the vicinity of the workplace and those that originate from outside the workplace. Secondly, there is a need to assess the risks associated with the hazards identified. Thirdly, controls should be deployed to reduce risks. For an effective process, employees must be involved.

1 Hope Kiwekete is a Management Systems Specialist at The South African Bureau of Standards (SABS) Training Division. He has practiced as a Management Systems Consultant and Trainer in a number of consulting and training assignments that entailed Quality Management, Occupational Health and Safety and Environmental Management Systems in various industry sectors in East and Southern Africa. He is also a member of the WHO Network of Experts in the Psychosocial Work Environment of Developing Countries, related hazards and work-related stress.
The British Standard, BS OHSAS 18001:2007 Occupational Health and Safety Management System Requirements, defines hazard identification as the process of recognizing that a hazard exists and defining its characteristics. (3.7) (2) This includes identifying hazards and assessing risks, putting precautions in place and checking they are used to protect people. Employers should use their health and safety policies to influence the selection of people, equipment and materials, the way work is done and how goods and services are provided. A written statement on the arrangements for implementing and monitoring policy shows that hazards have been identified and risks assessed, eliminated or controlled. However, events causing injuries and illness may also damage property and interrupt production, therefore, this is also considered.

**Role of government in providing an enabling framework**

Governments have a critical role in promoting health and safety in the workplace, which is the provision of a legislative framework that provides the necessary guidelines to the industry. Section 8 of the general duties of employers to their employees, the South African Occupational Health and Safety Amendment Act, No. 181 Of 1993, requires “every employer to provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees”. (3) (5) Employers are concerned with the risks the workplace operations and activities pose to the employees and the impact they will have on production. This is due to the fact that the health and safety policies are actionable and are viewed as platform to which employers can show commitment in minimizing and preventing ill health and injuries.

In August 2007, the Minister of Labour, Membathisi Mdladlana, called on companies to cooperate with labour inspectors after an incident where a labour inspector was issued with death threats after he issued a notice to stop operations due to non-compliance with the OHS Act of 1993. (4)

**Table 1. Examples of legislations that pertain to health and safety in South Africa**

<table>
<thead>
<tr>
<th>Act</th>
<th>Purpose</th>
<th>Custodian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Health &amp; Safety Act (OHSA), No. 85 of 1993</td>
<td>Ensures a healthy and safe environment</td>
<td>Department of Labour</td>
</tr>
<tr>
<td>Compensation for Occupational Injuries &amp; Diseases Act (COIDA), No. 130 of 1993</td>
<td>Determines conditions for compensation on work related injuries</td>
<td>Department of Labour</td>
</tr>
<tr>
<td>Mine Health and Safety Act (MHSA), 1996</td>
<td>Protection of the healthy and safety of employees and others person at mines</td>
<td>Department of Minerals &amp; Energy</td>
</tr>
</tbody>
</table>

**Giving training a high priority**

An employer has a responsibility to provide training to his employees. Effective procedures for ensuring the competence of personnel to carry out their designated functions should be made available so as to support employees with the right health and safety skills to keep them safe. The BS OHSAS 18001:2007 clause 4.4.2 requires “organizations to ensure that any person(s) under their control performing tasks that can impact on Occupational Healthy and Safety is (are) competent on the basis of appropriate education, training or experience”. (2) Although this is a voluntary standard, employers need to identify what type of health and safety skills are required hence contributing to the protection and promotion of health in the workplace.

**Monitoring and measurement of health and safety performance**

For health and safety to succeed, there is need for effective monitoring and measurement of health and safety. For most organizations, such systems are not in place or are insufficient. Employers tend to be reactive, focusing on compiling data once incidents or accidents have occurred in the workplace, and not being pro-active in identifying or preventing them from re-occurring. There is a need for monitoring the employees’ awareness and knowledge on health and safety matters. Some employees are involved in reviewing the adequacy of health and safety procedures. There is regular update and forums to discuss...
health and safety information. With such an approach, employees do not shun health and safety and thereby become motivated because they see management commitment to provide a safe and conducive work environment.

**Conclusion**

The aspects discussed above on policy statements, responsibilities of employers, role of government, hazard identification and assessing of risks, prioritizing training and monitoring and measurement of health and safety performance, are evident in the South African context. However, there is a need for continued protection and promotion of health and safety at work.

**References:**

---

**The role of codes of conduct in protecting and promoting workers’ health: an example in the cut-flower industry**

Yahya Khamis Msangi  
Dept. of Occupational Health, Safety & Environment  
Tanzania Plantation and Agricultural Workers Union  
aishamaulid@hotmail.com

**Introduction**

International instruments including conventions, work standards and codes have been instrumental in promoting and protecting workers’ health. Conventions and standards are normally enforceable through legal systems once such conventions or standards become legally binding to national governments. On the other hand, codes are implemented and complied with on a voluntary basis. Moreover, codes are based on ethical theories, in simplest form codes deal with ‘RIGHT’ and ‘WRONG’. The former United States Chief Justice Earl Warren once stated that ‘Society would come to grief without ethics, which is unenforceable in the courts, and cannot be made part of the law’ (1).

Ordinary citizens have ethical responsibilities, professionals and corporations have additional responsibilities. For example, professionals must shun participation in deception, avoid conflict of interest and follow ethical guidelines set by their profession while corporations are expected to exercise Corporate Social Responsibility (CSR) towards all stakeholders i.e. their employees, the surrounding communities, consumers and the general environment.

Corporate Social Responsibility is a concept whereby organizations consider the interests of society by taking responsibility for the impact of their activities on customers, employees, shareholders, communities and the environment in all aspects of their operations. This obligation is seen to extend beyond the statutory obligations to comply with legislation and sees organizations voluntarily taking further steps to improve the quality of life for employees and their families as well as the local community and society at large. The term CSR earned recognition in early 1970s while the term STAKEHOLDER became widely used around 1989 (2). In the corporate world, the term stakeholder means all who are impacted by an organization’s activities beyond the shareholders.

In the UK, the term Corporate Responsibility (CR) is increasingly used instead of CSR as a conscious move to expand the boundaries away from purely social or community issues to include broader areas of governance and environmental sustainability (3).
The United Nations Millennium Development Goals provided an increased awareness on CSR in which a major goal is the requirement for the increased contribution from large Multinational Corporations to help alleviate poverty and hunger and for business to be more aware of their impact to society (4).

Several approaches are used to implement CSR or CR. These include support to community based development projects, provision of aid to local communities or groups, etc. A number of CSR or CR auditing and reporting procedures have been established and these include AccountAbility’s AAA standards, Global Reporting Initiative’s Sustainability Reporting Guidelines, Verite’s Monitoring Guidelines, The ISO 14001 Environmental Management Standards, UN Global Compact’s Communication on Progress (COP) – 10 universal principles, and the FTSE4 Good Index.

However, from the trade unions’ perspective, most of these CSR/CR programmes, standards and associated auditing and reporting procedures have put more emphasis on local communities and the environment. Although corporations have built up their corporate image and improved their business profits, the workers on the other hand have not benefited much from these CSR/CR initiatives. This is due to the fact that most of these initiatives were designed by corporations with little participation of their employees and their trade unions.

Hence in 1998 a group of Trade Unions and NGOs decided to develop a programme in the cut-flower industry that aimed at ensuring a sustainable and fairer CSR/CR.

**The International Flower Campaign**

In 1998 a group of Trade Unions (affiliated to the IUF, the International Union for Food) and NGOs in Europe started the international flower campaign. The aim of the campaign was twofold: to improve working conditions for workers in the flower industry and to stimulate sustainable production of cut flowers. The collaboration between unions and NGOs resulted in the International Code of Conduct for the Production of Cut Flowers (5). Several important standards were used by the group to develop the ICC and these include the Universal Declaration of Human Rights, the Covenant on Economic, Social and Cultural Rights of the UN, the Covenant on Civil and Political rights of the UN, ILO Core Conventions (87, 98, 135, 100,111, 183, 29, 105, 138, 182, 110, 155, 170, & 184) and the Rio Declaration on Environment and Development. The ICC contains 10 elements i.e. requirements to be complied with by flower producers:

i. A guarantee on Freedom of Association and Collective Bargaining,

ii. Practicing Equality of Treatment to all regardless of sex, religion, race, nationality, social origin, tribe, or political affiliation

iii. Provision of Living Wages

iv. Provision of Working hours,

v. Promoting and protecting Health and Safety of workers and communities

vi. Ensuring sound management of Pesticides and Chemicals

vii. Ensuring Security of Employment

viii. Ensuring Protection of the Environment

ix. Prohibiting Child Labour

x. Prohibiting Forced Labour

The group also developed a guideline for the implementation of the code (6). The guideline provides a more detailed explanation on each item of the ICC and serves as an orientation for flower workers, growers, for interested traders, trade unions and NGOs to implement the ICC.

**The International Flower Programs**

Following the established and adoption of the ICC, two programs were established to implement it. The first, the Flower Labour Programme (FLP) was established in Germany and the second; MPS was
established in the Netherlands. The FLP was more focused on the implementation and monitoring of the social issues while MPS put more emphasis on environmental issues.

The cornerstone of both programmes was the provision of market labels once a producer complies or seems to comply with requirements of the ICC and its guidelines. The FLP and MPS are voluntary programmes but once a producer subscribes he has to undergo audits/inspections at least once per year. Audits or inspections are normally carried out by independent certified bodies and the cost of these audits/inspections are borne by the producer.

After 3-4 years of operation, some challenges were identified by stakeholders. Local Trade unions and NGOs complained of non-involvement in audits/inspections, non-provision of feedbacks from the auditing firms, lack of funding, lack of awareness amongst flower workers and communities, too much reliance on foreign auditors, certification of unqualified producers, use of market labels by unsubscribed producers, and inspectors and little improvement in working conditions. On the other hand, producers complained about high costs of audits/inspections and lack of added market advantage compared to non–subscribed producers. The same producers are also participating in other certification programmes such as FLO (7) and ISO 140001 (8). They also bare the cost of national inspections.

In 2006, key stakeholders decided to consolidate the programmes and a new programme known as Fair Flowers Fair Plants (FFP) was established (9).

**The Fair Flowers Fair Plants (FFP) programme and how it operates**

**The Administrative arrangement**

The FFP consists of a Board which is the executive body comprising of representatives from Trade Unions, NGOs, Industry, and Government. An Advisory Forum consisting of experts assist the Board on technical matters. The Board is also supported by two committees i.e. the Industry Committee and the Review Committee. The Industry Committee consists of individuals from the industry while the Review Committee consists of members from Trade Unions and NGOs. A Secretariat consisting of 2 people (one for Europe and based in the Netherlands and another in Kenya for the Africa Region) assists the Review Committee.

