



# **WHO Global Plan of Action on Workers' Health (2008-2017): Baseline for Implementation**

**Global Country Survey 2008/2009**  
Executive Summary and Survey Findings

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Executive Summary and Survey Findings

Geneva, April 2013

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# EXECUTIVE SUMMARY

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Only a small proportion of the global workforce has access to occupational health services for primary prevention and control of diseases and injuries caused or aggravated by work. In 2007, the 60<sup>th</sup> World Health Assembly endorsed a Global Plan of Action on Workers' Health for 2008-2017 and urged WHO member states to devise national policies and plans for its implementation<sup>1</sup>.

## ESTABLISHING A BASELINE

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Implementing this plan requires measuring progress towards achieving the objectives set out in the Global Plan of Action. To establish a baseline for measuring progress, information was collected in 2008-2009 from Member States using a survey with questions measuring country status relative to five Global Plan of Action objectives:

1. Devising workers' health policy
2. Protecting and promoting health at the workplace
3. Improving performance of and access to occupational health services
4. Providing evidence for action
5. Incorporating workers' health into other policies.

This report presents the findings of that survey. Detailed information about the tools used to collect the data can be found in Annex I.

## KEY FINDINGS

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### ■ POLICY

- Two thirds of countries participating in the survey have policy frameworks for workers' health.
- Less than half of countries surveyed have endorsed or drafted a national plan of action on workers' health.

### ■ PROTECTING WORKERS' HEALTH

- Although respiratory diseases and musculoskeletal disorders are the most common occupational diseases, only one third of countries have special programmes to address them.
- While most countries have introduced ways of addressing risks at the workplace such as integrated management of chemicals and tobacco smoking bans, enforcement of regulations for workplace health protection remains insufficient.
- While workers' health is often incorporated into health promotion, injury prevention, and HIV programmes, it is rarely found in programmes dealing with cancer, malaria, and family health.

1. The full text of resolution WHA60.26 is available in English, Russian, French, Arabic, Spanish, and Chinese at: [http://www.who.int/occupational\\_health/publications/global\\_plan/en/index.html](http://www.who.int/occupational_health/publications/global_plan/en/index.html)

## ■ PERFORMANCE AND ACCESS

- Only one third of countries cover more than 30 percent of their workers with occupational health services.
- Policy- and standard-setting ministries lack capacity for enforcement and monitoring. One third of countries have no ministry of health staff dedicated to workers' health.
- While most countries have some human resources for health, academic training needs to be scaled up.

## ■ EVIDENCE FOR ACTION

- Although half the countries have national workers' health profiles with data on occupational diseases, injuries, and legislation, information about communicable and noncommunicable diseases among workers and about lifestyle risks are the least-covered topics.
- Most countries have national institutions carrying out research and training, but the distribution of such entities is uneven across country groups.
- Although most countries have registries of occupational diseases, few countries have developed national information systems dealing with other aspects of workers' health.
- Awareness about workers' health problems remains low, both in the media and among the general public.

## ■ HEALTH IN OTHER POLICIES

- Workers' health issues feature in policies concerning management of chemicals, emergency preparedness and response, employment strategies, and vocational training. However, workers' health is seldom considered in policies regarding climate change, trade, economic development, poverty reduction, and general education.

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# ABBREVIATIONS

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<b>AFR</b>	WHO African Region
<b>AMR</b>	WHO American Region
<b>GPA</b>	WHO Global Plan of Action on Workers' Health
<b>EMR</b>	WHO Eastern Mediterranean Region
<b>EUR</b>	WHO European Region
<b>SEAR</b>	WHO South-East Asian Region
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization
<b>WPR</b>	WHO Western Pacific Region



# INTRODUCTION

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Half of the world's people are economically active and spend at least one third of their time at the workplace. Fair employment and decent work are important social determinants of health, and a healthy workforce is an essential prerequisite for productivity and economic development.

Yet only a small proportion of the global workforce has access to occupational health services for primary prevention and control of occupational and work-related diseases and injuries.

Certain global health problems, such as noncommunicable diseases, result in increasing rates of long-term illness and absence from work. These problems challenge health systems' ability to preserve and restore the capacity of workers to maintain economically active.

Recognizing that occupational health is closely linked to public health and health system development, the World Health Organization developed a Global Plan of Action on Workers' Health (2008-2017). The plan seeks to address all determinants of workers' health, including risks of disease and injury in the occupational environment, social and individual factors, and access to health services.

This report provides a snapshot of countries' status in relation to the objectives set by the plan by presenting data from a 2008/2009 country questionnaire survey. This survey sought to establish a baseline for monitoring implementation of the Global Plan of Action (hereafter referred to as GPA).

## WHO ACTION ON WORKERS' HEALTH

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WHO is mandated by Article 2 of its constitution to promote the improvement of working conditions and other aspects of environmental hygiene. In 2007, the 60<sup>th</sup> World Health Assembly expressed concern that despite effective interventions for preventing occupational hazards and developing healthy workplaces, major gaps remain. Such gaps within and between countries include exposure of workers and communities to occupational hazards and lack of access to occupational health services.

Stressing that workers' health is an essential prerequisite for productivity and economic development, the 60<sup>th</sup> World Health Assembly endorsed the GPA with Resolution WHA60.26.

The GPA provides a new policy framework for concerted action to protect, promote and improve the health of all workers. It addresses primary prevention of occupational hazards, protection and promotion of health at work, employment conditions, and improved health system responses to workers' health. The plan links occupational health to public health by identifying the following objectives for global action:

- (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;
- (5) To incorporate workers' health into other policies.

The plan was developed to guide workers' health activities carried out by WHO and Member States during the period 2008-2017. It is intended to stimulate development of policies, infrastructure, technologies, and partnerships to improve the health of all workers. The plan thus promotes a basic level of health protection in all workplaces throughout the world.

## IMPLEMENTING THE GLOBAL PLAN OF ACTION

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The 193 WHO Member States were urged to devise national policies and plans for implementing the GPA in consultation with workers, employers, and their organizations. The national policies should aim to provide interventions and services for all workers, including those in the informal economy and in small and medium-sized enterprises as well as agricultural and migrant workers. The plans should include essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries.

Particular measures were required to establish and strengthen core institutional capacities and ensure adequate human resources to address workers' specific health needs. The Health Assembly emphasized the importance of ensuring collaboration between all national health programmes relevant to workers' health. These include occupational health, communicable and chronic diseases, health promotion, mental health, environmental health, and health systems development. In addition, Member States were invited to:

- address health and environmental problems of local communities arising from industrial activities;
- incorporate workers' health issues in policies for sustainable development, poverty reduction, employment, trade, environmental protection, and education;
- develop strategies to ensure re-integration of sick and injured workers into mainstream society.

## ESTABLISHING A BASELINE TO MONITOR PROGRESS

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The 60<sup>th</sup> World Health Assembly requested that WHO support and monitor national and international implementation of the GPA by providing a definite timeline for the establishment of occupational health services. A set of national and international indicators were to be devised and used to monitor progress on implementation of the Global Plan of Action. In order to establish a monitoring baseline, WHO surveyed Member States in 2008-2009 about their status regarding the objectives and actions foreseen in the GPA. This report analyses the findings of that survey.

## METHODS

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Data collected from 121 countries (response rate 61%) that returned questionnaires were analysed globally, by WHO region, and by income grouping. Country income groupings followed the World Bank classification and were divided into low, lower middle, upper middle and high income groups. Detailed information on survey questions, data collection methods, and types of statistical analysis are provided in Annex I, Technical specifications.

## KEY FINDINGS

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### ■ POLICY

- Two thirds of countries surveyed had national policy frameworks for workers' health dealing with enactment of legislation, intersectoral coordination, and integration of workers' health objectives into national strategies. Most countries had policies covering occupational health and safety. Other areas of workers' health were less well covered. Policies were developed by health and labour ministries in collaboration with trade unions and employers' organizations.
- Less than half the countries surveyed had recently endorsed or drafted a national plan of action on workers' health that included priorities, objectives and targets, actions, and mechanisms for implementation, monitoring, and evaluation. Where national plans existed, they dealt primarily with workplace health promotion and occupational health and safety. In most of these cases, specific funds were allocated for implementation of the national plan.

### ■ PROTECTING WORKERS' HEALTH

- Although respiratory diseases and musculoskeletal disorders are the leading occupational diseases, only one third of countries participating in the survey had special programmes to address these issues. The majority of countries have taken regulatory action to eliminate asbestos-related diseases. Most have established special programmes for the occupational health and safety of health-care workers and to immunize these workers against hepatitis B. However, many countries reported continuing inequalities in workers' health.
- Most countries have introduced modern ways of addressing certain workplace health risks. These include integrated management of chemicals, tobacco smoking bans, and healthy workplace initiatives. However, enforcement of workplace health regulations remained insufficient in most countries.
- While workers' health was often incorporated into national programmes dealing with health promotion, injury prevention, and HIV/AIDS, workers' health was rarely considered in programmes dealing with cancer, malaria, and family health.

### ■ PERFORMANCE AND ACCESS

- Although most countries surveyed had some strategies, standards, and targets for coverage of occupational health services, only one third of these countries covered more than 30% of their workers with such services.
- While ministries of health are traditionally strong in legislation, policy- and standard-setting for occupational health services, in most countries these ministries lacked sufficient capacity to deal with workplace inspection and monitoring of workers' health trends. In one third of countries surveyed, ministries of health had no staff dedicated to workers' health.
- Most countries had some human resources for occupational health. However, academic training in occupational health needs to be scaled up at both undergraduate and postgraduate levels.

## ■ EVIDENCE FOR ACTION

- Although a majority of countries had national scientific entities carrying out research and training to provide support for frontline occupational health services, distribution of these capacities was uneven across country groups.
- Half the countries surveyed had national profiles for workers' health developed mainly by ministries of labour and health with input from academic institutions. Most profiles included statistics on occupational diseases and injuries as well as information on legislation and the occupational health system. Communicable and noncommunicable diseases among workers and individual risk factors were the areas least covered by these profiles.
- Although most countries have some registries of occupational diseases, the level of registration remained low. Few countries had developed comprehensive national information systems dealing with other aspects of workers' health. Many countries lacked programmes supporting research on workers' health.
- Respondents reported insufficient awareness about workers' health problems, particularly among the media and the general public.

## ■ HEALTH IN OTHER POLICIES

- Workers' health issues were well represented in plans for management of chemicals, emergency preparedness and response, employment strategies, and vocational training. Workers' health was very seldom considered in policies about climate change, trade, economic development, poverty reduction, and general education.

# SURVEY FINDINGS IN DETAIL

The survey results have been organized according to the objectives of the Global Plan of Action on Workers' Health. These results show how different country health systems address workers' health in terms of:

- devising and implementing policy instruments concerning workers' health;
- protecting and promoting health at the workplace;
- improving performance of and access to occupational health services;

- providing and communicating evidence for action and practice;
- incorporating workers' health into other policies.

The objectives are presented as described in the Global Plan of Action. The following pages analyse trends revealed by the results, and focus on major departures from the average. The statistical annex provides results globally and by country groupings by WHO region and income.



# 1. NATIONAL POLICY INSTRUMENTS

Objective 1 of the Global Plan of Action urges countries to strengthen governance by devising and implementing policy instruments to promote workers' health. Country actions include:

- national policy frameworks;
- national workers' health profiles;
- national plans of action;

- capacities of ministries of health in the area of workers' health;
- national programmes and campaigns for priority occupational diseases to minimize inequalities, to eliminate asbestos-related diseases, and to immunize health-care workers against hepatitis B.

Questions were devised to measure these actions.

## GPA OBJECTIVE 1: To devise and implement policy instruments on workers' health

“ 6. National policy frameworks for workers' health should be formulated taking account of the relevant international labour conventions and should include: enactment of legislation; establishment of mechanisms for intersectoral coordination of activities; funding and resource mobilization for protection and promotion of workers' health; strengthening of the role and capacities of ministries of health; and integration of objectives and actions for workers' health into national health strategies.

7. National action plans on workers' health should be elaborated between relevant ministries, such as health and labour, and other major national stakeholders taking also into consideration the Promotional Framework for Occupational Safety and Health Convention, 2006. Such plans should include: national profiles; priorities for action; objectives and targets; actions; mechanisms for implementation; human and financial resources; monitoring, evaluation and updating; reporting and accountability.