Observers from Trade Unions and NGOs are located at national level and these have the obligation of accompanying the Lead Auditor from the Certifying Agency (currently MPS) on every audit. Their participation costs are covered by the Review Committee Secretariat.

An interested producer has to inform the FFP Manager who then informs the Certifying Agency (currently MPS); MPS sets an audit date with the producer and informs the FFP Manager accordingly. The FFP Manager then informs the Review Committee through its Secretariat and eventually local observers are notified.

**The Audit Procedure**

The audit procedure consists of a pre-audit, and audit and a post-audit. In the case of compliance with the ICC and its Benchmark (formerly the Guideline), the producer may be issued the right to use the FFP market label.

**Challenges and Achievements**

One of the strong points of FFP is that it allows for independent observers and it has also put into place a mechanism for any party including employees to lodge a complaint to the top decision–making bodies. FFP has also incorporated the principle of tripartite plus in its organization structure thus ensuring that the interests of all stakeholders are taken into account.

The major challenge to FFP is on the market side where a lot remains to be done to encourage consumers to demand FFP-Labelled flowers. A vigorous campaign in consumer countries is needed to convince consumers to pay more for ethical and environmental – friendly flowers. FFP producers need a tangible market advantage over other producers for them to be able to pay for audit and other associated costs.
However, since its inception, the FFP team has somehow managed to attract demand for FFP labelled flowers in the UK, Italy, Sweden, Netherlands, and Germany. It is anticipated that as the demand for FFP Flowers grow, more and more producers will subscribe to the programme.

At national level, experience has shown that workers in FFP producing companies are enjoying better working conditions than their colleagues in non–FFP producing companies. These conditions include better salaries, transport and housing arrangements, better provision of personal protective equipment, elimination of child and forced labour, and decrease in cases of sexual harassment.

In FFP producers, environmental protection has improved through improved water recycling and use of constructed wetlands for bioremediation of waste water. These farms have also adopted the use of substrate (coconut mesh) as a growth media instead of natural soil. The use of a substrate reduces the fungal problem and consequently the use of fungicides. Some of the FFP producers have also established empty containers immobilization programmes whereby by empty pesticide containers are punctured to prevent their use by workers and communities for domestic purposes.

In conclusion, codes can play a significant role in the promotion and protection of workers’ health by allowing for multi-stakeholder participation, a transparent monitoring and evaluation system, feedback mechanism and ownership at the local level.

References

Healthy workplaces in Canada

Michael Abromeit
Vice-President of Operations and Marketing
mabromeit@iapa.ca

Joan Burton
Senior Strategy Advisor, Healthy Workplaces
jburton@iapa.ca

Maureen Shaw
President and CEO
mshaw@iapa.ca

IAPA (Industrial Accident Prevention Association), Canada
A WHO Collaborating Centres in Occupational Health
In October 2007, Virginia West, the Deputy Minister for the province of Ontario’s Ministry of Labour, gave a presentation in Toronto. The topic: government’s role as legislator, policy maker and employer in advancing the healthy workplace concept. “Ten years ago,” observed West from the podium, “you wouldn’t have had a room full of people talking about healthy workplaces.”

By “healthy workplaces,” West was referring to a three-pronged approach that includes the physical environment, health practice factors (lifestyle), and psychosocial factors (work organization). This approach is based on a model developed in the 1970s by Health Canada—a federal government department—and other organizations. The occasion for West’s presentation was a national “summit” on organizational excellence. Organizers timed the summit to occur during an annual, national “Healthy Workplace Week” (www.healthyworkplaceweek.ca). On the day’s agenda were a series of sessions and networking opportunities, followed by an awards ceremony. Although the healthy workplace concept was just one of many topics under discussion, the sessions and the awards recognized it, implicitly and explicitly, as an essential component of organizational excellence. Attending the event were corporate leaders, researchers, management experts, and interest groups from across the country and every major industry sector. All were represented in Virginia West’s session.

**Event multi-tasking**

Also taking place at the summit was a meeting of the Forum on the Advancement of Healthy Workplaces. The forum engages key stakeholders from various health and safety disciplines, organizations, governments, and other interest groups, who share ideas on how to work together to promote healthy workplaces (www.healthy-workplace.org/roundtable.html). The context in which this meeting took place, as well as initiatives undertaken by various forum members, offers a snapshot of progress to date. The annual summit on organizational excellence is hosted by the National Quality Institute (NQI). A not-for-profit organization, NQI’s goal is to help Canada work better. The means: strategic business frameworks, services and tools that support ongoing performance improvement in quality and healthy workplace environments (www.nqi.ca).

In 1998, NQI teamed with Health Canada and other healthy workplace advocates, including IAPA, to establish the Canadian Healthy Workplace Criteria. These criteria bring together environmental, physical, mental, health, safety and social issues into a strategic model that helps organizations set goals and manage wellness programs. The criteria build on principles and planning tools that Health Canada and others created in the late 1970s. To help workplaces implement the criteria, NQI developed progressive excellence certification programs for both quality and healthy workplaces. These four-level programs support ISO and other management systems such as Total Productive Maintenance (TPM), Six Sigma and LEAN manufacturing, allowing program participants to incorporate it into existing organizational improvement efforts. The programs have been adopted by organizations across the country, including private sector employers, governments and associations, such as IAPA. The entire government for the province of Nova Scotia, for example, recently achieved Level 1 certification for healthy workplaces. NQI and IAPA are both members of the Forum on the Advancement of Healthy Workplaces. The forum is co-chaired by Virginia West and Jean Lam, Acting Deputy Minister, Ontario Ministry of Health Promotion.

Government participation in the forum highlights the evolving role of Canadian legislators and policy makers with regard to healthy workplaces. “Regulation doesn’t work for everything,” acknowledges West. In this instance, “the better course is helping people to understand that it’s in their collective self-interest to undertake a certain initiative, to carry out certain behaviour, to include certain approaches in their workplace. They’re going to do this more effectively and passionately if they understand it and believe in it.”

In 2005, the province established the Ministry of Health Promotion to create programs promoting healthy choices and lifestyles. The ministry works with partners, stakeholders and all levels of government. Public programs to date include a multi-faceted, multi-partner Healthy Eating and Active Living Action Plan (www.mhp.gov.on.ca). The ministries’ participation in the forum, continues West, allows the province to build on existing community partnerships, “to find the best approach, support one another, and get
The message out.” This also applies to the government’s role as one of the country’s largest employers, with 65,000 employees. “It’s critical,” says West, “that the province demonstrate the behaviours it is encouraging in others.”

**Provincial strategy for government employees**

Three years ago, Ontario’s Ministry of Government and Consumer Services devised a strategic human resources plan for all government employees. “One of the plan’s priorities,” says HR Policy and Planning Director Brian Fior, “is to engage our employees, and one of the strategies we identified was to focus on organizational health and wellness.” To implement this strategy, the ministry has been building a conceptual framework that reflects the NQI approach. “We have three key areas of focus: a safe and healthy workplace, a supportive work culture, and healthy living.” Architects of the holistic framework, says Fior, “are drawing on research, best practices and, because we represent a large, diverse workforce, broad consultation across our organization.”

The province didn’t start the process with a blank page; it already had a number of policies, programs and initiatives in place. For instance, says Fior, “we’ve invested significantly in ongoing support services, such as employee assistance programs” (EAPs). At the other end of the scale are seasonal, issue-oriented projects, such as flu clinics, and campaigns on West Nile Virus and hand washing as a means of preventing transmission of communicable illnesses. “One of our most important initiatives involves the Employee Accommodation (EA) and Return to Work (RTW) Operating Policy,” says Fior. “We’ve totally revamped it to provide greater clarity, direction and guidance to workplace parties.

Central to the government’s strategic HR Plan is the implementation of a new HR service delivery model, which has already begun. This new model ensures that HR services are coordinated, integrated and efficient. A key feature is a Centre for Employee Health, Safety and Wellness, which will help the government to achieve its organizational health and wellness goals.

**IAPA’s strategy**

IAPA, like other members of the Forum on the Advancement of Healthy Workplaces, participates as both a healthy workplace advocate and as an employer. A not-for-profit, member-driven association, IAPA represents 50,000 member firms and 1.5 million workers. Since IAPA began operating in 1917, it has evolved into Canada’s leading health and safety training and consulting organization. IAPA believes that, to generate significant breakthroughs in preventing injury and illness, we have to look at workplace health and safety with a holistic, comprehensive perspective that includes traditional bio-mechanical approaches, as well as mental health, the psychosocial environment, organizational culture, health practices, and even spiritual health. The goal is to address the overall well-being of the individual.

- To help our member firms and clients provide healthier workplaces, IAPA has developed and begun implementing a multi-year strategic plan. Components include:
  - communicating the features and benefits of a healthy workplace approach through briefings, presentations, and other opportunities
  - integrating a healthy workplace approach into IAPA’s information, product, and service portfolio
  - training IAPA consultants to promote and implement the healthy workplace approach
  - developing assessment and intervention tools. Many are already accessible, some as free downloads on our website (www.iapa.ca).
  - leveraging relationships to increase outreach. IAPA actively seeks new, non-traditional partners, such as the Ontario Chamber of Commerce, which represents 160 community boards of trade and chambers of commerce.

IAPA also believes in working with the broader community. This takes many forms. Here is a sampling:

- membership in the Forum on the Advancement of Healthy Workplaces.
- regional and national conferences. Twenty years ago, conference content was mostly bio-mechanical.
Today, the content reflects a more comprehensive approach that includes mental health and healthy workplace practices.

- sponsorship of Canadian Manufacturers & Exporters’ Canadian Innovation Award for the Promotion of Health and Safety Practices in the Workplace (www.cme-mec.ca).
- membership on the Board of Directors for Minerva, a Canadian not-for-profit corporation dedicated to improving business effectiveness through health and safety management education in post-secondary business and engineering schools (www.safetymanagementeducation.com).

IAPA has also turned its healthy workplace focus inward, assessing management practices and the quality of relationships. We believe that everyone deserves to be respected and to be respectful, regardless of rank or power. Accordingly, the organization is undertaking a number of initiatives. One in particular addresses the issues of respect and fairness: training for all staff on IAPA’s respectful workplace policy and positive dispute resolution procedures. This proactive, preventive training centres on proper, respectful communication, and conflict/disagreement resolution. Many other initiatives are already in place, from a home office ergonomic furniture purchase program to smoking cessation support.

The goals of our healthy workplace initiatives are to improve employees’ physical and mental health, the physical and psychosocial work environment, and the organization’s health. As part of a continuous improvement process, IAPA is completing a self-assessment for an NQI Canada Award for Excellence, Healthy Workplace Category. The assessment will help us to identify strengths and opportunities, and develop an ongoing action plan.

Moving forward

- IAPA believes organizations can extend this understanding beyond their own walls; for example, by
- incorporating their own healthy workplace criteria into a supply chain management policy or code of conduct;
- integrating criteria into supplier contracts;
- supporting suppliers through knowledge transfer, capacity building and mentoring; and
- monitoring acceptance through supplier audits/assessments.

A number of Canadian-based initiatives are also encouraging non-traditional partners to create new and innovative solutions. These include

- a leadership summit at IAPA’s annual national conference. This year, business leaders discussed how corporate social responsibility can translate into a sustainable business advantage;
- CEO Health and Safety Leadership Charter;
- Global Business and Economic Roundtable on Addiction and Mental Health, which defines itself as an instrument of information analysis and ideas concerning the linkage between business, the economy, mental health and work. Members include business, health and education leaders who recognize that mental health is a business and economic issue (www.mentalhealthroundtable.ca); and
- US-Canada Forum on Mental Health and Productivity. In February 2007, Canada’s ambassador to the US convened a meeting in Washington, DC of business and political leaders, academics and others to discuss opportunities on mental health and the workplace. In November 2007, a second forum took place in Ottawa. It was jointly hosted by Canada and the US.

Just ahead is an international Healthy Workplace Forum, following IAPA’s 2008 national conference. Organized by IAPA and the WHO, the forum will invite global experts to comment on a draft global guide for developing healthy workplaces, including practical implementation tools for experts and non-experts. The draft is based on Creating Healthy Workplaces, an IAPA document that identifies legal and economic reasons for healthy workplaces, and presents an overview on how to create one (www.iapa.ca/resources/resources_downloads.asp#healthy). These activities are just a sample of what is taking place in Canada and elsewhere—multiple voices with a shared message. Regardless of the approach, the
desired outcome is the same: applying a greater understanding of how a healthy workplace contributes to organizational health and, increasingly, the tools to achieve it.

For more information: www.iapa.ca/healthy_workplace

Resources for workplace health: The Canadian experience

Norma Gibson-MacDonald
Canadian Centre for Occupational Health and Safety (CCOHS)
A WHO Collaborating Centres in Occupational Health

normag@ccohs.ca

Making the connection in Canada

There is a strong connection between the health and well-being of people and their work environments, and therefore, many reasons to develop healthy workplaces. Healthier workplaces can improve workers’ health, job satisfaction, morale, profitability, productivity, increase retention and recruitment, as well as reduce injuries. Families and communities also benefit through improved mental health, enhanced physical levels, reduced health costs, improved public safety and an overall improved work-life quality. The availability of - and easy access to - reliable and timely health and safety information and resources is key to promoting and protecting health in the workplace. Through staff training, adopting healthy work practices and work organization and by fostering a healthy workplace culture, organizations can increase their capabilities to help prevent occupational hazards, diseases and injuries. This is made easier by having the required tools and information readily available.

The Canadian experience

The Canadian Centre for Occupational Health and Safety (CCOHS) is Canada’s national workplace health and safety resource, mandated to promote the fundamental right of Canadians to a healthy and safe working environment. Since 1978, CCOHS has provided unbiased, relevant information, training, services and advice to encourage attitudes and methods that will lead to improved worker physical and mental health.

CCOHS regards “workplace health” as a comprehensive and integrated approach to health, focusing on both the general population at a workplace and the organization as a whole. Workplace health addresses a broad range of health issues including physical and psychosocial, environmental, health practices and personal resources. With an emphasis on preventing illnesses, injuries and fatalities, CCOHS works in concert with national and international workplace health and safety organizations, to extend outreach and accessibility to workplace health and safety training and information. The objective is to assist Canadians to easily acquire - and then apply the information - to help create solutions and keep the workplace free from injury and disease.

Free and easy access to credible information and tools

- CCOHS works to put information into the hands of Canadian workers by providing a variety of free public services including:
  - Inquiries Service - the confidential, person-to-person service for Canadians;
  - OSH Answers - easy-to-read questions and answers on the CCOHS website;
  - Health and Safety Report - monthly electronic newsletter;
  - Bringing Health to Work portal with information on creating healthy workplaces;
  - Pandemic Planning web portal;
  - Webinar presentations on topics promoting healthy workplaces;
JobOne Canada website for new and young workers; and
- CANOSH website.

OSH Answers is a free, trilingual (English, French, Spanish) service available on the CCOHS website. Information based on questions asked of the CCOHS Inquiries Service is prepared for the web and written in a practical question and answer format. Users can browse almost 670 web documents by topic or use a keyword search engine. The topics span the full health and safety spectrum ranging from health promotion, wellness and psychosocial to diseases, disorders and injuries, to biological hazards. In 2006-2007 more than 2.5 million individual visitors accessed health and safety question-and-answers over 6.6 million times, via OSH Answers. These documents are very popular, non-technical tools to assist in improving the workplace environment.

Bringing Health to Work, a web portal service offered by CCOHS, provides Canadian employers, employees and practitioners, free and easy access to a comprehensive collection of credible resources and practical tools for creating and promoting healthy workplaces. Last year approximately 32,000 visitors accessed the portal more than 52,000 times. CCOHS also promotes comprehensive workplace health through its involvement in Canada’s Healthy Workplace Week, which promotes fostering a workplace culture of trust and respect and where people are happy and healthy at work. The web site for Canada’s Healthy Workplace Week (www.healthyworkplaceweek.ca) provides short-term practical tools and ideas for organizations to participate in the Week, as well as long-term strategies and case studies to encourage companies to embrace a comprehensive and integrated approach to organizational health. The “Resource Well” section of the website features web-based resources that provide on-going information on healthy workplaces.

CCOHS bridges the gap between traditional occupational health and safety practitioners and those who see the workplace as a public health setting. There is a place for both in the workplace, as each has the mandate to help improve and protect the health of people. In short, the workplace is not only a determinant of health but also a place to practice health promotion.

Literacy

An important consideration in Canada is to provide the right type of information to address the needs of different users. Workplace health information may be delivered directly to workers or made available through health intermediaries. To help Canadians make healthy decisions for themselves, CCOHS collects materials at a variety of reading comprehension levels and languages. For individuals who may be marginalized because of literacy challenges, CCOHS includes information useful to health promoters working with these individuals and groups.

Partnerships

In Canada the CCOHS approach has been to find ways to reach the various audiences by collaborating with credible partners. One prime example of leveraging this synergy is CCOHS’ involvement in the Canadian Health Network (CHN), a national, non-commercial, bilingual web portal providing a single source of health promotion and prevention information to Canadians on a wide variety of health topics. CHN is a collaboration among major health organizations across Canada, funded by the Public Health Agency of Canada, providing access to quality-assured e-health information through the CHN Web site (www.canadian-health-network.ca). Underlying values respect diversity, inclusiveness, and a desire for high standards of ethics and integrity. A basic operating premise holds that CHN maintains quality, credible, and practical health information for the public good. This unique collaboration is one of the most dynamic and comprehensive information networks anywhere in the world. CCOHS and CHN are able to provide users with easy access to the best workplace health information available anywhere – information that everyone can use to help stay healthy at work. CHN includes over 20,000 resources from over 2,100 Canadian information providers. It covers 7 population groups and 25 health topics.

CCOHS is responsible for the Workplace Health Centre that serves Canadian workers and their families and health promotion intermediaries (practitioners, health and safety committees, human resources professionals and librarians). Through the CHN, workplace health is put in the context of many different
topics and groups to encourage the prevention of ill-health and promote well being with topics including everything from “Active Living” to “Healthy Eating” to “Violence Prevention” and groups such as “Youth” and “Aboriginal Peoples”. The workplace health collection strives to be comprehensive and well balanced to meet the wide range of information needs of the audience groups; improve access to credible and practical workplace health information from organizations across Canada; and ensure that it is timely, relevant and responsive to users’ needs.

**Workplace Health – A Continuous Evolution**

CCOHS continues to take a comprehensive approach to health and safety in the services it provides to the Canadian people. The impact of a healthy workplace is far reaching. They contribute to the productivity, competitiveness and wealth of our economy and impact the quality of working life, affecting families, communities and the whole of our society. CCOHS will continue to improve and expand the content they provide to Canadians and is committed to inspire and enable people to participate in making their workplaces healthy so that all may benefit and thrive.

**References:**

Health Canada Workplace Health Strategies Bureau ([www.hc-sc.gc.ca/ewh-semt/occup-travail/work-travail/wh-mat-strategies_e.html](http://www.hc-sc.gc.ca/ewh-semt/occup-travail/work-travail/wh-mat-strategies_e.html)). Resources include health promotion models developed for larger corporations, small businesses and farms, as well as various workplace health surveys for employees.

---

**Integrating health protection and health promotion at the workplace: The Center for the Promotion of Health in the New England Workplaces (CPH-NEW)**

Laura Punnett  
Department of Work Environment  
University of Massachusetts Lowell, USA  
A WHO Collaborating Centres in Occupational Health  

Laura_Punnett@uml.edu

The Center for the Promotion of Health in the New England Workplace (CPH-NEW) is a Center for Excellence funded by the U.S. National Institute for Occupational Safety and Health (NIOSH) in 2006. It is a collaborative research-to-practice initiative by researchers from the University of Massachusetts Lowell and the University of Connecticut, both public institutions.

The Center’s goal is to implement and compare several strategies for integrating two core public health areas, occupational health and safety (OHS) and health promotion (HP) at the workplace. Across all CPH-NEW projects, the health outcomes of particular interest are musculoskeletal health, mental health, and cardiovascular health, which share many common risk factors in terms of both physical and psychosocial features of work and their organizational determinants (work scheduling, decision latitude, division of labor, quality of supervision, etc.) (1).

Through several different projects, we will evaluate opportunities for, and obstacles to, these OHS/HP integration efforts. In two different research projects with complementary study designs, we will evaluate whether this strategy provides enhanced health benefits and/or greater cost-effectiveness than OHS interventions alone. A third dissemination/translation project will develop and evaluate educational curriculum for health care professionals to improve their knowledge and practice skills related to workplace stress and its influence on health behaviors.
One study, “Promoting Physical and Mental Health of Caregivers through Trans-disciplinary Intervention (Pro-Care),” is being carried out in a chain of more than 200 nursing homes (long-term care facilities for elderly and disabled persons). The company has already implemented an ergonomics program that focuses on introduction of mechanical resident handling devices coupled with employee training. The study will compare worker health outcomes and cost-effectiveness in three categories: a. Workplace lifting reduction program only; b. Lifting reduction plus a traditional health promotion program; and c. Lifting reduction plus a participatory HP program initiated by the investigators in conjunction with employee volunteers.