8. National approaches to prevention of occupational diseases and injuries should be developed according to countries' priorities, and in concert with WHO's global campaigns.

9. Measures need to be taken to minimize the gaps between different groups of workers in terms of levels of risk and health status. Particular attention should be paid to high-risk sectors of economic activity, and to the underserved and vulnerable working populations, such as younger and older workers, persons with disabilities and migrant workers, taking account of gender aspects. Specific programmes should be established for the occupational health and safety of health-care workers.

10. WHO will work with Member States to strengthen the capacities of the ministries of health to provide leadership for activities related to workers' health, to formulate and implement policies and action plans, and to stimulate intersectoral collaboration.

Its activities will include global campaigns for elimination of asbestos-related diseases – bearing in mind a differentiated approach to regulating its various forms – in line with relevant international legal instruments and the latest evidence for effective interventions, as well as immunization of health-care workers against hepatitis B, and other actions addressing priority work-related health outcomes. ”

*Global Plan of Action on Workers' Health, Resolution WHA 60.26*



## NATIONAL POLICY FRAMEWORKS

Two thirds of countries had national policy frameworks for workers' health dealing with enactment of legislation, intersectoral coordination, and integration of workers' health objectives into national strategies. Policies focused on occupational health and safety rather than other areas of workers' health. They were developed by health and labour ministries in collaboration with trade unions and employers' organizations.

National policy frameworks are political documents that set strategic directions for protecting and promoting workers' health. The survey found that as of July 2009, 63% of countries had national policy frameworks, most of them in the higher

and the lower middle income groups. The highest percentages of countries with national policy frameworks were found in the WHO European, American and South-East Asian regions (Table 4 in Annex II).



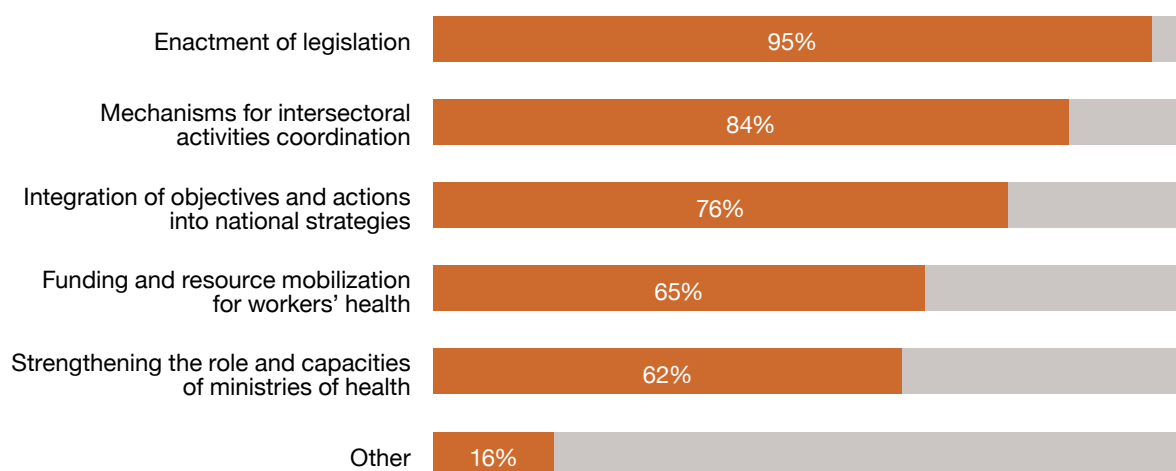
## ■ ELEMENTS INCLUDED IN POLICY FRAMEWORKS

Those countries with policy frameworks were asked about specific elements (see Figure 1). Most countries included enactment of legislation, intersectoral coordination of activities and integration of objectives and actions for workers' health. Funding and resource mobilization for workers' health were less common (65%), as was strengthening the roles and capacities of ministries of health (62%). However, when policy framework

elements were analysed by country income groups, funding and resource mobilization were more strongly represented in low-income country policy frameworks (77%), as was strengthening the roles and capacities of ministries of health (85%). Strengthening ministry of health capacity became less common as country incomes increased, with less than half of high-income countries (45%) including this in their policy frameworks (see Tables 5 and 6 in Annex II).

**Figure (1)**

### **Q1.1. Which of the following elements does this policy framework include?** (% of those having a policy)





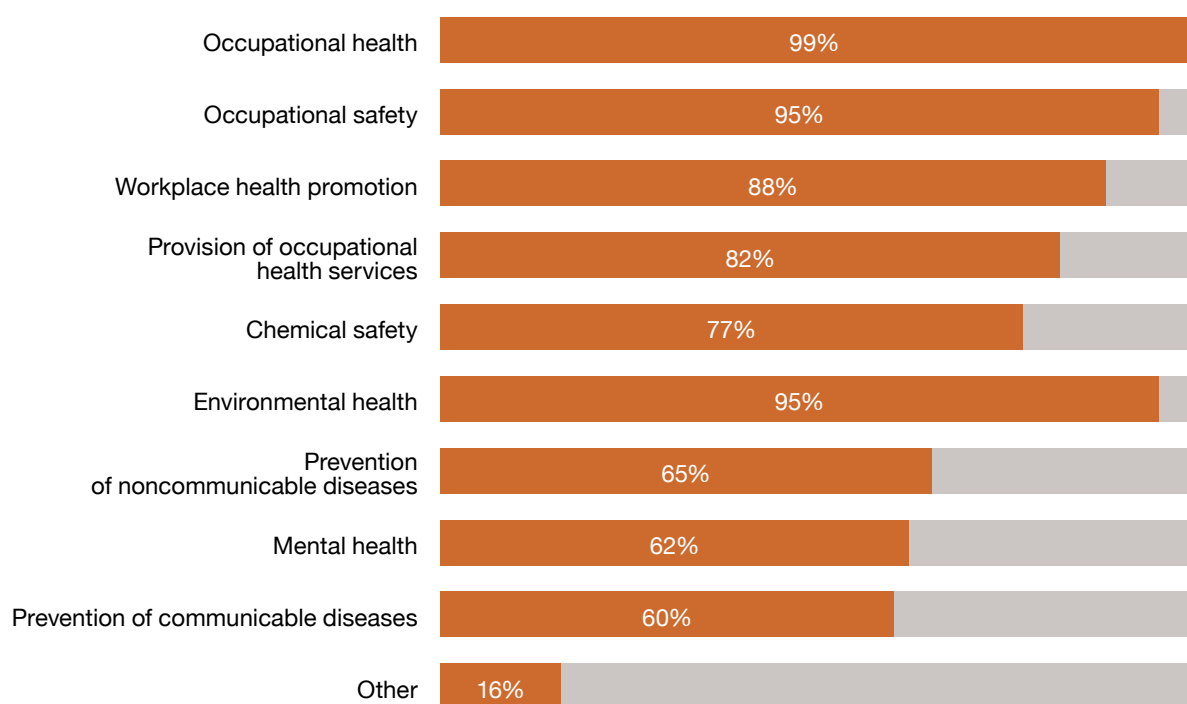
## ■ FOCUSES OF POLICY FRAMEWORKS

Most national policy frameworks included both occupational health and occupational safety (more than 90%), followed by workplace health promotion (88%), provision of occupational health services (82%), and chemical safety (77%). Mental health and prevention of communicable diseases at the workplace were least represented, appearing in less than two thirds of policy frameworks (Figure 2). The coverage varied by region and income group, particularly regarding chemical safety, noncommunicable diseases and mental health.

Countries in the African Region were least likely to have national policies dealing with chemical safety (40%), noncommunicable diseases (30%) and mental health (20%), although most covered environmental health (80%). Mental health was also less prominent in policy frameworks in the Eastern Mediterranean Region (33.3%), upper middle income (33.3%) and low income (33.3%) countries. However, most high income countries (86.2%) and those in the European region (81.6%) included mental health in their policies (see Tables 7 and 8 in Annex II).

**Figure (2)**

**Q1.2. Which of the following aspects of workers' health are covered by this policy framework? (% of those having a policy)**



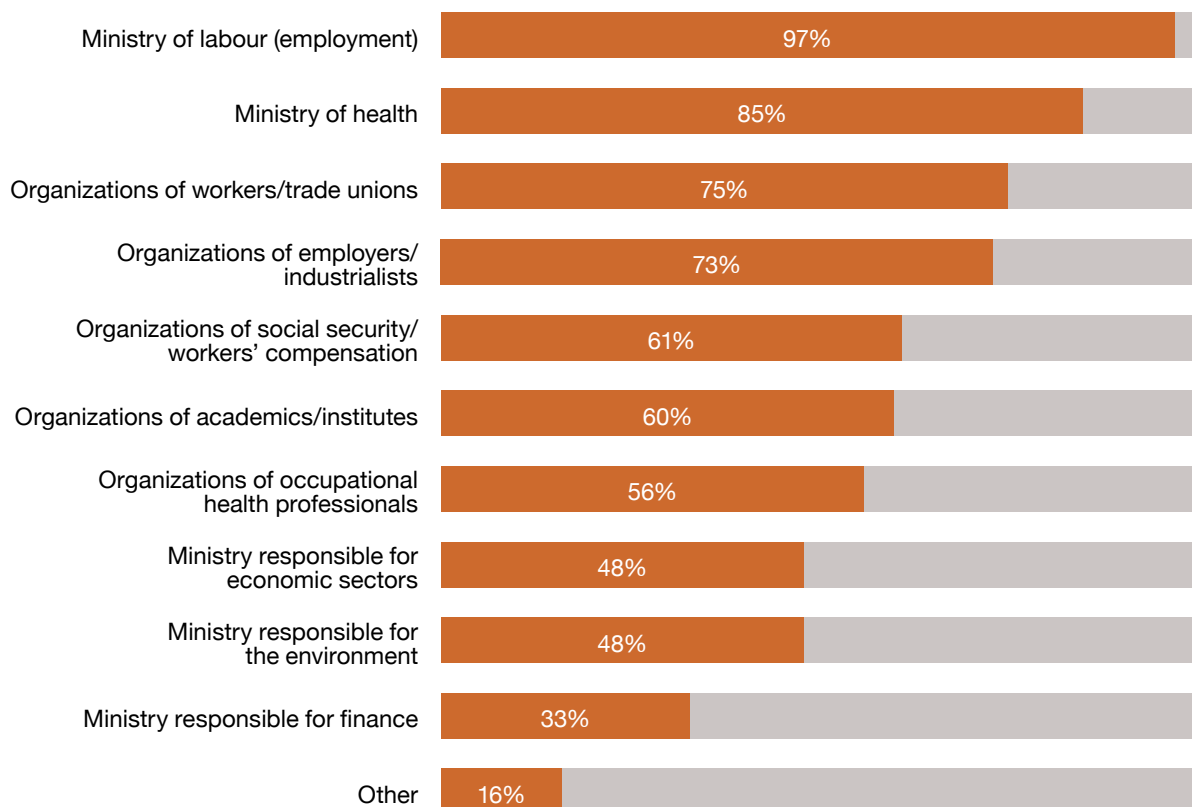
## ■ INSTITUTIONS INVOLVED IN POLICY FRAMEWORK DEVELOPMENT

A variety of institutions were involved in development of national policy frameworks for workers' health. In most countries, the development of such policies was led by ministries of labour, ministries of health or both, in collaboration with organizations of workers, trade unions, and employers/industrialists.

In the Western Pacific Region, only half of countries involved their ministries of labour when developing national policies on workers' health. Organizations of occupational health professionals were most involved in the development of national policies in countries with high income (76%) and least in those with low income (25%). See Tables 9 and 10 in Annex II for details.

**Figure (3)**

### Q1.3. Which institutions were involved in the development of the national policy for workers' health? (% of those having a policy)



## NATIONAL PROFILES

Half of countries surveyed had national profiles for workers' health. Most of these were developed by ministries of labour and health with input from academic institutions. Most profiles included statistics on occupational diseases and injuries as well as information about legislation and the organizational structures for occupational health. Information about communicable and noncommunicable diseases in workers and individual (lifestyle) risk factors was included less often.