The other study, “Health Improvement through Training and Employee Control (HITEC),” involves pairs of workplaces matched on an economic sector (e.g., manufacturing or state government). Within each pair, one site will implement a traditional but “best practices” workplace HP program along with ergonomics interventions developed by the investigators and customized to the needs of those workplaces. The other site within each pair will implement an experimental program featuring employee participatory design and control of both the ergonomics and the HP activities. Worker health outcomes and cost-effectiveness will be compared by program type.

Health promotion programs have traditionally targeted individual health behaviors such as exercise, diet, and smoking, as well as their immediate consequences such as obesity. These are established risk factors for chronic health conditions such as cardio-vascular disease (CVD) and diabetes; there is some empirical evidence that they contribute to the development of musculo-skeletal disorders (MSDs) but little knowledge of whether or not they interact with physical workload to increase risk even further. It is possible that successful HP programs could have the potential to enhance the health benefits of occupational ergonomic improvements for musculoskeletal health.

However, too often workplace HP has focused on health behaviors, stress management, or coping skills while ignoring the underlying causes of stress (2). Occupational ergonomics in its broadest conceptualization provides a framework to address the workplace preconditions of job stress. Psychosocial conditions such as the opportunity to participate in decisions about how and when tasks are done, use of existing skills as well as opportunities to learn new ones, consistent and constructive feedback, and positive interpersonal relationships at work are known to be directly related with both cardiovascular and mental health (3-6).

Probably less widely recognized is the extent to which individual health behaviors are actually associated with working conditions. Features of the work environment ranging from work scheduling to supervisor-employee relations can be either barriers to or facilitators of healthy behaviors. Improved work organization can provide time, space, and material and social support for improvements in dietary choices, smoking cessation, participation in exercise classes, and improved work-family balance. Psychosocial stressors at work, especially low decision latitude, have been associated with obesity (7), alcohol consumption (8), smoking and aerobic exercise during leisure time (9). Thus individual health behaviors represent decisions made not only in relation to intrinsic factors (knowledge, beliefs, motivation) but also in relation to the physical and psychosocial environment.

It is also known that sustainable changes in health behaviors depend on health self-efficacy (HSE), or belief in one’s ability to improve one’s health, as well as on environmental factors. HSE is affected positively by successful experiences with and opportunities for decision-making. Thus it is especially important to create environmental conditions that foster self-efficacy and healthy behaviors, such as positive human relations at work (10) and opportunities for decision-making (11). Workplace programs empowering participant decision-making over workplace factors that affect mental or physical health could reduce psychosocial strain and its negative health consequences (12). Participatory selection, design, and implementation of health promotion interventions are ways to instill a sense of empowerment and bolster program effectiveness. Workers themselves, the “targets” of the intervention, are best qualified to identify obstacles and opportunities present in their daily lives and their home and work environments (13,14), so their input is crucial to designing interventions that are feasible in these contexts. Also, the
very act of participating in a team with a common goal has been shown to improve psychosocial aspects of the work environment (15,16).

The definition of health promotion has been evolving in recent years to a concept that is broader than the prevention of specific diseases or their separate risk factors. As discussed by the World Health Organization (17), HP should encompass the ability of people to increase their control over their health and to reduce health disparities within or across different societies. Workplace HP programs are likely to be much more effective if they empower employees to address hazards present in the work environment (18), as well as constraints on health behaviors that result from the conditions of work. A focus on work organization interventions and on employee participatory processes offers a way to improve health by empowering healthy decision-making.

More information about CPH-NEW is available at: http://www.uml.edu/centers/cph-new/ or by e-mail to cphnew@uml.edu.

References:

How to make the business case for health promotion at the workplace

Wolf Kirsten
International Health Consulting
Berlin, Germany
wk@wolfkirsten.com

A recent worldwide survey of 555 companies by Buck Consultants and Vielife entitled “Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies” stated that 86% of North American employers (who responded) offered health promotion or wellness programs at the workplace while only 25% did in Europe and 21% in Asia. The main reason for this imbalance is because US employers are keen on controlling the costs of providing health care benefits for their workers. When asked what the main reason for offering wellness programs was, European employers listed the reduction of employee absences as the number one reason (improving workplace morale as number two) while US employers listed reducing health care costs as number one (and improving worker productivity as number two). These are important findings in the realm of advancing health promotion at the workplace.

Employers need to be convinced that investing in the health of their employees is in their best interest from a business perspective. Legislation and occupational health standards will only go so far when it comes to workplace health promotion. Legislating exposures to dangerous substances and poor working conditions – still a major challenge in developing countries – is both necessary and effective, but chronic diseases are not as straightforward to handle. The impact employers can have on tackling the global chronic disease challenge is enormous. Therefore, the WHO Global Plan of Action on Workers’ Health includes “health promotion and prevention of chronic and communicable diseases” as a key pillar. The bad news is that health promotion is still a relatively new field and changing behaviors is a complex issue and often unsuccessful. The good news is that a growing number of workplaces have recognized the need for implementing health promotion and wellness programs. In addition, significant international organizations like the WHO and the World Economic Forum are supporting this trend. Nevertheless, when looking at employers worldwide, including small- and medium sized enterprises, as well as the informal sector, only a minority are offering programs for their employees. So how can we increase this number?

Making the business case

The Global Plan of Action on Workers’ Health will provide much needed guidance on how to create healthier workplaces and make its way to the member countries through their respective ministries of health. However, the business world, i.e., for-profit and non-profit employers, needs to be convinced of the value of investing more in the health of their employees. In addition to the central goal of improving the health and quality of life of people, health promotion professionals need to make the case in business terms. The company CEO has to be convinced to dedicate funds and resources to a health promotion

---

**Top Reasons for Offering Health Promotion / Wellness Programs**

<table>
<thead>
<tr>
<th>United States</th>
<th>Europe</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>reducing health care costs</td>
<td>reducing employee absences</td>
<td>improving workplace morale</td>
</tr>
<tr>
<td>improving worker productivity</td>
<td>improving workforce safety</td>
<td>improving worker productivity</td>
</tr>
<tr>
<td>reducing employee absences</td>
<td>improving workplace safety</td>
<td>attracting and retaining employees</td>
</tr>
</tbody>
</table>

**Source:** Buck Consultants, 2007
program. This is not an easy job with competing proposals and needs within a company and a potential downsizing period around the corner. Health promotion and wellness are newcomers on the block and are often regarded as soft concepts or fields. In addition, health promotion professionals often lack the marketing and business communication skills to make the case. In the United States, one can effectively argue that healthier employees will affect the bottom line of a company as the employer provides health insurance for their employees and carries the burden of rising health care costs. This is underlined by an abundance of studies and reports that exist on the cost-benefit and return-on-investment of workplace health promotion programs. Typically, a health promotion professional would walk into a meeting with the CEO or Human Resources (HR) manager with four persuasive sets of documents in hand:

1. a number of published and peer-reviewed cost-benefit studies;
2. an estimate of prevailing health risks amongst employees;
3. a projection of how this will affect the company bottom line in the future given the aging employee population, and
4. several examples of successful programs at leading companies (ideally in the same industry).

One can build a relatively strong case with such supporting documentation. However, it is a different story in Europe. Here, employers often rely on the existing legislation and public health promotion initiatives. The understanding is that the employer provides a healthy (physical) working environment – and little else - and the employee leaves his or her private life at home. For example, this is evident with regard to smoking at the workplace in numerous European countries, which is perceived as an individual right which the employer should not meddle with. Given the rapidly aging workforce, the alarming increase in obesity, diabetes (and related chronic disease) and stress-related disease, this thinking has become outdated. These developments of concern have led employers to gradually rethink their involvement in the employees’ health and well-being, especially as public and health insurance-driven initiatives are slow to come and are fragmented.

Although the direct cost impact of poor employee health is not felt by European employers as it is in the US, indirect costs in the form of absenteeism, turnover, morale etc. are significant and growing. Therefore, the business case must be made in a different manner. The reduction of absenteeism is still attractive to employers, but has its limitations due to other non-health-related influences and the currently low rates in many countries to begin with. Convincing senior management of the benefits of health promotion in improving workplace morale and reducing turnover is promising, but the huge potential with regard to “presenteeism” will make a better argument in the future. The phenomenon of presenteeism – employees at work who are not performing at their maximum capacity due to disease or health risk behavior – and its implications with regard to productivity and cost is gradually being understood. Although hard to quantify and without a large research foundation (most studies come out of the US) referring to presenteeism is too good of an opportunity to pass up when making the business case. The potential related productivity gain through health promotion and the resulting competitive advantage is music in the ears of every CEO or CFO and multiple times that of reducing absenteeism.

Several questionnaires measuring the impact of health on productivity have been validated (e.g., Work Limitations Questionnaire, Health and Work Performance Questionnaire (HPQ)) and are being featured in research studies. This field of study is growing and will provide further supporting arguments in the near future. Having pointed out the significance of good data and scientific evidence, whether health promotion is implemented at a workplace or not often comes down to a personal decision of one or two people at the top. Has the leader understood and personally experienced the benefits of health promotion (e.g., lost weight, ran a marathon, successfully recovered from a heart attack) he or she will much more likely wholeheartedly support the initiative.

**Employers worldwide want a healthy and productive worker**

The promising news is that several multinational organizations are planning to expand programs globally: a 2006 Watson Wyatt study reports that 35% of surveyed multi-national organizations plan to add
health promotion programs. Employers worldwide want a healthy and productive workforce. Leading corporations like Johnson & Johnson have ambitious plans to advance health promotion globally to all of their sites, whether in Brazil, Belgium or India. This involves providing standards, policies and support from the headquarters in the US. Information technology (IT) companies, such as Intel and Cisco Systems, have also recognized the global significance of health in human capital management of their mostly young employee population. As they massively expand into Asia (e.g., India and China) talented employees need to be attracted, retained, healthy and productive in their demanding jobs. However, the foresight of leading multi-national organizations will only concern a fraction of the employee population in any country as the majority of enterprises are small and medium-sized or of an informal nature. This is where the WHO can have a significant impact and encourage state institutions, public agencies and health insurances to be more proactive, recognize the problematic trends and support workplace health promotion initiatives.

Workers’ health in the petrochemical and oil-extraction sector in the Bashkirian Republic of the Russian Federation

A.B. Bakirov
Institute of Occupational Health and Human Ecology, Ufa, Russia
A WHO Collaborating Centres in Occupational Health
Bakirov@anrb.ru

The highly developed multisectoral economic structure of the Bashkirian Republic ranks fifth in the Russian Federation. Bashkoria is one of the basic oil extraction regions in Russia. Over the past years, based on oil extraction, power engineering, oil refinery, chemical, gas and oil industries as well as oil engineering have been developed.