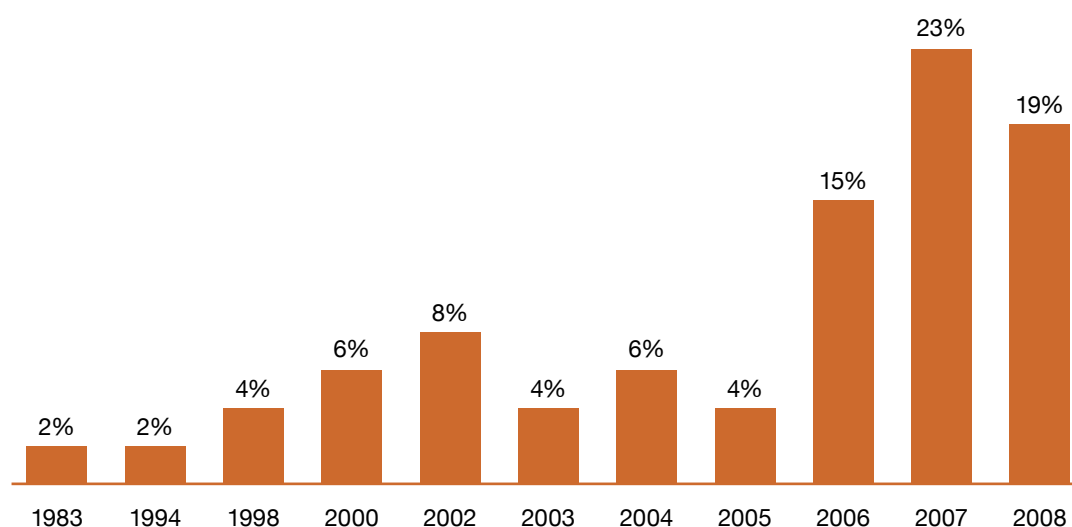
A national profile for workers' health documents quantitative and qualitative information about the status of and trends in the health of a country's workforce. Such documents are usually developed in collaboration with major stakeholders and are publicly available. National profiles serve as a basis for developing actions, monitoring progress and benchmarking between countries.

### ■ DATE OF NATIONAL PROFILE PUBLICATION

Half of countries surveyed (53%) had already developed a national profile for workers' health by 2009. Most countries in the European Region (73%) had developed such profiles, but less than 20% of countries in the American and in the Eastern Mediterranean regions had national profiles. Most profiles (57%) were published after 2005.

**Figure (4)**

#### **Q2.1. When was this profile published ?**



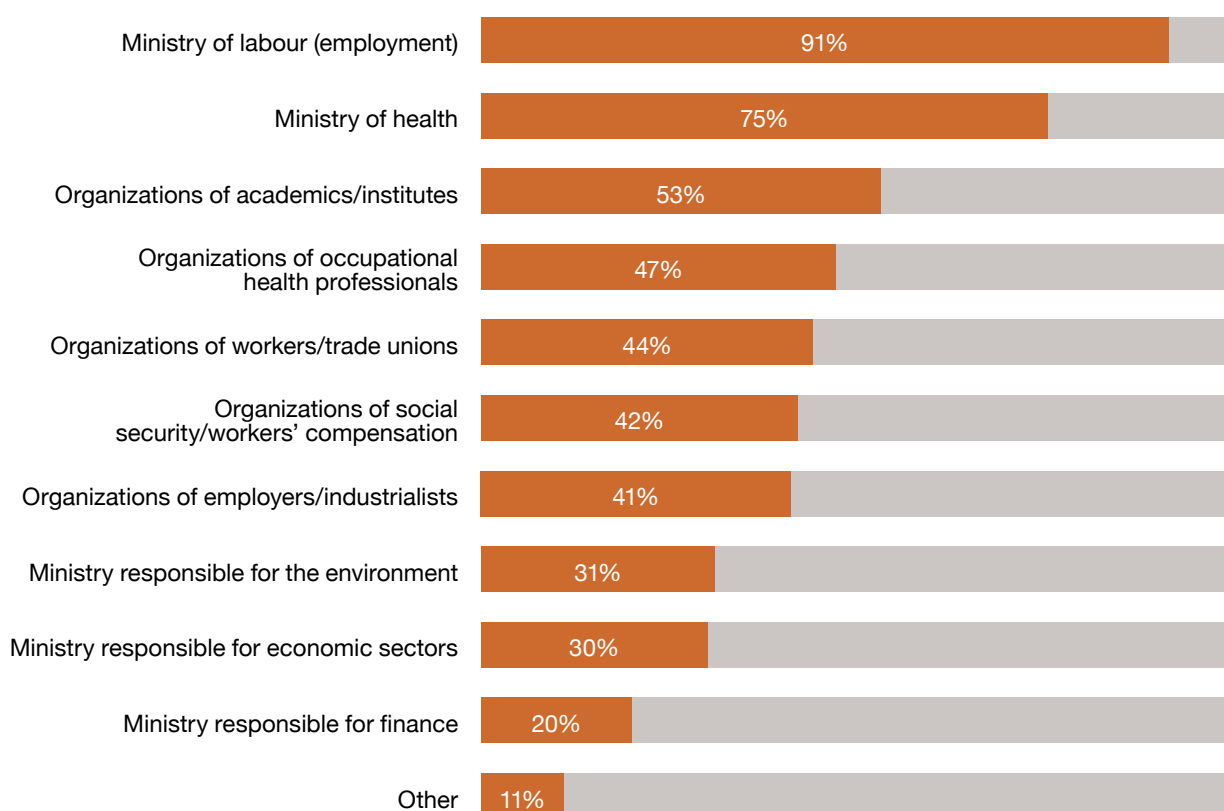
## ■ INSTITUTIONS INVOLVED IN DEVELOPING THE NATIONAL PROFILE

Ministries of labour and health were the bodies most frequently involved in the development of national profiles, followed by organizations of academics and institutes (Figure 5). In the American Region, no country involved their ministry of the environment,

while in the Eastern Mediterranean Region all countries involved environment ministries in national profile development. Lower income countries were also more likely to involve the ministry responsible for the environment. See Tables 15 and 16 in Annex II for details.

**Figure (5)**

### Q2.2. Which institutions were involved in the development of the national profile? (% of those having a national profile)



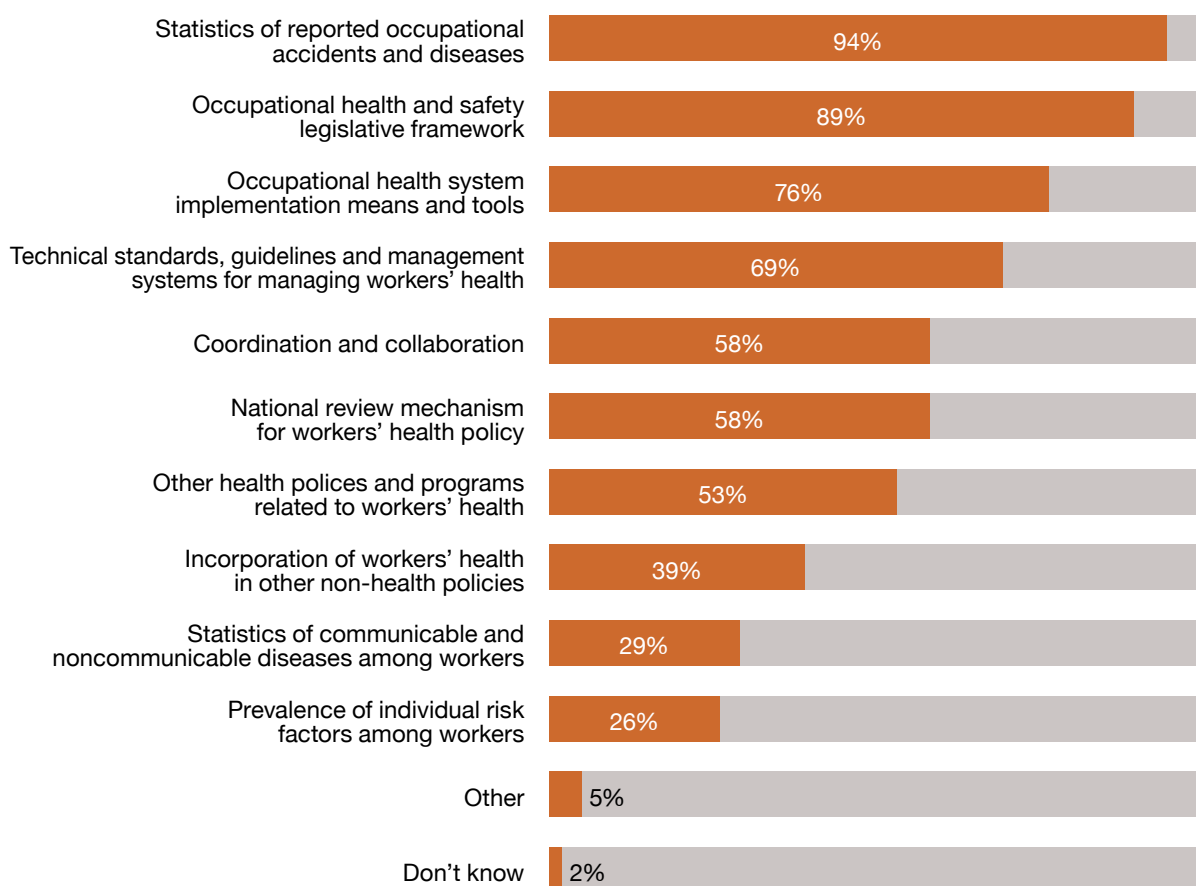
## ■ ASPECTS OF WORKERS' HEALTH INCLUDED IN NATIONAL PROFILES

Most national profiles included data about occupational accidents and diseases as well as occupational health and safety legislative frameworks (see Figure 6). Countries in the African Region (60%) and low income countries

(69%) were less likely to include such data in their national profiles. However, none of the countries in the American Region reported incorporation of workers' health in other non-health policies, while all countries in the Eastern Mediterranean Region did so (Tables 17 and 18 in Annex II).

**Figure (6)**

### **Q2.3. Which of the following aspects of workers' health are covered by this national profile? (% of those having a national profile)**



## NATIONAL PLANS OF ACTION

Less than half of countries had recently endorsed or drafted a national plan of action on workers' health that included priorities, objectives, and targets, actions and mechanisms for implementation, monitoring, and evaluation. The plans dealt primarily with occupational health and safety and workplace health promotion, and in most cases specific funds were allocated for their implementation.

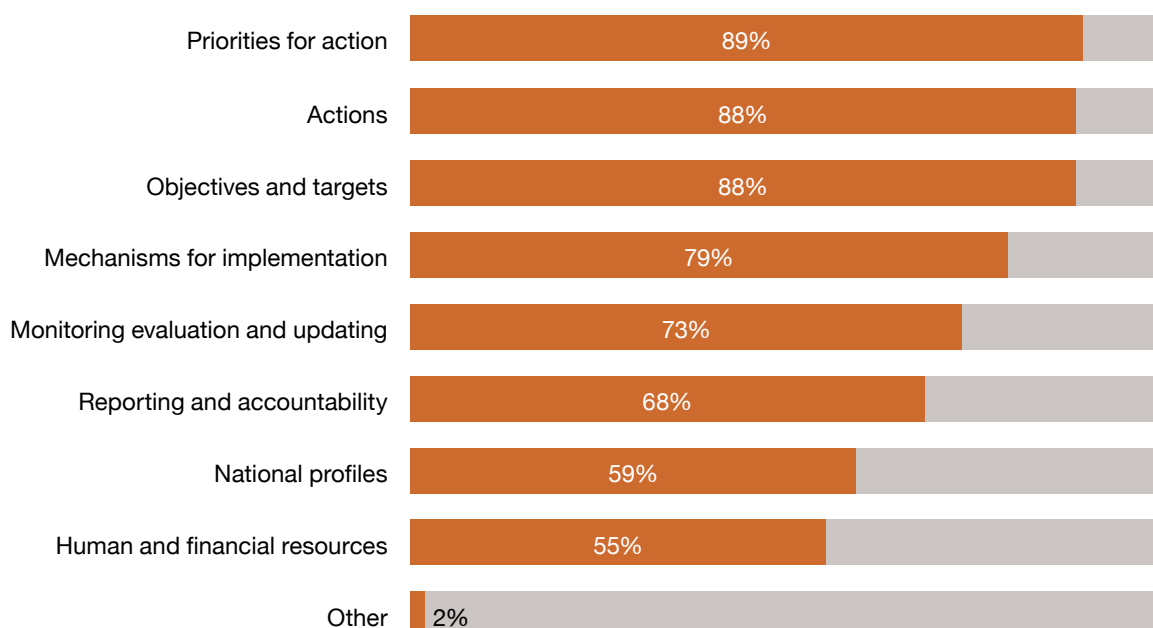
National plans of action are official documents that set priorities and list specific actions for workers' health along with measures for implementation. Just under half of countries surveyed (47%) had a national plan of action on workers' health as of 2009. Countries in the Western Pacific Region were most likely to have such plans (60%), while those in the American region were least likely (20%) to have them.

### ■ ELEMENTS IN NATIONAL PLANS OF ACTION

Existing national plans of action on workers' health dealt most frequently with setting priorities, actions, objectives and targets; they dealt less often with reporting, accountability, and human resource capacities (Figure 7). There were no clear trends by region and income; see Tables 21 and 22 in Annex II for details.

**Figure (7)**

**Q3.1. Which of the following elements does this plan of action include?**  
(% of those having a national plan of action)



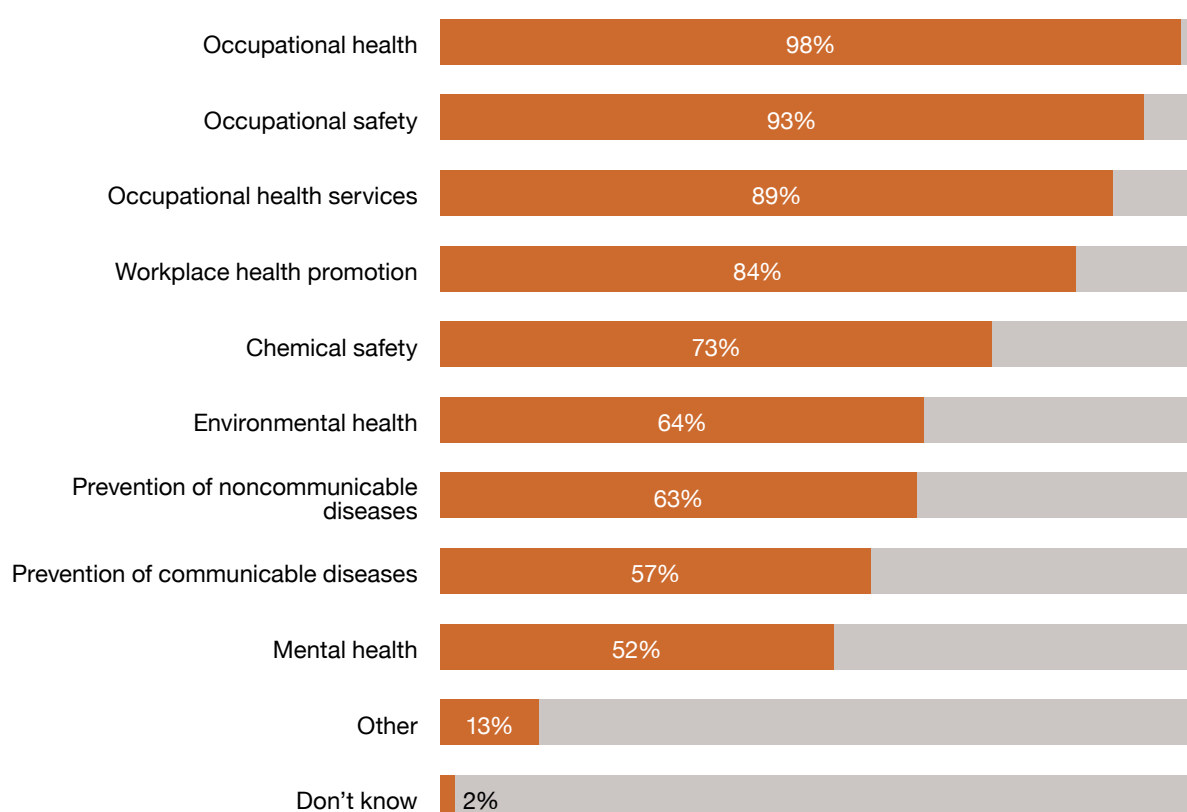
### ■ ASPECTS OF WORKERS' HEALTH COVERED BY NATIONAL PLANS

National actions most commonly involved occupational health and safety and development of occupational health services. Workplace health promotion and chemical safety were also regularly included. Mental health was seldom

included in national plans in the African Region (22%) and low income countries (18%). Most high income countries (78%) and those in the American and European regions included mental health in their national action plans (see Tables 23 and 24 in Annex II).

**Figure (8)**

**Q3.2.** Which of the following aspects of workers' health are covered by this plan of action? (% of those having a national plan of action)



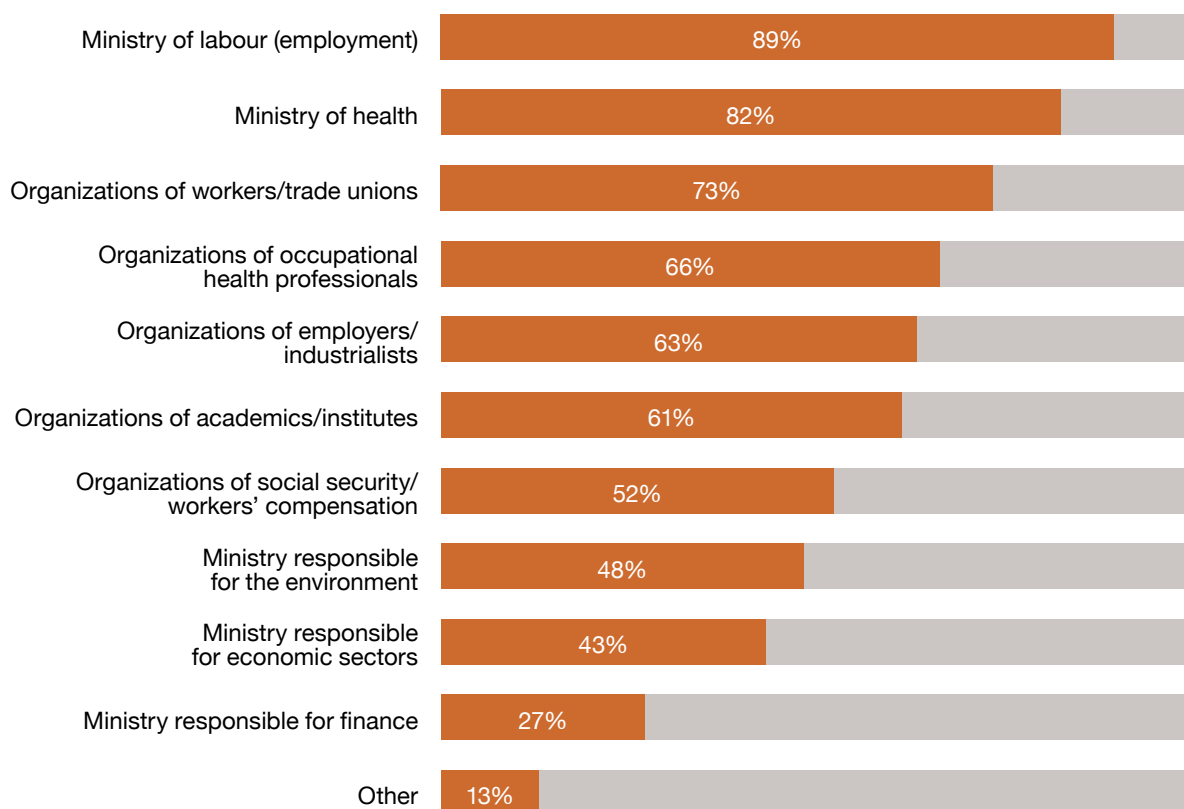
### ■ INSTITUTIONS INVOLVED IN DEVELOPING NATIONAL ACTION PLANS

In most countries, development of the national action plans was led by ministries of health, ministries of labour or both. There were varying degrees of input from other stakeholders such as organizations of workers and trade unions, occupational health professionals, employers/industrialists, academics, and government ministries involving social security,

workers' compensation and the environment. Ministries of finance were involved in drafting one out of five national action plans (Figure 9). Organizations of occupational health professionals were most often involved in the European Region (84%) and least involved in the African and Eastern Mediterranean regions (33% each; see Tables 25 and 26 in Annex II for details).

**Figure (9)**

#### **Q3.3. Which institutions were involved in the development of the national plan of action on workers' health? (% of those having a national plan of action)**





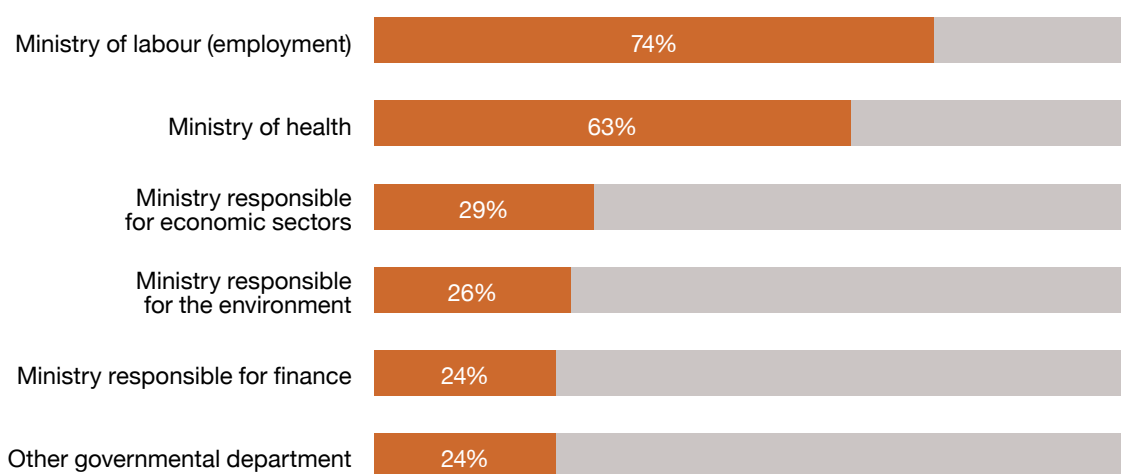
## ■ ENDORSEMENT OF NATIONAL ACTION PLANS

Most (69%) of the existing national plans of action were formally endorsed by the time of the survey; 29% were still being drafted. Formal endorsement was least common in the African Region (45%;

see Tables 27 and 28 in Annex II). Most plans were endorsed at ministerial level by ministries of labour and/or health. Few were endorsed by other relevant ministries, such as those dealing with economic sectors, environment and finance (Figure 10).