About 88,000 people are working under conditions unfavourable for health. Work environment hazards include high levels of noise, ultra- and infrasound, dusty indoor air, vibration, and ionizing radiation. The number of heavy physical workers employed in enterprises of raw oil and natural gas extraction, oil production processes, and construction is high. The problem of improving female working conditions is still urgent. About 22,000 women (13.4%) are exposed to hazardous factors. More than 3,000 women are in physically demanding employment. A total of 12,500 people (7.7% of the total number of workers involved in 150 republican enterprises representing different types of industries) are exposed to carcinogenic substances and products.

Risk factors present in the work environment, the use of unsophisticated equipment and imperfect technological processes cause complete or partial work disability and occupational diseases. Under these conditions, the development and implementation of measures aimed at the elimination of work-related illnesses and accidents are of great importance for occupational safety, maintaining health and work ability in the workplace.

Occupational morbidity formed by 9-10 basic republican economic sectors makes up 70-80% of all occupational pathology. The level of occupational morbidity in these industries is 1.5-1.8 times greater than the average republican one. Women are affected by 36.4% of occupational diseases. The average age of persons with occupational diseases is 50 years. Their mean length of work with a harmful impact on human health is 23.4 years.

Our concern is focused on a low level of occupational diseases detection at an early stage. In 2006, health examinations detected 56.9 % of chronic occupational diseases. The majority of cases were identified during health care visits. This is due to a poor quality of medical examinations, shortage of well trained occupational health professionals, employers' unwillingness to carry out regular health examinations. The burden of the cost of ill health related to occupational morbidity is steadily increasing. In 2006, annual payments of compensation from social insurance funds for work-related injuries and diseases...
accounted for 550.6 million roubles including 181.7 million roubles for medical, social and occupational rehabilitation of workers as well as the financing of supplementary medical examinations of workers involved in hazardous work environment. Over the last decade, economic and social conditions in the Republic, as well as in the whole country, have changed significantly. The percentage of the self-employed has increased. Both employees' and employers' attitude towards job has changed, too.

At present, with unemployment and its threat, special emphasis should be placed on the issues of the balance of relationships between the State, labour and business, resulting in a new attitude of employers towards legislation related to the control of working conditions and workers' health, including a sharp decrease in the number of occupational health units and health resorts. With the current traditional approaches to occupational risk assessment based on the analysis of chemical, physical and biological hazards alone, none of these problems can be solved. Consequently, quite a new approach to the issues of the working potential formation as well as its working longevity in this country is needed.

The Ufa Institute of Occupational Health and Human Ecology is a WHO Collaborating Centre. Since 2001, it has been carrying out complex scientific studies on the European HESSME model with the support of WHO headquarters. The model is a complex system of health, environment, safety and social management in enterprises at different levels – from a workplace to the country overall. To implement the European model of workplace health management, a concept taking into account the socio-economic realities and current occupational safety system in the Russian Federation has been formulated. It significantly differs from that of the European Union countries.

According to the concept, a complex system of health, environment and safety management in enterprises is a multidisciplinary approach that can be used by industrial and other enterprises to promote health and safety in the workplace and to minimize its harmful impact on the environment.

The system includes the aspects of environmental safety related to the impact of the workplace and the whole enterprise as well as its products on neighbourhood health. It results from a long-term purposeful policy pursued by enterprises as well as the State itself and implies involving all stakeholders inside and outside an enterprise.

The system aims at:

- making statements about health place and role in the structure of personal and social moral values;
- developing healthy life style as a prevalent way of the working population vital activity;
- sustaining the health and maintaining the work ability of the population;
- promoting occupational and environmental health and safety;
- preventing occupational, work-related and outside work diseases; and
- developing an appropriate work culture and work organization contributing to health protection and safety.

The structure of HESSME functioning consists of three main levels:

1. the local level including two sublevels: a/ workplace; b/ enterprise (organization, institution, company);
2. the regional level; territorial (a subject of the Federation) and sectoral (enterprises of one economic sector)
3. the federal level is also considered in two projects – territorial (Federation on the whole) and sectoral.

The model has been applied at the pilot workplaces in petrochemical and oil-gas-extraction enterprises. The following stages have been proposed:

- assessment of employees’ needs for health promotion and their satisfaction;
- assessment of the state of health of the working age population;
assess and improve working conditions; and
development of measures aimed at the working population health protection and improvement.

The studies show that in both the “Bashneft” and “Salavatneftorgsintez” joint stock companies the employers take radical and effective measures to maintain the workers’ health. In addition to the developed system of occupational and environmental safety, the enterprises have a powerful social infrastructure including health resorts, occupational health units with sophisticated equipment, and sports complexes. Much attention is paid to pre-school and school institutions. The working conditions in both oil-extraction and petrochemical enterprises meet the technical demands. Technological advances used in both enterprises allow decreasing the rate of work-related injuries and morbidity.

Occupational morbidity is one of the most objective criteria of precarious work impact on workers’ health. Only single cases of occupational morbidity are registered in oil enterprises. In petrochemistry and oil-extraction, the rate of occupational morbidity is higher than average republican levels and can be estimated at between “mean” and “low” levels. In the last few years, a tendency towards an increase in occupational morbidity including toxic hepatitis has been observed in the “Salavatneftorgsintez” joint stock company.

Today, the analysis of the data on technological factors impact on working age population is impossible without psychosocial aspects including work-related and outside-work stress. A strong possibility of stress combined with low resistance to it affects on an individual. The research of work-related stress has demonstrated that its possibility according to hygienic criteria in both economic sectors frequently corresponds to a mean rather than high level. As for the individual’s stress resistance, about 35% of employees tend to have low and very low levels of resistance. Besides, the data obtained show that there is a difference of opinion between the employer and the employees regarding health promotion issues. To help employees solve health maintenance problems a special training programme is necessary.

To provide activities for employees in the implementation of health management system, employers have to:

admit a leading role of the employees in solving health promotion issues;
show economic and moral concern for the employees, separate work forces and the enterprise;
reflect health problems in the company policy and in the enterprise’s continuous performance; and
give the employees an opportunity to share their experience and knowledge with the enterprise leaders, and persons concerned about the system implementation.

The Government of the Republic of Bashkortostan generally recognizes the fact that health is of high priority. In accordance with the European approaches, the Republican Government focuses on the improvement of the population health. This issue is known to be important for not only public health but also other sectors, enterprises and organizations as well as every individual employee. Issues concerning constitutional rights of the population to have healthy and safe working conditions are under the legislative and executive regulations in force in the Republic of Bashkortostan. Occupational health and safety issues are legislative and protected by the authority organs. The republican law of occupational safety has been adopted. The main aim of the current law is the development of new mechanisms of economic stimulation of all workplace stakeholders regarding the improvement of working environment and work as well as social security of the working population. The Bashkirian Cabinet of Ministers has developed and introduced a republican programme on healthy lifestyle for 2008. The Government is financing the priority issues of reproductive health, mothers’ and children’s’ health protection, and control of communicable diseases.

In conclusion, occupational health and safety, the maintenance and promotion of health and work ability of the working population are strategic priorities in the Republic of Bashkortostan. Effective measures for individual, social and occupational rehabilitation are being taken. The Ufa Institute of Occupational
Health and Human Ecology is successfully implementing the European model of workplace health management. The programme developed concentrates on the promotion of occupational and environmental health as applied to working conditions of oil extraction and petrochemical enterprises.

### Occupational Health Technicians

**Ed Robinson** is the business manager for the Centre for Workplace Health and deputy manager for Activity Area 2 for the WHO Network of Collaborating Centres in Occupational Health

*Edward.Robinson@hsl.gov.uk*

**Jo Harris-Roberts** heads the Centre for Workplace Health team at HSL and is Activity Area 2 programme manager for the WHO Network of Collaborating Centres in Occupational Health

*Jo.Harris-Roberts@hsl.gov.uk*

Health & Safety Laboratory, Buxton, UK

A Collaborating Centre in Occupational Health

Within the UK, there is an accepted need to develop a workforce that is equipped with knowledge, skills and competence to deliver the government’s occupational health (OH) and safety agenda, which supports the commitment to improving the health and well-being of the working age population. (This is a key element of a wider UK welfare reform agenda as set out in the Government’s White Paper; Choosing Health: Making Healthier Choices Easier\(^1\).)

The provision of education is therefore key, and developing an OH strategy within an organisation would benefit employees and the business itself by maintaining a healthy workforce, improving efficiency and reducing the costs related to poor health. However, it is vital that appropriately trained individuals are readily accessible to deliver and support these OH initiatives.

It is acknowledged that qualified OH nurses, doctors and other OH specialists are in short supply, which poses a fundamental problem in terms of achieving this remit. Furthermore, where they are employed, there is a need to ensure their competence to practice remains extant through regular, high-quality and focused education. The development of specialist skilled leaders in the field of occupational health and safety through Master (MSc) level enquiry is a critical factor in workforce development and leadership, and it is also recognized that the new and emerging roles of those allied to OH specialists, such as technicians, must be developed if the aspirations of the Department of Health, Department of Work and Pensions and the Health & Safety Executive are to be met.

The Centre for Workplace Health (CWH) represents a formal partnership between the Health & Safety Laboratory (an agency of the UK’s Health & Safety Executive), the University of Sheffield and the Sheffield Teaching Hospitals NHS Foundation Trust. This centre has its roots in developing simple and practical solutions to workplace ill-health issues, backed up by a solid evidence base to deliver its aims of high quality research, OH service delivery and OH training.

---

CWH has supported its own model for service delivery by utilising ‘Occupational Health Technicians’ (OHT’s) as a cornerstone of the OH team which also includes OH Nurses and Physicians. In this scenario, the role of the OHT is to carry out routine elements of an OH service and typical tasks would include pre-employment screening, health surveillance (e.g. for Hand-arm vibration, respiratory conditions and hearing) and assessments such as display screen equipment and work station suitability. Using this model, the service is effectively technician-delivered and nurse-managed, with interpretation of results and feedback provided by those suitably qualified (nurses and physicians).

This approach to service delivery has been well received by CWH customers as it provides easy access to high quality service provision at a more cost effective level than through the sole use of nurses or physicians. Furthermore, this approach ensures that the skills of the OH team are used effectively and allows those individuals time to provide other OH service components more suited to their level of expertise (e.g. review and development of policy) but also to pursue other research or training activities whilst overseeing the work of the OHT’s.