**Figure (10)**

### Q3.4.1. Which governmental institution(s) endorsed the document? (% of those where it has been formally endorsed)

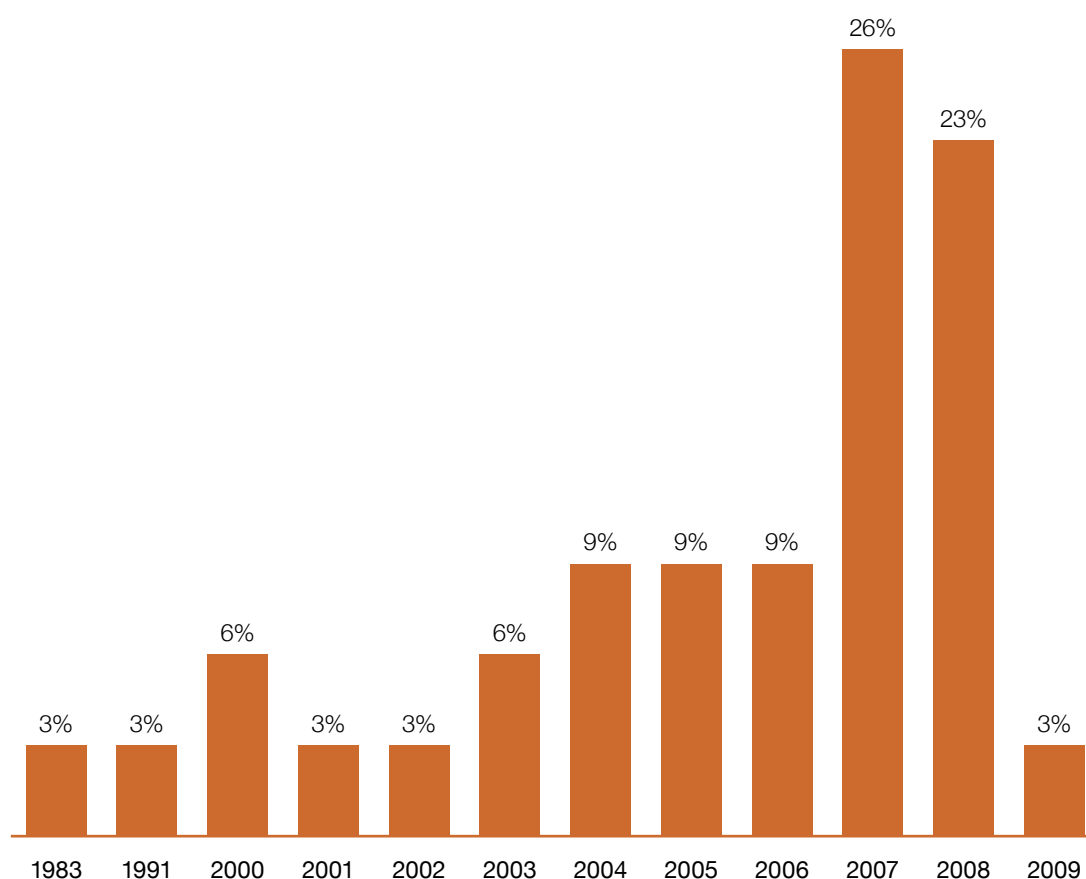


### ■ TIMING OF ENDORSEMENT

The national plans of action were endorsed between 1983 and 2009. More than half of those endorsements occurred around the time of the adoption of the GPA at the World Health Assembly in 2007 (Figure 11).

Figure (11)

#### Q3.4.2. When was this document endorsed?



### ■ FUNDING OF NATIONAL ACTION PLANS

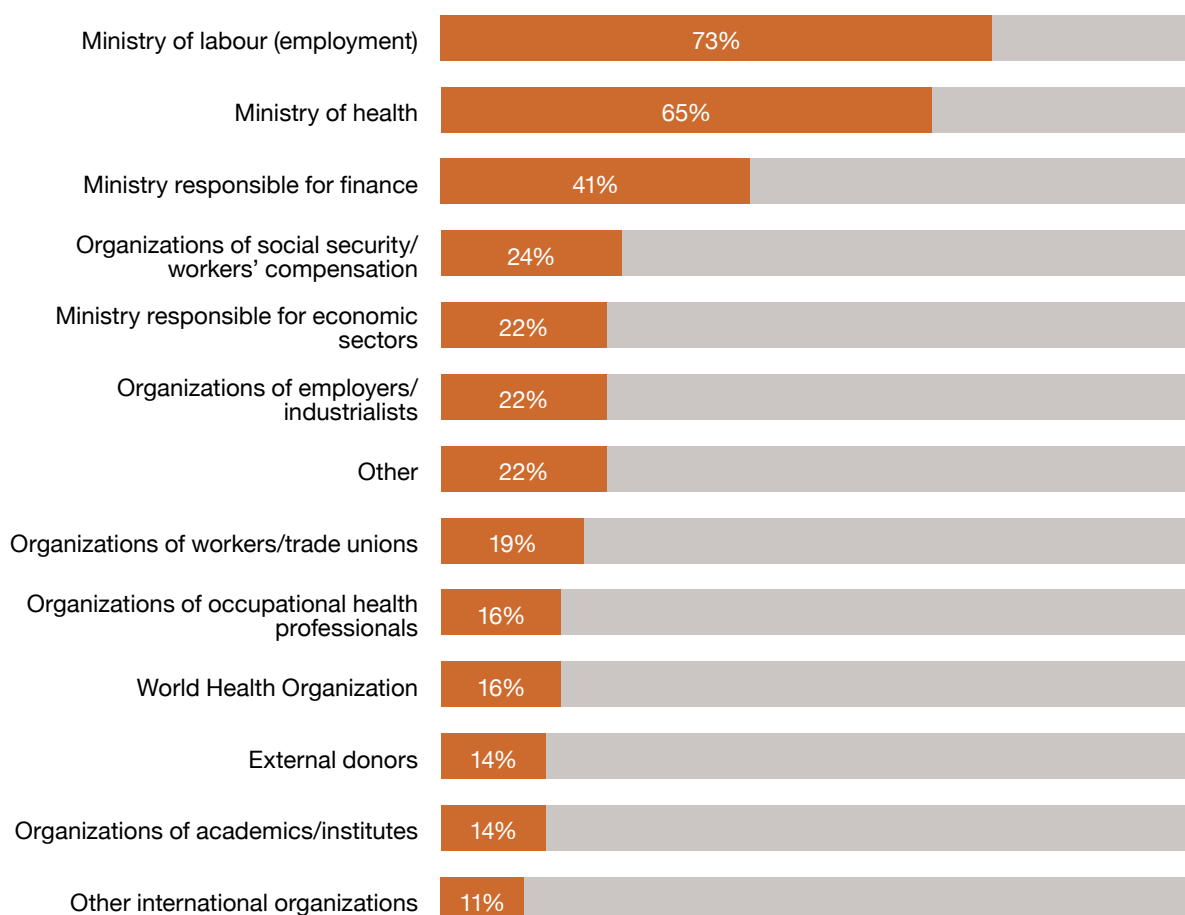
Two thirds of countries with national plans allocated funding for their implementation. Such funds came from ministries of labour (73%), ministries of health (65%), and ministries of finance (41%). Other sources of funding were social security (24%), economic ministries (22%), and employers/industrialists (22%; see Figure 12).

WHO provided direct financial support for implementation of national plans in the European,

South-East Asian, Western Pacific and Eastern Mediterranean regions, and provided technical assistance in the other regions. Workers' organizations/trade unions and employers/industrialists provided funds to implement national action plans in half of lower and upper middle income countries, but no high income countries reported such funding (see Tables 33 and 34 in Annex II).

**Figure (12)**

#### **Q3.5.1. Where do these funds come from?** (% of those with existing funds)



## CAPACITIES OF MINISTRIES OF HEALTH

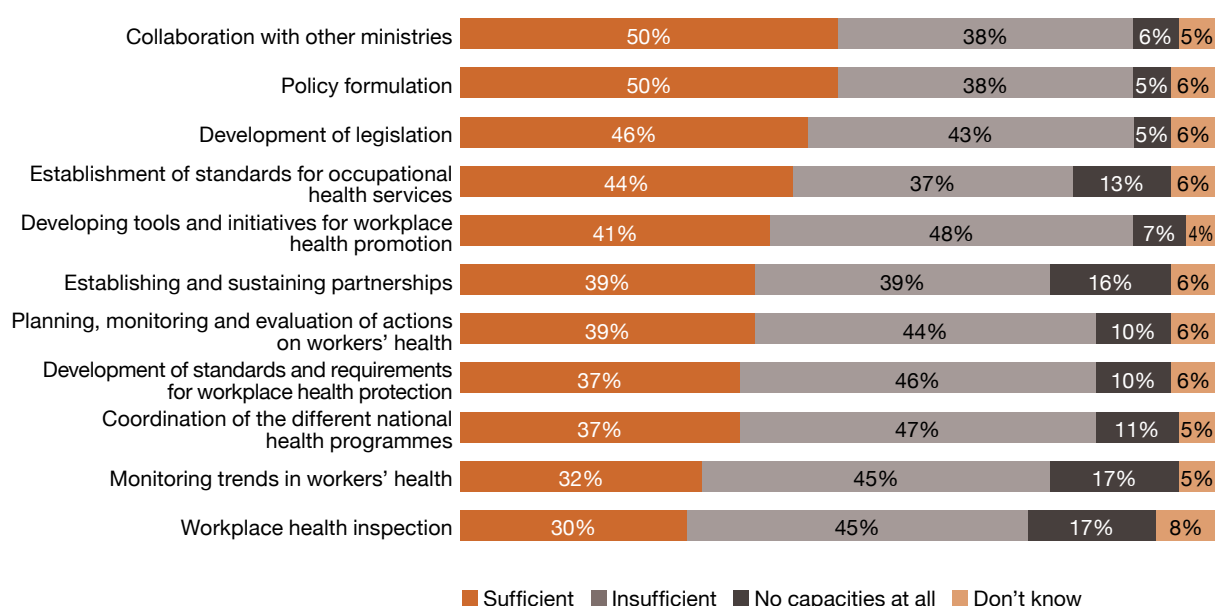
Ministries of health are strong in legislation, policy, intersectoral collaboration, and setting standards for services, but lack sufficient capacity for workplace health inspections and for monitoring workers' health trends. In one third of countries, ministries of health have no staff dealing with workers' health.

Allocation of responsibilities for workers' health between government departments varies from country to country according to traditions and political structures. This survey measured the extent to which the health sector, specifically ministries of health and their specialized agencies, have capacities to provide leadership in the area of workers' health. Respondents were asked to rate the capacities of their health ministries regarding policy, legislation, planning, inspection, standard-setting, information, coordination, and partnerships. Half the countries rated their ministries of health as having sufficient capacity for policy formulation and collaboration with other ministries. Ministerial

capacity for developing legislation was considered sufficient by 46%, and capacity for setting standards for occupational health services was considered sufficient by 44%. About two thirds of countries rated their ministry of health as having insufficient or no capacity for monitoring trends in workers' health and for workplace health inspections. This was especially so in the South-East Asian and Eastern Mediterranean Regions. Figure 13 shows how countries allocate responsibilities for workers' health between different government agencies. Rating of ministerial capacities did not seem to be influenced by country incomes (see Tables 37 and 38 in Annex II).

**Figure (13)**

**Q4. What are the capacities of the Ministry of Health, including its specialized agencies in your country, to provide leadership in the area of workers' health?**



Countries were asked whether or not special units in their health ministries were dedicated to workers' health. While two thirds of countries did have such units, most with full-time staff, one third of countries

had no health ministry staff dedicated to workers' health. Low income countries were the most likely to have ministry staff dedicated to workers' health (see Tables 39 and 40 in Annex II).

## NATIONAL PROGRAMMES AND CAMPAIGNS

Respiratory diseases and musculoskeletal disorders are considered the leading occupational diseases in most countries, but only one third of surveyed countries have special programmes to address these issues. A majority of countries have taken regulatory action to eliminate asbestos-related diseases. Most countries have established programmes to protect health-care workers, including immunizing them against hepatitis B. However, many countries face continuing difficulties in reducing inequalities in workers' health.

The survey quantified countries' reported actions on specific issues noted in the Global Plan of Action on Workers' Health. These issues included defining and addressing priority occupational diseases, identifying high-risk and vulnerable groups of workers, elimination of asbestos-related diseases, and immunization of health-care workers against hepatitis B.

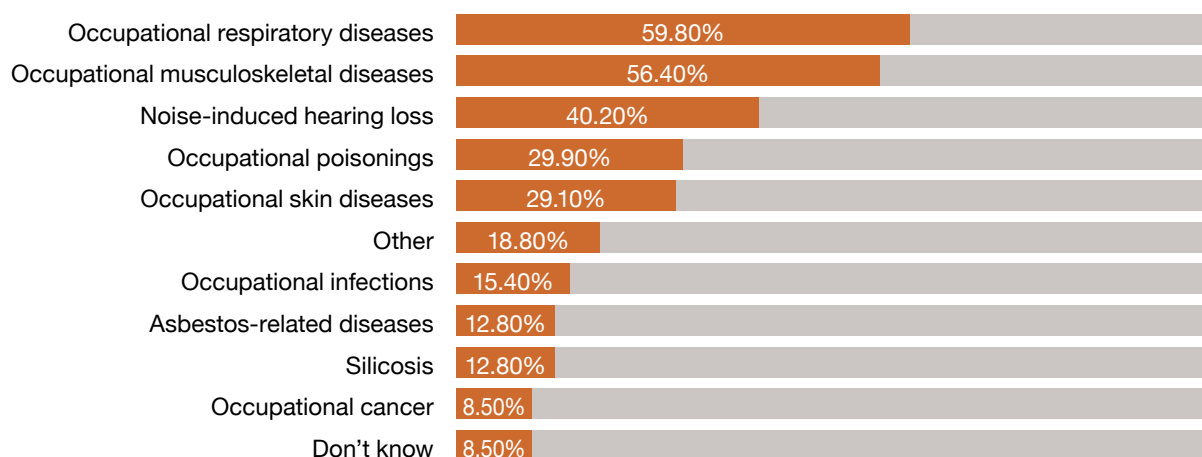
### ■ PROGRAMMES FOR PRIORITY OCCUPATIONAL DISEASES

Only one third of countries, most of them upper middle and high income countries, had special programmes dealing with priority occupational

diseases. When asked about the three top-priority occupational diseases in their countries, respondents most frequently indicated respiratory diseases, musculoskeletal disorders and noise-induced hearing loss (Figure 14). In high income countries, musculoskeletal disorders were listed most often; in lower middle income countries respiratory diseases were the biggest problem. Lower middle income countries were more likely to highlight occupational poisonings than countries in other income groups. Similarly, high income countries were more likely to consider occupational cancers a priority (see Tables 41 and 42 in Annex II).

**Figure (14)**

**Q6. Which are the three top-priority occupational diseases in your country according to governmental sources?**



### ■ INITIATIVES FOR MINIMIZING RISK AND HEALTH STATUS GAPS

Forty-six percent of countries reported initiatives aimed at minimizing risk and health status gaps between different groups of workers. Countries in the South-East Asian and Western Pacific Regions were most likely to have such initiatives; countries in the African Region were least likely to have them (see Tables 45 and 46 in Annex II).

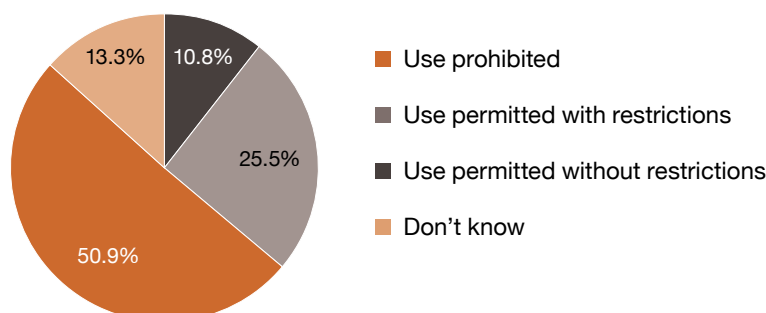
### ■ ELIMINATION OF ASBESTOS-RELATED DISEASES

Half of countries surveyed (51%) prohibit the use of chrysotile asbestos; 25% of countries permit its restricted use and 11% of countries do not restrict its use, while 13% of countries reported uncertainty about regulations regarding chrysotile asbestos.

No high income country permitted unrestricted use of chrysotile asbestos and 80% prohibited its use altogether. However, 46% of upper middle income countries still allowed its use, which was unrestricted in 25% and restricted in 21% of these countries. In lower middle income countries, use of chrysotile asbestos was prohibited in 41% of countries, but was permitted with restrictions in another 41%. In low income countries or areas, 43% allowed its use, half of them with restrictions, while it was prohibited by 26% of low income countries. Thirty percent of respondents from low income countries reported that they did not know whether or not use of chrysotile asbestos was legally permitted in their country; see Figure 15 and Tables 49 and 50 in Annex II.

**Figure (15)**

**Q10. Is the use of chrysotile asbestos legally permitted in your country?**



### ■ IMMUNIZING HEALTH-CARE WORKERS AGAINST HEPATITIS B

About half of surveyed countries, mostly in the high income group, had national programmes for occupational health and safety of health-care workers. Most countries (72%) required that health-care workers be immunized against hepatitis B;

however, in half of those countries the requirements were judged as “partial.” One quarter of countries had no immunization requirements. Countries with higher incomes were more likely to require health-care workers to be vaccinated against hepatitis B (see Tables 51 and 52 in Annex II).

## 2. ACTION AT THE WORKPLACE

Country actions regarding GPA Objective 2 include:

- Improving assessment and management of health risks at the workplace by defining essential interventions;
- 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;
- Building capacity for primary prevention of occupational hazards, diseases, and injuries; and

- Stimulating health promotion and prevention of noncommunicable diseases at the workplace.
- The survey noted actions for protecting and promoting occupational health; these included integrated management of chemicals, elimination of second-hand tobacco smoke, health inspections, developing healthy workplaces, and incorporating workers' health into other public health programmes. Questions were devised to measure these actions.

### GPA OBJECTIVE 2: To protect and promote health at the workplace

“ 11. 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 include also 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.

12. 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, ensuring an appropriate level of enforcement, strengthening workplace health inspection, and building up collaboration between the competent regulatory agencies according to specific national circumstances.

13. Capacities should be built for primary prevention of occupational hazards, diseases and injuries, including strengthening of human, methodological and technological resources, training of workers and employers, introduction of healthy work practices and work organization, and of a health-promoting culture at the workplace. Mechanisms need to be established to stimulate the development of healthy workplaces, including consultation with, and participation of workers, and employers.

14. Health promotion and prevention of noncommunicable diseases should be further stimulated at the workplace, in particular by advocating healthy diet and physical activity among workers, and promoting 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.

15. WHO will work on 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. It will also incorporate workplace actions in international programmes dealing with global health threats. ”

*Global Plan of Action on Workers' Health, Resolution WHA 60.26*



## MANAGEMENT OF WORKPLACE HEALTH RISKS

Most countries have introduced modern ways of addressing workplace health risks such as integrated management of chemicals, tobacco smoking bans, and healthy workplace initiatives. However, enforcement of these regulations remains insufficient in the majority of countries.

### ■ **MANAGING CHEMICALS AT THE WORKPLACE**

Most countries (82%) had full or partial requirements that chemicals be managed at workplaces in an integrated way that covers all phases of the chemical cycle (production, use, and waste). Countries in the Western Pacific and European regions were most likely to require integrated management of chemicals at the workplace. Partial requirements were more prominent in the African, American, Eastern Mediterranean, and South-East Asian regions. Many countries in the African and South-East Asian regions lacked chemical management requirements. The likelihood that countries had chemical management restrictions increased with income level, as did the proportion of countries with full requirements (see Tables 53 and 54 in Annex II).

### ■ **ELIMINATION OF TOBACCO SMOKE FROM INDOOR WORKPLACES**

Tobacco smoking at indoor workplaces was fully prohibited in 58% of countries and partially prohibited in 34%. Only 8% of countries surveyed still allowed tobacco smoking at indoor workplaces (see Tables 55 and 56 in Annex II).

### ■ **WORKPLACE HEALTH INSPECTIONS**

Capacity to carry out workplace health inspections was rated as “sufficient” by 30% of countries, and as “insufficient” by 62%. Three percent reported no capacity for such inspections. While half of the countries in the European and Western Pacific regions reported sufficient capacity for this, more than 85% of countries in the African, American, Eastern Mediterranean and South-East Asian regions reported insufficient capacity in this area (see Table 57 in Annex II). Higher country incomes were associated with better capacity for workplace health inspections (see Table 58 in Annex II).

### ■ **HEALTHY WORKPLACE PROGRAMMES**

Most countries (73%) across all regions and income groups reported initiatives supporting development of healthy workplace programmes to promote health and prevent noncommunicable diseases (see Tables 59 and 60 in Annex II).



## PUBLIC HEALTH PROGRAMMES WITH WORKPLACE COMPONENTS

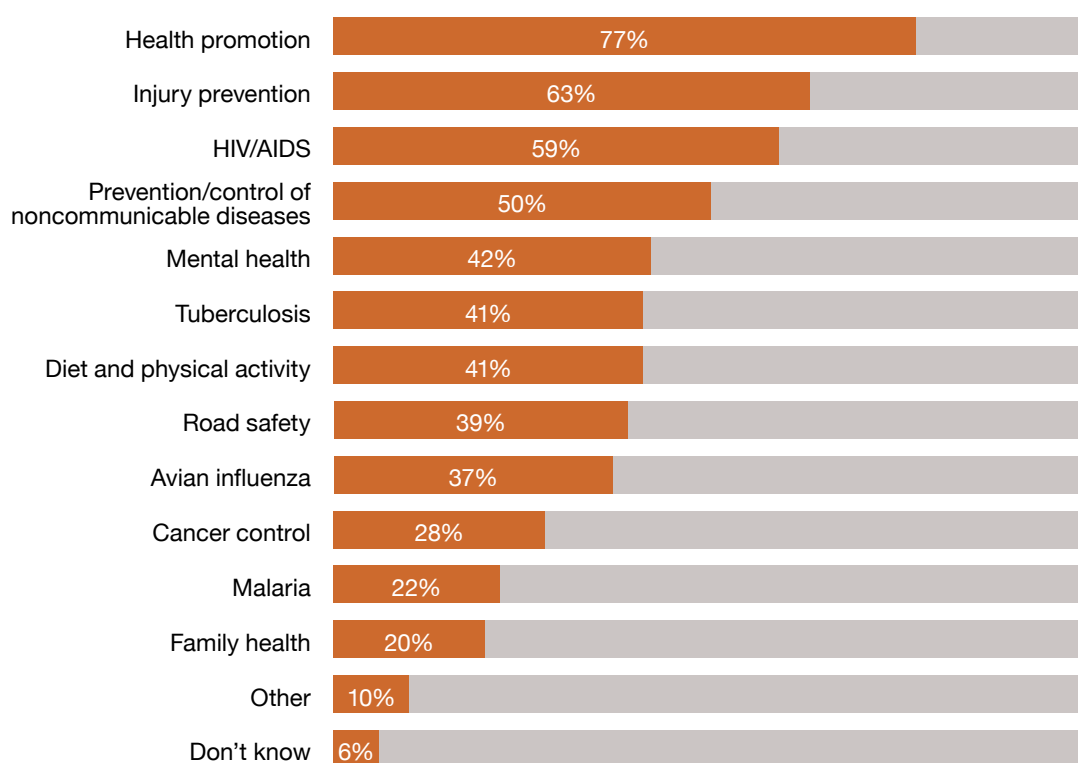
Workers' health was most often incorporated into national programmes dealing with health promotion, injury prevention, or HIV/AIDS; workers' health was seldom incorporated in programmes dealing with cancer, malaria, or family health.

Respondents were asked whether other national health programmes included components related to workplaces or workers' health. National programmes for health promotion, injury prevention and HIV/AIDS were most frequently mentioned as including workplace components (Figure 16). Most HIV/AIDS and malaria programmes

in the African and South-East Asian regions and in lower income groups had a workplace component, while higher-income countries were more likely to include workplace components in their programmes for mental health, diet, physical activity, and cancer control.

**Figure (16)**

**Q16. Which of the following health programs in your country include workplace components?**



# 3. OCCUPATIONAL HEALTH SERVICES

Country actions for achieving this objective include:

- Integration of occupational health services into national health strategies;
- Developing standards for coverage and organization of occupational health services;
- Setting targets for increasing the coverage of such services;
- Pooling resources for financing occupational health services; and
- Building human resource capacities for occupational health.

## GPA OBJECTIVE 3: To improve performance of and access to occupational health services

“ 16. Coverage and quality of occupational health services should be improved by: integrating their development into national health strategies, health-sector reforms and plans for improving health-systems performance; determining standards for organization and coverage of occupational health services; setting targets for increasing the coverage of the working population with occupational health services; creating mechanisms for pooling resources and for financing the delivery of occupational health services; ensuring sufficient and competent human resources; and establishing quality-assurance systems. Basic occupational health services should be provided for all workers, including those in the informal economy, small enterprises, and agriculture.

17. Core institutional capacities should be built at national and local levels in order to provide technical support for basic occupational health services, in terms of

planning, monitoring and quality of service delivery, design of new interventions, dissemination of information, and provision of specialized expertise.

18. Development of human resources for workers' health should be further strengthened by: further postgraduate training in relevant disciplines; building capacity for basic occupational health services; incorporating workers' health in the training of primary health care practitioners and other professionals needed for occupational health services; creating incentives for attracting and retaining human resources for workers' health, and encouraging the establishment of networks of services and professional associations. Attention should be given not only to postgraduate but also to basic training for health professionals in various fields such as promotion of workers' health and the prevention and treatment of workers' health problems. This should be a particular priority in primary health care.