Recognizing the advantages to this model of service delivery and how such a model could transform the provision of OH services within the workplace, CWH has taken steps to formalize the training for OHT’s to prepare them for their role. By working closely with the University of Sheffield School of Nursing and Midwifery staff (and the newly formed Centre for Health & Social Care Studies and Service Development), CWH has developed the first “Occupational Health Technician in Practice: Short Course”.

The course is run over 10 study days and is focussed on a combination of academic and practical sessions for practitioners who have no formal OH specialist qualifications but need to develop skills to undertake and develop a range of OH surveillance and environmental risk assessment activities. It will enable those who are involved with occupational health & safety issues (for example; nurses, health and safety advisors, safety representatives, human resource advisors, and those working in small/medium enterprises), to apply these skills independently or as part of a multi-disciplinary team. The course covers risk assessments, health surveillance and screening, sickness absence, mental health issues, respiratory disease, hand-arm vibration and skin disease, musculoskeletal disease, stress and also legal, compliance and quality issues.

Currently, there is no set standard criteria for an OHT course, however, as a formal course of the University of Sheffield, the content and format has undergone a rigorous validation procedure to ensure that it is fit for purpose and it will also undergo an assessment process in the future to determine its effectiveness. This will include formalized feedback from the students which will highlight if any modifications to the course are required. Since the launch of the course, there has been significant interest from the health and safety community in the UK and indeed larger organizations have approached CWH to arrange bespoke training for several members of their staff. This has the advantage of tailoring the course content to suit the requirements of the specific industry sector so that students are well versed in applying their skills within their place of work.

Whilst the course is still very much in the early stages (the first intake began studying September 2007), it will be important to assess the practical application of the learnt content in the workplace by the technicians themselves. Furthermore, it is intended that the course can be used as a stepping stone to further educational opportunities in the field of occupational health and safety, and it is important that it can deliver the right level of content for this purpose too, as well as motivate students to consider pursuing a career in OH which in turn will help to build a culture of effective OH provision within organizations, delivered and supported by qualified practitioners.

For more information about the OHT short course, please contact the Centre for Workplace Health: www.cwh@hsl.gov.uk
The hidden cost of computing: most Irish organisations underestimate the cost of ergonomics in office environments

Olive Sheehan
Director, Occuhealth Ltd.

Technology has had a profound effect on the way we live and work. As a result, we are spending more time sitting at desks and using computers, it has greatly increased the occurrence of related musculoskeletal disorders. Recruitment and retraining costs have increased significantly over the last decade. Skilled and experienced office personal need to be replaced due to occupational health related injuries. The average cost of replacing employees due to injury, long-term illness or early retirement is approximately €3,800-4,500 per employee (Source: The RSI Association).

According to a recent US survey, nearly 60% of office workers using a computer suffer from wrist pain while at the computer, and 51.2% say their keyboards are placed too high. But ergonomics are not the only problem: 49.7% percent of employees say they ignore recommendations to take breaks from their computers. (Source: VHI website)

Employers whose staff develop RSI conditions as a result of work face a range of costs, some evident, others hidden. These include:
- Loss of production
- Poor worker morale
- Sickness payments for those unable to work
- Ill-health retirement costs for those permanently unable to work
- Injury benefits payments in some industries
- Bad publicity
- Difficulties with recruitment due to a number of the above factors
- Litigation costs and compensation payments to those successfully pursuing negligence claims
- Increased insurance premiums
- In some cases, the total cost to an employer of an ill-managed RSI condition can be the equivalent of up to 50 percent of the employee’s salary.

How can we improve our work practices? Experience shows, that adequate training in ergonomics can significantly reduce the risk of injury. However, what exactly is ergonomics? Office ergonomics applies science to workplace design to maximize productivity while reducing operator fatigue and discomfort. Many computer users have noticed the occasional aches and pains and discomforts that go hand in hand with spending long periods of time in front of the computer. Staring at a monitor for hours on end, year after year will most likely cause pains magnifying in frequency and severity. Already many computer users in Ireland experience discomfort when using the computer, which has become part of the daily routine. Research shows that these symptoms are especially noticeable when using a poor ergonomic setup in the office workplace. These symptoms can present a major problem in the ability to work effectively and healthily. Poor ergonomics in a computer environment can lead to permanent personal injury.

The most common occupational injuries for computer users in Ireland are computer related Repetitive Strain Injuries (RSIs), including conditions like Carpal Tunnel Syndrome and Tendonitis. Many of these cases would be easily preventable, but still occur due to ignorance of the symptoms or the severity of the injury. Ironically, repetitive strain injuries have been documented as far back as 1793. RSI is caused by making the same movement over and over again. For computer users RSI can result from poorly
designed workstations with monitor, keyboards placed too high, ill-fitting chairs, stressful conditions, extended hours of typing, and using a mouse. When spending long hours in front of the computer, the style of sitting, typing, pointing, and swiping, can affect more than the daily performance - it can influence long-term health.

The ILO Occupational Health Services Convention No. 161 and Recommendation No. 171 promote the advisory role of occupational health professionals in enterprise. Occupational health services should act as advisers on occupational health, hygiene and ergonomics. They should advise on the planning and organization of work, the design of workplaces, on the choice, maintenance and condition of machinery and other equipment, as well as on the substances and materials used in the enterprise.

A summary of what a company can do to promote a healthier work environment includes the following:

- Educate employers and supervisors and employees about the risks;
- Provide proper workstations and assistive devices;
- Schedule alternative work activities and frequent breaks for employees engaged in highly repetitive tasks; and
- Develop procedures to respond to employee concerns about RSI problems and integrate ergonomics into the company’s total safety management.

Sensible introduction of ergonomic principles will help provide a healthy workplace for computer users as well as reduce and prevent the human and financial costs of computer-related health problems. Ergonomic program evaluation should not be seen as a one-time effort; it should be a continuous, ongoing approach used to optimize the working environment. Olive Sheehan, Director of Occuhealth says “setting up your workstation properly may be the single easiest way to prevent injuries; we need to be aware of how the design and the arrangement of our equipment can impact our comfort, health, and productivity.”

Injuries due to manual handling account for one in every three accidents reported to the Health and Safety Authority (H.S.A.) in Ireland. Although discussions indicate that Manual Handling awareness increased in recent years many employers are still unaware of the regulations. The Manual Handling of Loads Regulation place a requirement on the employer to avoid/reduce hazardous manual handling, conduct Manual Handling Risk Assessment, and to provide instruction and training.

Traditionally in Ireland there has been an over reliance on the provision of training in correct manual handling as the only means of reducing the risk of injury. For example a H.S.A. study carried out in 2001 found that 83% of workplaces did not conduct manual handling risk assessment where required. Although there are many case studies and indications that poorly arranged ergonomic settings in an office environment can affect the employee’s health, many Irish companies are still unaware of the risks. In the year 2000 alone, over 10,000 compensation claims with regard to work related injuries and ill-health were lodged in Ireland at a cost of approximately 200 million Euros. The Irish Quarterly National Household Survey for 2000 found that over 1.1 million working days were lost due to work-related injuries and ill-health.

Clearly, the reduction of preventable workplace accidents is compatible with the profit-making motive of companies and the implementation of sound health and safety practices can deliver considerable savings to business. The employee’s health is not put at risk. ‘Health’ and ‘safety’ in this context means the prevention of accidents and ill-health while at work. By implementing proper procedures management can eliminate or minimize risks to employees (H.S.A.). Compared to the USA, Canada and Australia, the awareness of Occupational health, training and the added benefits are still not realized in Europe. Many companies are not that attentive to the legal requirements (e.g. Health and Safety Regulations). However, experience shows that training, advice and guidance can prevent the consequences of a poorly designed workstation setup. It leads to a positive and safe work practice. Due to a general shift towards the use of technology over the past decades, injuries with machines have reduced. However manual
Handling injuries still account for a large proportion of injuries recorded. Technology, while helping to reduce risks has given rise to its own hazards from working with visual display units (VDU) or computers for long periods of time. Poor ergonomics (badly designed workplaces or workstations) can cause physical injuries as can poor manual handling, slips, trips and falls. (Health & Safety Authority). Employers should think not only in terms of Euros but moreover in terms of their employees' health and welfare.

More research is required to investigate why companies are so reluctant to adopt policies and legislation. Our review showed that there are appropriate policies in place. We need to protect and promote health at the workplace. However, national and international action plans and strategies need to be enforced.

---

The National Register of radiofrequency workers

Ian Litchfield
Institute of Occupational and Environmental Medicine
University of Birmingham

i.litchfield@bham.ac.uk

Introduction

Public concerns over the health effects of exposure to radiofrequency (RF) radiation have been with us since the proliferation of mobile telephony and associated technology in the late 1990's. In response to these concerns, the British Government called on the head of, what is now, the Radiation Protection Division of the Health Protection Agency (HPA), to form the Independent Expert Group on Mobile Phones (IEGMP). Chaired by Sir William Stewart, now Chairman of the HPA, this group embarked on a broad programme of consultation across the UK and abroad. Meeting with scientists, network operators, broadcasters, pressure groups and members of the public they also assessed peer-reviewed literature and other scientific writings. After two years they produced their first report which concluded there was no evidence to suggest that exposures to radiofrequency (RF) radiation below the international guidelines cause adverse health effects. However, it was acknowledged that there may be biological effects occurring at exposures below these guidelines, so a precautionary approach was adopted and the implications of this approach were reflected in the recommendations made by the group. One of these recommendations was that a register of occupationally exposed workers be established enabling a long-term follow-up study of cancer risks and mortality, amongst those occupationally exposed at relatively high levels. Ultimately, if adverse effects of exposure to RF radiation are identified, then the Health and Safety Executive of the UK (HSE) would establish a system of health surveillance of the affected groups.

The Establishment of the Register

In response to the recommendation of the IEGMP report the HSE established a Steering Group consisting of delegates from across the industrial sector that utilized transmitting antennas, as the recommendation was made in a report concerning mobile telephony. The Steering Group included representatives from the television and radio broadcasters, the Mobile Operators Association, the Ministry of Defence and the relevant trade unions.

At this stage it was decided that the database would be named the National Register of RF Workers and would be confined to those exposed to intentional emitters, i.e. those whose work brings them in close proximity to transmitting antennas on telecommunication, broadcasting masts and similar structures. Because of this the decision was taken not to include groups that use RF outside of this context, for example welding, induction heating or in health care. It was agreed that a decision would be made on extending the Register to include workers in these sectors after the Register in its initial form had been firmly established.
The HSE in accordance with the Steering Group contracted the Institute of Occupational and Environmental Medicine (IOEM) at the University of Birmingham to administer the Register. Led by Tom Sorahan Professor of Occupational Epidemiology their responsibilities include the storage and administration of the database and the recruitment of individuals.