19. WHO will provide guidance to the Member States for the development of basic packages, information products, tools and working methods, and models of good practice for occupational health services. It will also stimulate international efforts for building the necessary human and institutional capacities. ”

*Global Plan of Action on Workers' Health, Resolution WHA 60.26*

## COVERAGE OF OCCUPATIONAL HEALTH SERVICES

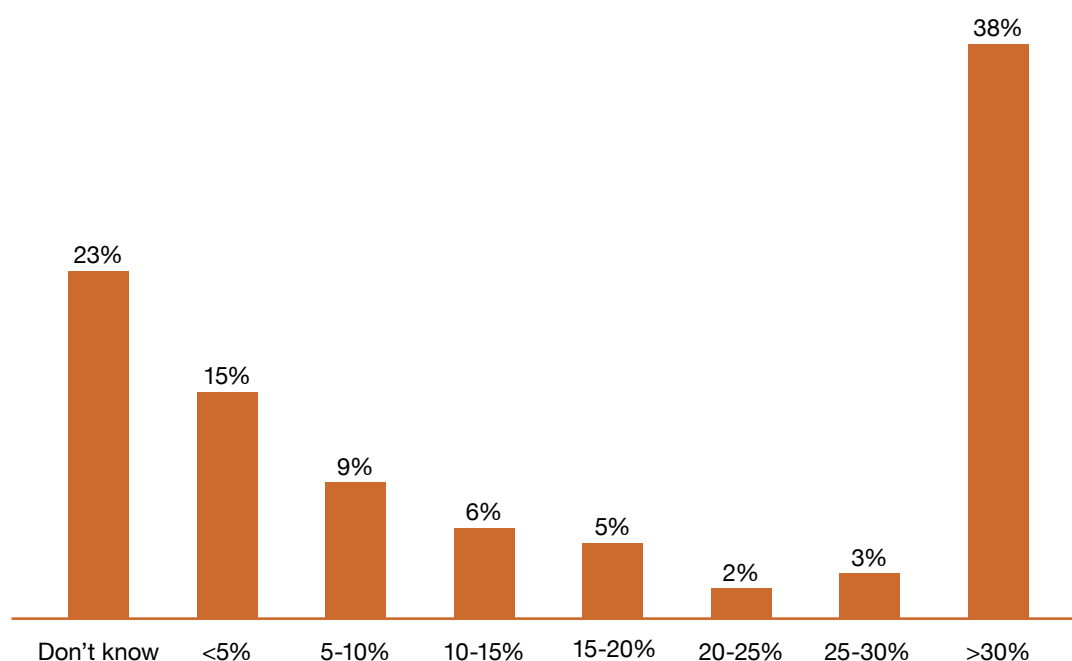
Although most countries reported strategies, standards and targets for coverage of occupational health services, only one third of them cover more than 30% of their workers with such services.

Just over one third of respondents rated the coverage of occupational health services in their countries as greater than 30%, while 15% said services reached fewer than 5% of workers. In 23% of countries, respondents could not gauge occupational health services' coverage levels. Coverage of workers with occupational health

services increased with country income. The highest coverage levels were reported by countries from the European and American regions and the lowest coverage levels by countries in the African and South-East Asian regions (see Tables 63 and 64 in Annex II).

**Figure (17)**

**Q17.** What is the current level of coverage of workers in your country with occupational health services according to governmental estimates?



### ■ NATIONAL HEALTH STRATEGIES

Most countries (81%) incorporated the development of occupational health services into their national health strategies, but this was usually reported as a “partial” incorporation. Again, the higher the national income, the more likely development of occupational health services were to be included in national health strategies (Figure 18).

### ■ STANDARDS FOR SERVICES

More than 80% of countries reported setting standards for organization and coverage of occupational health services, but many reported these as “partial.” About one third of countries, primarily in the upper middle and higher income groups, had full standards for such services (Figure 18).

### ■ TARGETS FOR COVERAGE

Most countries had set targets for increasing the coverage of the working population with occupational health services (69%), but most of these were rated as “partial.” One quarter of countries had not set any targets (Figure 18).

### ■ FINANCING OF SERVICE DELIVERY

Just over half of countries (56%) reported mechanisms to pool together funds and to purchase the delivery of occupational health services, while more than one third of countries had no such mechanisms. Countries in the Western Pacific, European and Eastern Mediterranean regions and those in the higher income group were more likely to have such mechanisms in place (Figure 18).

### ■ HUMAN RESOURCES

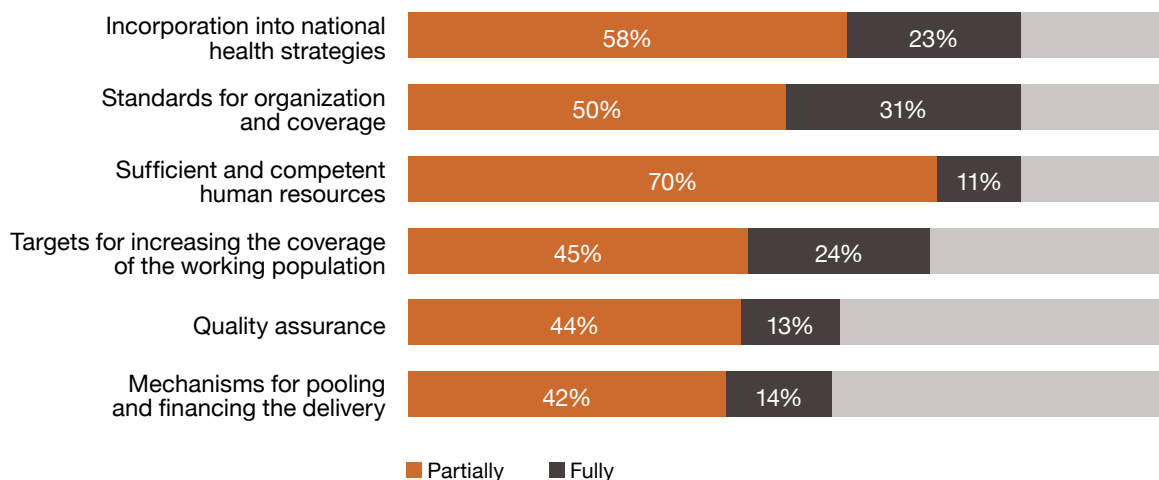
Most respondents reported their human resources for workers’ health to be partially sufficient and competent. In 17% of countries, mostly those in the low income group, human resources for occupational health were not at all sufficient. Only 11% of respondents were satisfied with the availability of human resources for occupational health in their country; 18% reported having no such resources (Figure 18).

### ■ QUALITY ASSURANCE

Just over half of countries reported having partial quality assurance systems for occupational health services (56%); most of these were in the European and Western Pacific regions. About 41% of countries lacked quality assurance systems (Figure 18).

Figure (18)

#### Q18. - Q23. Occupational health services



## INSTITUTIONS RESPONSIBLE FOR OCCUPATIONAL HEALTH

The majority of countries have a national scientific entity carrying out research and training to provide support for occupational health services. However, the distribution of such capacities is uneven across country groups.

### ■ SCIENTIFIC ENTITIES DEALING WITH OCCUPATIONAL HEALTH

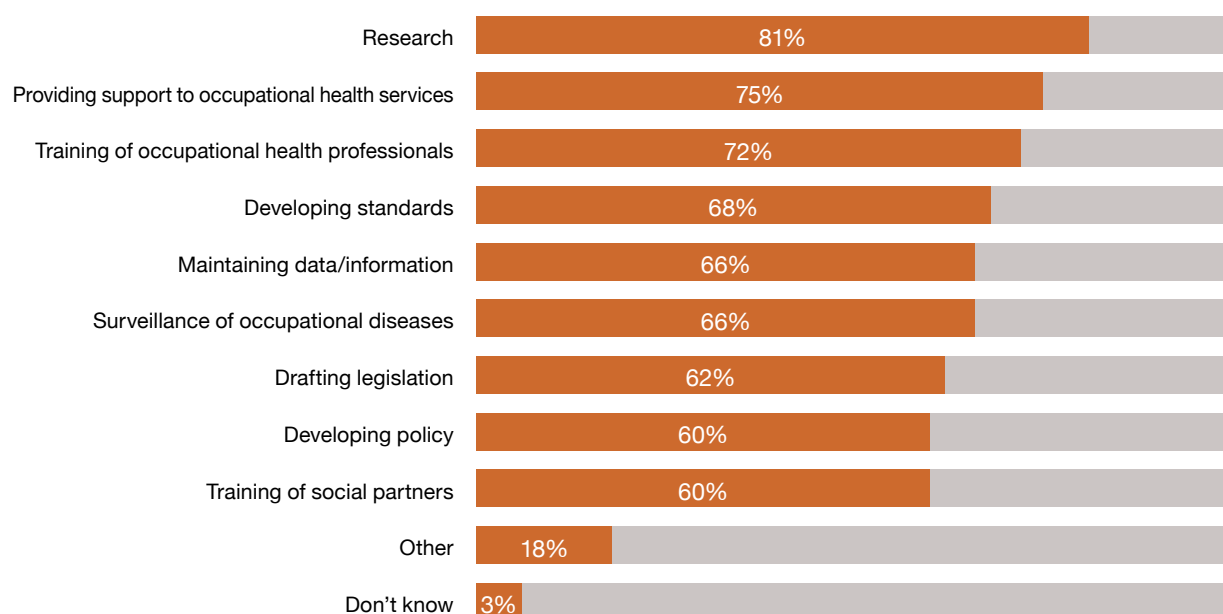
National scientific entities tasked with occupational health were present in 59% of countries either as separate institutes or as part of another institute. However, 41% of countries, most of them in the Eastern Mediterranean, African and American regions, lacked research institutes for occupational health.

### ■ TASKS OF INSTITUTES FOR OCCUPATIONAL HEALTH

Most such institutes dealt with research, provided support to occupational health services and carried out training of occupational health professionals. Institutes in the European Region were more likely to be in charge of drafting legislation (78%) than those in the African Region (29%). Institutes from higher income countries were most likely to maintain data and/or information resources and to develop standards for occupational health and safety (Figure 19).

**Figure (19)**

#### **Q24.1. What are the tasks of the national institute responsible for occupational health?** (% of those which have one)



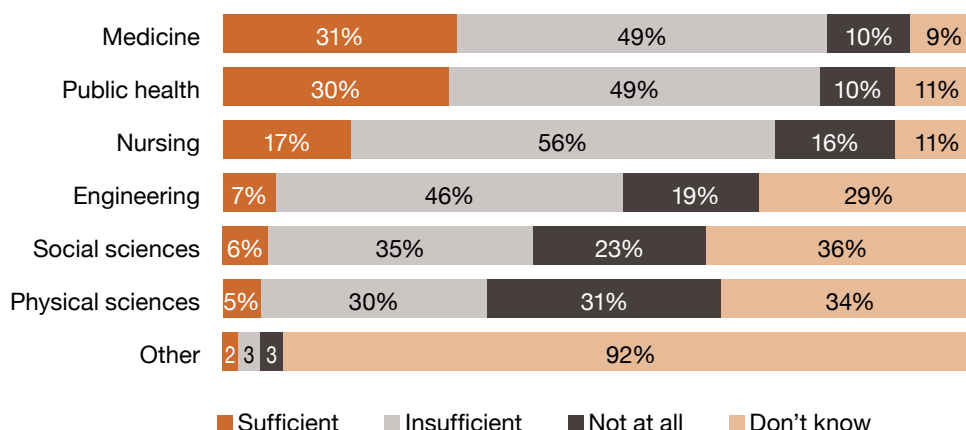
## ■ OCCUPATIONAL HEALTH IN ACADEMIC TRAINING

Respondents were asked to rate the extent to which occupational health was included in undergraduate and postgraduate training in their country in various disciplines. Several countries reported that occupational health was not included in undergraduate training in medicine (10%), nursing (16%), public health (10%), engineering (19%), and

physical science (31%; see Figure 20). In those countries where occupational health was included in undergraduate training, this training was usually rated as “insufficient.” Only in the Western Pacific Region were the majority of respondents satisfied with the level of inclusion of occupational health in undergraduate training in medicine (see Tables 81 and 82 in Annex II).