**Recruitment**

As a result of the Data Protection Act (UK), each person invited to join must provide informed consent before the Register can legally retain information including the individual’s unique identifier, details on their current post, work history and incidents of known high exposure. A variety of methods were used to promote the Register and encourage the participation of workers. These methods included distributing a range of promotional material to training providers and relevant companies, including information booklets and FAQ leaflets. Members of the Register team also visited company premises and made presentations to company executives and staff groups.

Identifying and contacting some of the smaller companies has taken some time due to the fluid nature of the industry, however we have now contacted all relevant companies within the UK and the Register continues to grow. Next year will see recruitment in the Ministry of Defence and the National Air Traffic Service start in earnest though Professor Sorahan believes “…more work is needed to ensure that all individuals eligible to join are aware of the Register and have made an informed decision on whether to participate…it is important that as many of the relevant individuals as possible join the Register as the greater the number of participants the greater the confidence we can have in the findings”.

**The follow-up study**

**Study population**

Ultimately the cohort will comprise of a minimum of 2,500 male employees. All employees will have some period of employment working in the environments described previously in the period 1961 onwards. In order to account for variation in exposure between different occupationally exposed jobs, participants are asked to supply their job title. This is then placed in one of seven job categories. The level of exposure typically experienced by each job category is informed by a five-year study undertaken by the IOEM in conjunction with the Radiation Protection Division of the Health Protection Agency. This work, entitled ‘A Feasibility Study for an Epidemiological Investigation into the Health Effects of Radiofrequency Fields and Radiation’ produced a job exposure matrix for job titles relevant to the Register. The Register follow-up study will receive follow-up particulars (copies of death certificates and cancer registration (incidence) details from the National Health Service Central Register (NHSCR) of the Office of National Statistics (ONS). Underlying cause and multiple-cause coding will be supplied by the ONS for all deaths according to the tenth revision of the International Classification of Diseases (ICD-10). The Register follow-up study will receive follow-up particulars (copies of death certificates and cancer registration (incidence) details from the National Health Service Central Register (NHSCR) of the Office of National Statistics (ONS). Underlying cause and multiple-cause coding will be supplied by the ONS for all deaths according to the tenth revision of the International Classification of Diseases (ICD-10).

**Standardized mortality ratios and standardized registration ratios**

The mortality experience of the cohort will be compared with that which might have been expected to occur if rates of mortality for the general population of England and Wales had been operating on the study cohort, having due regard to the composition of the study cohort by sex, age (five-year age groups), and calendar year (five-year calendar periods). Expectations based on person-years-at-risk (pyr) will be calculated using the PersonYears computer program. Individuals enter the pyr on the date of consenting to join the Register. Individuals leave the pyr on the date of death, date of emigration, date last known alive or the closing date of the study, whichever is the earlier. Individuals make no further contributions to expected or observed numbers past the age of 85. Standardized mortality ratios (SMRs) will be calculated as the ratio of observed to expected numbers of deaths expressed as a percentage. In calculating P-values and confidence intervals, it will be assumed that deaths occur as a Poisson process.
Any significance tests will be two-tailed. Similar analyses will be performed on the cancer registration data to calculate standardized registration ratios (SRRs). Overall SMRs and SRRs will be calculated for individual sites of cancer (3-digit IICD codes) as well as SMRs for broader non-cancer causes (ICD chapters). Causes of special interest will be selected on the basis of significantly elevated SMRs or SRRs obtained either from this study or from similar studies of RF workers in other parts of the world. For causes of special interest, SMRs and SRRs will also be calculated by industry sector (telecommunications or broadcast), job type (1-7 names) and period from first RF work (ten-year intervals). In addition SMRs and SRRs for causes of special interest will also be calculated separately for workers reporting any high exposure incidents. The follow-up study is expected to start by the end of 2008 and run for the next ten to fifteen years.

Collaboration

The Register has close links with the Mobile Telephone and Health Research programme (MTHR) in the UK. Chairman of the Register Steering Group is National Health and Safety Manager for National Grid Wireless, Steve Wilkinson. He welcomes the relationship between the two organizations and is “…delighted that the MTHR recognize the importance of our work and acknowledge the benefits such research provides, both to employees and employers”.

But it is not only the MTHR that recognize the value of the Register. Sir William Stewart, Chairman of the HPA recently commented that his organization “…welcomes the establishment of the Register by the Institute of Occupational and Environmental Medicine at the University of Birmingham. This should facilitate the determination of whether, occupationally, there are health effects from exposure to RF fields not observed in the general public.” Going forward, the Steering Group would like to collaborate with other bodies undertaking similar research across Europe and the rest of the world to the mutual benefit of all those working with RF radiation.

References

1. Independent Expert Group on Mobile Phones; Mobile Phones and Health, 2000 (IEGMP pub)
2. A feasibility study for an epidemiological investigation into the health effects of radiofrequency fields and radiation (University of Birmingham, unpublished)
Building capacities for primary prevention of occupational hazards, diseases and injuries in New Zealand

Rosaleen Loughman
rosaleenl@nzctu.org.nz
New Zealand Council of Trade Unions

Te Kauae Kaimahi

One of the most notable achievements of the New Zealand Council of Trade Unions – Te Kauae Kaimahi (CTU) over the last five years is a health and safety project which to date has trained almost 18,000 elected health and safety representatives through a recognized and government endorsed/funded health and safety training programme.

Effective worker participation in injury prevention and health protection in the workplace has been identified as the key to successful safety management since the Woodhouse Report (1) which introduced the Accident Compensation Commission (ACC) scheme in New Zealand in 1967. The Woodhouse report specifically endorsed the Swedish approach of ‘active co-operation between management and employee and in a wider sense between the trade unions and employers’.

International research has shown that worker participation leads to safer workplaces through the promotion and integration of a safety culture into the workplace (2). A report (3) prepared by Cardiff University for the Health and Safety Executive (UK) identified prerequisites for effective worker participation, which included:

- A legislative requirement for worker participation;
- Effective external inspection and control;
- Commitment by senior management to health and safety;
- Competent hazard assessments and controls; and
- Communication between worker representatives and their constituencies.

Employee participation is the base of the New Zealand model and is established in the Health and Safety in Employment Amendment (HSE) Act 2002, which requires the employer to provide reasonable opportunities for employees to participate effectively in ongoing improvement of health and safety in the workplace.

In New Zealand, worker and union participation is not only a democratic right but also best practice. Promoting sustainable and productive relationships between employers and employees based on mutual trust and confidence is a key component of New Zealand employment legislation.

There are two main Acts which govern health and safety management within New Zealand and promote the capacity for the primary prevention of occupational hazards, diseases and injuries. The Health and Safety in Employment (HSE) Act, and its 2002 Amendment, focuses on relationships within the workplace, by providing for employee participation. This reflects and builds on the good faith requirements of the Employment Relations Act 2000, which encourages employment relationships built on mutual obligations of trust and confidence. Successful management of health and safety in workplaces is best achieved through employers and employees co-operating in good faith to identify and solve problems before harm occurs.

The second Act, the Injury Prevention, Rehabilitation and Compensation Act governs the ACC. New Zealand’s accident compensation scheme is administered by ACC which provides personal injury cover...
for all New Zealand citizens, residents and temporary visitors to New Zealand. In return people do not have the right to sue for personal injury, other than for exemplary damages.

A report by the National Occupational Health and Safety Advisory Committee (NOHSAC) reported in 2006 that while awareness of health and safety issues had increased markedly, some groups such as non-unionised workforces are very difficult to reach (4). The CTU which represents 40 affiliated unions, and their 350,000+ members, has accepted responsibility to act on behalf of all workers, and not just union members. The CTU regards workplace health and safety as a crucially important issue and though resources are limited, have established the network and experience to reach out to all workplaces.

Walters et al (5) proposed reasons for why unions play a vital role in supporting workplace health and safety. These include: the networks of unions which enable representatives to share ideas and benefit from the experience of others, on a local, national and in some communities, on an international level.

The CTU sees health and safety as a core issue towards improving work conditions and unions are encouraged and supported to raise awareness around workplace health and safety. The CTU, using a holistic definition of `health and safety, works in a tripartite framework on reviewing legislation, developing codes of practice and other reference materials which improve workers’ health and safety. In New Zealand, unions through their involvement in training health and safety representatives, not only support the workplace activities and achievements of the health and safety reps through articles in their newsletter and their web based resources, but also act as a stimulus for their initiation and development.

One of the most important roles of the 18,000 trained health and safety reps is to influence the behaviour of others in actions to contribute to a safer workplace. It may take the form of gaining support, inspiring others, persuading other people to become champions, engaging someone’s imagination, or creating relationships. It may be showing someone a safer way to do their job, or making a recommendation to the employer about making a system of work safer. Other people like being around someone who can use their influence to the benefits of others. There’s a kind of exciting buzz, or sense that good things happen when health and safety representatives are about.

The training provided by the CTU and ACC, now in its fifth year, gives elected health and safety representatives the confidence and knowledge to improve health and safety at work. In particular stage three of the training programme (a programme developed in consultation with Business New Zealand), draws on aspects of the Workplace Productivity Education Programme (6) to look at the drivers behind promoting a good safety culture within the workplace with benefits to the employer and the employee. The training provides representatives with the skills of effective health and safety action to initiate actions themselves, while strengthening their autonomy in health and safety management. Reasons for the success of the training and the CTU being the largest health and safety training provider, can be attributed to the fact that unions are serious, competent and professional about health and safety and the effective role that unions can play in achieving change. The health and safety training course based on adult learning principles has led the way in engaging employees in participating in health and safety.

However, even with the legislative support for the employee participation system; training leave for elected health and safety representatives; injury prevention and rehabilitation programmes, workplace accidents and exposures still account for (7):

- about 700–1000 deaths from occupational disease
- about 100 deaths from occupational injury
- 17,000 – 20,000 new cases of work related disease
- About 200,000 occupational accidents resulting in ACC (Accident Compensation Corporation) claims, about half of which result in disability and about 6% in permanent disability

Taking these statistics into consideration, the challenges faced by the CTU to build greater capacity for prevention of occupational hazards, diseases and injuries include:
The necessity for active support of employers, unions and government agencies.

- The need for Health and Safety representatives to have a reasonable level of respect, time and resources in the workplace in order to undertake the role effectively.

- Demanding compliance by employers for the provision of a safe and healthy workplace and work practices and for the Department of Labour to ensure enforcement.

- Continually reviewing and promoting the health and safety training programme

- Building sustainable partnerships.

Barriers to effective workplace consultation are a change in Government and political climate, performance of the regulator, legislative weaknesses and lack of competence/commitment (8). The CTU tackles these issues through the tri-partite relationship between unions, the Government and Business New Zealand.

At the recent CTU Conference 2007, the political strategy was launched which included building stronger worker participation on the issue of health and safety as key to protecting and enhancing workers rights.

References


(2) Walters, D. A review of the evidence of the effectiveness of representation and consultation on health and safety at work.


4th Croatian Congress on Occupational Health in Dubrovnik, Croatia, and 14th International Congress on Occupational Health Services

Rajna Golubic
Department for Environmental and Occupational Health
”Andrija Stampar” School of Public Health, Zagreb, Croatia
rajna.golubic@gmail.com

From the 8th until 11th of November 2007, the beautiful city of Dubrovnik at the Adriatic coast was the venue of the 4th Croatian Congress on Occupational Health that was held in conjunction with the 14th International Congress of the ICOH Scientific Committee on Health Services Research and Evaluation in Occupational Health. The congress was held under the presidency of Jadranka Bozin Juracic (President of the Organizing Committee), Carel Hulshof (Chairman of the ICOH Committee) and Jadranka Mustajbegovic (President of the Congress Scientific Committee).

The programme comprised 9 keynotes delivered by European researchers and practitioners, the WHO/HQ and WHO/EURO offices, 85 oral presentations, 50 posters and some special sessions.
Furthermore, three workshops were held during the Congress: Migrant workers; HIV/AIDS and Occupational health specialists in insurance and medical expertise.

The program also covered the following five areas of occupational medicine:

- **Finding a new balance in OHS in or after a transition process** (post-war, legislation, EU regulations, privatization, shift in responsibility for occupational health from employers to partly also employees);
- **From Occupational Health to Workers' Health** (WHO Global Plan of Action on workers’ health, health promotion, the obesity epidemic, mental health at work, relationship with primary health care and sports medicine);
- **The need for evidence-based workers' health care** (cost-)effectiveness studies, systematic reviews, evidence-based guidelines, Cochrane Occupational Health Field, HINARI project);
- **New technologies** (related health problems, internet-based services, knowledge sharing); and
- **Permanent issues in OHS** (professional ethics, quality assurance, small and medium-sized companies, occupational rehabilitation).

The central topics of the congress were ‘occupational health services in transition in Eastern and Western Europe’ and ‘Health and work - key of life’. Many different issues were presented and discussed in a stimulating, and friendly atmosphere.

Altogether, more than 350 participants from 23 countries participated in the Congress. The authors presented the results of their research as well as their experiences with occupational health practice. Finally, the Congress was very well organized, fruitful and a successful event, and we look forward to having more such events in Croatia in the future.

---

**Meeting Reports**

**Workers’ Health in Africa: Priorities for Action**

An African regional meeting on implementing WHO’s Global Plan of Action on Workers’ Health was held from 21 to 23 August 2007 in Brazzaville, Republic of Congo. The meeting was attended by experts from Benin, Botswana, Kenya, Namibia, South Africa, Swaziland, and The Gambia, as well by representatives of WHO and ILO, Finnish Institute of Occupational Health, University of Illinois in Chicago, USA, and the University of Abomey Calavi, Benin the International Organization of Employers and Pan-African Employers’ Confederation.
The meeting reconfirmed the need to continue the WHO/ILO Joint Effort on Occupational Health in Africa and identified the following priorities for action in the coming years:

1. Align national policy instruments with WHA Resolution 60.26 Workers’ Health: Global Plan of Action and the ILO Promotional Framework for Occupational Safety and Health Convention. The transposition of these documents into the national policy instruments requires:
   a. enhancing the collaboration between ministries of health and ministries of labour;
   b. involving workers' and employers' organizations;
   c. establishing and sustaining partnerships for workers' health with civil society and private sector;
   d. building critical core capacities for implementation of actions to protect and promote workers’ health.

1. Devise national approaches for development of human resources for workers' health taking into account the specific needs and capacities of the countries that include:
   a. setting up long-term objectives for education and training;
   b. establishment and expanding postgraduate programmes for training of different experts in the area of workers' health;
   c. introduction of resource-efficient training methods, such as outreaching and distance learning and making use of WHO Collaborating Centres for Occupational Health and ILO Centres for Information on Safety.

1. Develop special country and inter-country projects and programmes with support from WHO and ILO, particularly in the following areas:
   a. piloting innovative models for basic occupational health services;
   b. prevention of priority occupational injuries and diseases, as well as HIV/AIDS, TB and Malaria at the workplace;
   c. prevention of work-related stress and violence as well as promotion of mental health at work;
   d. development of a preventative safety and health-promoting culture through campaigns, education, information sharing, development of healthy workplaces and making better use of the World Day for Safety and Health at Work and other international and national public health events;
   e. promoting occupational safety and health management systems and tools, including control banding, ergonomics, and cost effective interventions;
   f. strengthening the capacities for workplace health and safety inspection;
   g. elimination of silica- and asbestos-related diseases;
   h. reviewing and updating national lists of occupational diseases and improving their registration and notification;
   i. developing national indicators and profiles for workers’ health;
   j. setting up programmes for protection and promotion of health in informal economy;
   k. creating linkages between national efforts on workers health and poverty reduction strategies.

Announcements

Carlos Corvalan has been the Coordinator of the Occupational Health Programme since 2004. Carlos has a distinguished track record in leading WHO’s work on pertinent issues such as environmental health indicators and climate change. He has been at HQ for almost 15 years and is now taking up new responsibilities at the country-level in Brazil. Carlos will be missed in our offices not only for his knowledge and scientific leadership, but also for his pleasant personality, collegiality, openness, and most of all his refreshing sense of humour.

We wish Carlos all the best in his new functions.
Dear colleagues

This is not a farewell….just a “see you soon”, hasta pronto…

It has been a pleasure for me to have known you and worked with you all. I truly believe that over the last years we have made important progress. The Global Plan of Action on Workers Health has been endorsed in the World Health Assembly this year by the Ministers of Health; this is an important milestone, and we could not have done it without your continuous support.

The work that is going on to reach the most vulnerable workers, implementing basic occupational health services for those who never had preventive services in the past, applying simple tools addressing chemical hazards, silica, needlestick injuries and many other hazards, is groundbreaking and needs to be continued. Reducing the gaps, the inequities between countries and groups of workers in terms of working and employment conditions remains one of our most important challenges.

My new job in Mexico will still include workers’ health, but goes beyond that into topics such as climate change, water and sanitation, healthy settings and road safety. I hope we will continue to work together and again, thank you very much for your support, trust, friendship and hard work. It has been a privilege to be in this position and to have partners such as you.

Un abrazo para todos

Gerry

---

**GOHNET Newsletter - Contributors’ Information**

**General**

GOHNET is a vehicle for information distribution and communication for all who are involved, active and interested in the subject areas of occupational health.

The Editor reserves the right to edit all copy published.

Contributors of all material offered for publication are requested to provide full names, titles, Programmes or Departments, Institute names, and e-mail addresses.

**Why write for GOHNET?**

All experts have a professional responsibility to disseminate their views and knowledge. The Network of occupational health experts is constantly growing, and the Newsletter can therefore help you to reach a large audience in the occupational health community. This can help you to make new contacts, exchange views and expertise.

**What kinds of article do we publish in GOHNET?**

Our diverse audience means that articles should be not only informative but also engaging and accessible for the non-specialist. We do not accept articles based on data that has not been accepted for publication following peer review. Such articles are more appropriate for submission to a journal.

Articles may provide a broad overview of a particular area; discuss theory; add a critical commentary on recent articles within a GOHNET Newsletter; or debate applied, practical and professional issues. You can view examples of issued Newsletters, which are available at http://www.who.int/occupational_health
How should I go about writing my article?
Articles should be written as for an intelligent, educated but non-specialist audience, as the majority of readers will not necessarily be familiar with the topic of any individual article. Articles need to be written in clear, non-technical language, and aim to engage the interest of the membership at large.
Sexist, racist and other discriminatory or devaluing language should be avoided.
Articles can be of any length from 800 up to a maximum of 2000 words (excluding references), double spaced, with complete references and a precise word count (excluding references). Relevant high-quality scanned image materials is also welcome.

How do I submit my work?
Send your article as a word attachment to ochmail@who.int, attention: Evelyn Kortum.

Counterpoint articles
If you have a view on an article we have published, your best route is an e-mail or a letter to the Editor. If you wish to add a substantial amount of evidence on a significantly different angle, we welcome commentary pieces of up to 1000 words, submitted within four months of the original piece.

Conference or workshop reports
Brief reports on conferences or workshops of interest to a wider audience (any length up to 700 words) should be sent, within a month of the event, to the Editor. Focus on what is new and of general interest, rather than including a lot of background information about the conference.

Reference style
Below is an example of the reference style to be used:
WHO CONTACTS

WHO headquarters (www.who.int/occupational_health)
Department of Public Health and Environment
Occupational and Environmental Health Programme
Geneva, Switzerland Fax: (41) 22 791 1383
e-mail: ochmail@who.int

WHO Regional Advisers in Occupational Health
Regional Office for Africa (AFRO) (www.whoafr.org/)
Brazzaville, Congo Fax: (242) 81 14 09 or 8119 39
Attention: Mr Thebe Pule
e-mail: pulet@afro.who.int

Regional Office for the Americas (AMRO) (www.paho.org/)
Pan American Health Organization (PAHO)
Washington DC, USA Fax: (202) 974 36 63
Attention: Dr Luz Maritza Tenasssee
e-mail: tennasssm@paho.org

Regional Office for the Eastern Mediterranean (EMRO) (www.who.sci.eg)
Cairo, Egypt Fax: (202) 670 24 92 or 670 24 94
Attention: Dr Said Arnaout
e-mail: arnaouts@emro.who.int

WHO/EURO Centre for Environmental Health (www.who.euro.int)
Bonn, Germany Fax: (49) 228 2094 201
Attention: Dr Rokho Kim
e-mail: rki@ecenhbonn.euro.who.int

Regional Office for South-East Asia (SEARO) (http://www.whosea.org/)
New Delhi, India Fax: (91) 11 332 79 72
Attention: Dr Habibullah Saiyed, Regional Adviser in Occupational Health
e-mail: saiyedh@searo.who.int

Regional Office for the Western Pacific (WPRO) (http://www.wpro.who.int/)
Manila, Philippines Fax: (63) 2 521 10 36 or 2 526 02 79
Attention: Dr Hisashi Ogawa
e-mail: ogawah@wpro.who.int

Joining GOHNET

To join GOHNET, please complete the online form at this location:

https://extranet.who.int/datacol/survey.asp?survey_id=450

Username : guest Password : guest