Figure (20)

**Q25. In your view, to what extent is occupational health included in undergraduate training in the following areas?**



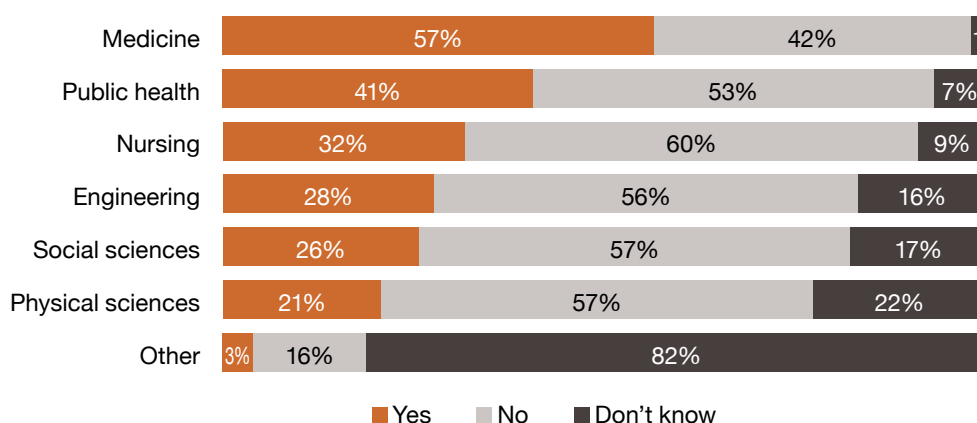
## ■ DEGREE PROGRAMMES IN THE AREA OF OCCUPATIONAL HEALTH

Degree programmes offering postgraduate training in occupational health were most commonly found in the disciplines of medicine, public health, and nursing (Figure 21). Social and physical sciences were least likely to have a degree programme in occupational health. The proportion of countries with occupational health degree programmes

in medicine was highest in the European and American regions and lowest in the South-East Asian and African regions. As country incomes rose, so did the proportion of countries offering such programmes. No degree programmes in safety engineering were available in countries in the African Region, while they were offered in half of American Region countries.

Figure (21)

**Q26. Does your country have a degree programme for post-graduate training on occupational health for professionals in the following areas?**



# 4. EVIDENCE

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## FOR ACTION

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## AND PRACTICE

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Country actions include:

- Designing surveillance systems to identify and control occupational hazards;
- Strengthening research on workers' health; and
- Using strategies and tools to raise awareness of workers' health issues.

The survey measured the existence of national information systems for workers' health, registration of occupational diseases, programmes for research, and levels of awareness on workers' health issues among major stakeholders.

### **GPA OBJECTIVE 4: To provide and communicate evidence for action and practice.**

“ 20. Systems for surveillance of workers' health should be designed with the objective of accurately identifying and controlling occupational hazards. This endeavour includes establishing national information systems, building capability to estimate the occupational burden of diseases and injuries, creating registries of exposure to major risks, occupational accidents and occupational diseases, and improving reporting and early detection of such accidents and diseases.

21. Research on workers' health needs to be further strengthened, in particular by framing special research agendas, giving it

priority in national research programmes and grant schemes, and fostering practical and participatory research.

22. Strategies and tools need to be elaborated, with the involvement of all stakeholders, for improving communication and raising awareness about workers' health. They should target workers, employers and their organizations, policy-makers, the general public, and the media. Knowledge of health practitioners about the link between health and work and the opportunities to solve health problems through workplace interventions should be improved.

23. WHO will define indicators and promote regional and global information platforms for surveillance of workers' health, will determine international exposure and diagnostic criteria for early detection of occupational diseases, and will include occupational causes of diseases in the eleventh revision of the International Statistical Classification of Diseases, and Related Health Problems. ”

*Global Plan of Action on Workers' Health, Resolution WHA 60.26*



## INFORMATION AND RESEARCH

Though most countries have registries of occupational diseases, registration levels are low. Few countries have developed comprehensive information systems dealing with other aspects of workers' health. Many countries lack research programmes supporting workers' health.

### ■ NATIONAL INFORMATION SYSTEMS

National information systems for workers' health existed in less than half of countries surveyed (42%). These countries ranged from a low of 14% in the African Region to a high of 59% in the European Region. When analysed by country income, existence of information systems ranged from 25% in upper middle income countries to 64% in high income countries. However, most countries (68%) indicated having national registries of occupational diseases and work accidents. The presence of such registries was highest in the European Region (83%) and lowest in South-East Asia (33%; see Tables 85-88 in Annex II).

### ■ REGISTRATION OF OCCUPATIONAL DISEASES

Registration of occupational diseases and accidents was relatively weak across all countries, with only 23% reporting high levels of registration, 37% reporting medium levels and 37% reporting low levels. There were no strong differences between regions or income levels (see Tables 89 and 90 in Annex II).

### ■ RESEARCH

Just over half of countries (56%) had programmes for research on workers' health existing either separately or as part of a general national research agenda; 43% of countries reported no research programmes. Countries in the European and South-East Asian regions were most likely to have national research programmes dealing with workers' health (see Tables 91 and 92 in Annex II).





## AWARENESS

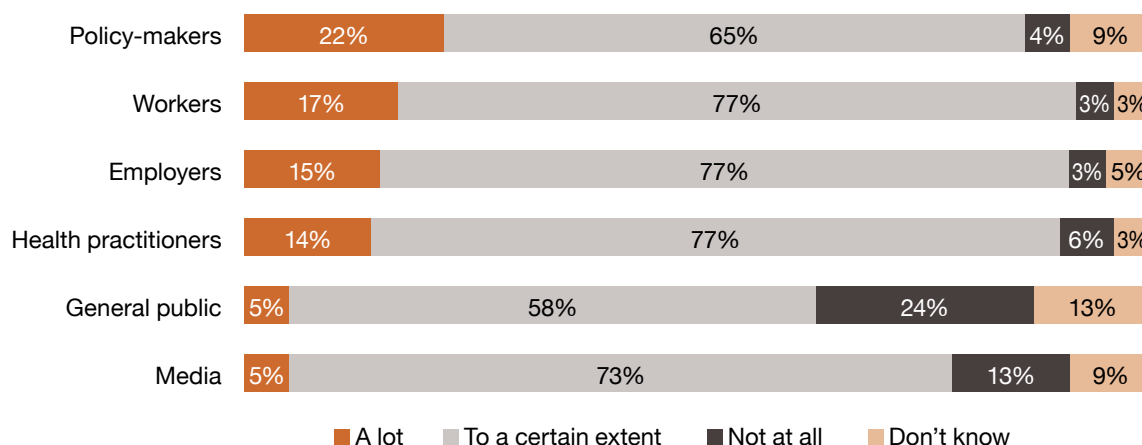
Awareness about workers' health problems remains insufficient, particularly among the media and the general public.

The general level of awareness of policy-makers, workers, employers, and health practitioners was rated as quite high, with more than 89% of respondents rating levels of awareness as “a lot” or “a certain extent.” However, 24% of respondents rated the general public as being “not at all” aware of workers' health, and 12% percent rated the media similarly.

Interestingly, about one tenth of respondents said they did not know how to rate the awareness of policy-makers, the public, and the media regarding workers' health (Figure 22). The awareness of employers was rated somewhat higher in countries with higher national incomes.

Figure (22)

**Q30. What is the general level of awareness of workers' health problems among major stakeholders?**



# 5. WORKERS' HEALTH IN OTHER POLICIES

GPA Objective 5 encourages countries to:

- Strengthen the capacity of the health sector to promote the inclusion of workers' health in other sectors' policies;
- Consider workers' health in the context of trade policies;
- Assess the health impact of employment strategies;
- Address workers' health in sectoral policies for different branches of economic activity; and
- Include workers' health issues in all levels of education and vocational training.

## GPA OBJECTIVE 5: To incorporate workers' health into other policies

“ 24. The capacities of the health sector to promote the inclusion of workers' health in other sectors' policies should be strengthened. Measures to protect workers' health should be incorporated in economic development policies and poverty reduction strategies. The health sector should collaborate with the private sector in order to avoid international transfer of occupational risks and to protect health at the workplace. Similar measures should be incorporated in national plans and programmes for sustainable development.

25. Workers' health should likewise be considered in the context of trade policies when taking measures as specified in resolution WHA59.26 on international trade and health.

26. Employment policies also influence health; assessment of the health impact of employment strategies should therefore be encouraged. Environmental protection should be strengthened in relation to workers' health through, for instance, implementation of the risk-reduction measures foreseen in the Strategic Approach to International Chemicals Management, and consideration of workers' health aspects of multilateral environmental agreements and mitigation strategies, environmental management systems and plans for emergency preparedness and response.

27. Workers' health should be addressed in the sectoral policies for different branches of economic activity, in particular those with the highest health risk.

28. Aspects of workers' health should be taken into account in primary, secondary and higher level education and vocational training. ”

*Global Plan of Action on Workers' Health, Resolution WHA 60.26*

## WORKERS' HEALTH IN NON-HEALTH POLICIES

Workers' health issues are well considered in policies on chemical management, emergency preparedness and response, employment strategies, and vocational training. However, they are seldom considered in policies regarding climate change, trade, economic development, poverty reduction, and general education.

More than half of countries surveyed reported that their policies on chemical management, emergency preparedness and response, and employment included measures regarding workers' health (Figure 23). Most countries in the high income group, particularly those in the European and Eastern Mediterranean regions, emphasized workers' health in chemical safety policies. Low

income countries tended to address workers' health through poverty reduction strategies and environmental management systems. Sector-specific policies dealing with workers' health existed in half of the surveyed countries; however, one fifth of respondents were unable to say whether such policies existed or not (Tables 95-98, Annex II).

**Figure (23)**

**Q31. Which of the following non-health policies in your country include measures on protecting and promoting workers' health?**



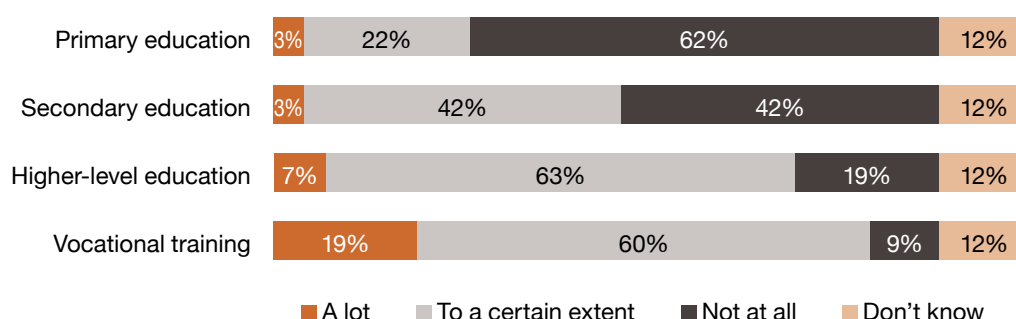
## WORKERS' HEALTH IN EDUCATION

The extent to which workers' health was included in general education varied by level of education: 26% inclusion was reported in primary education, 45% in secondary and 71% in higher education. A larger majority of countries (78%) included occupational health as part of vocational training (Figure 24). Countries from the American and Western Pacific

regions were more likely to include workers' health in programmes for education at the primary level, while those in the South-East Asian Region were less likely to include workers' health in general education programmes (see Tables 99 and 100 in Annex II).

**Figure (24)**

**Q33. To what extent is workers' health taken into account in education?**



# CONCLUSIONS

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This survey reports on the actions countries have taken regarding the WHO Global Plan of Action on Workers' Health, and it provides a baseline to measure progress on GPA implementation. As WHO intends to repeat the survey in 2017 to measure this progress, this later survey should aim for better representation from all country groupings, particularly from the American region and low income groups. This can be achieved through improving data collection methods.

This survey has also provided a basis for establishing GPA achievement indicators. The most robust indicators that can be verified independently of this survey include:

1. The number of countries that have adopted and financed national policy instruments for workers' health, such as policy frameworks and strategies, national plans of action, and national profiles;
2. The number of countries that have banned the use of all forms of asbestos, including chrysotile;
3. Coverage of workers with occupational health services (measurement needs to be improved), globally and by country;
4. The number of countries that have banned tobacco smoking in all workplaces;
5. The number of countries with national institutes or similar institutions concerned with occupational health;
6. The number of national public health programmes focusing on communicable and noncommunicable diseases that include workers' health;
7. The number of national programmes in other sectors addressing workers' health issues;
8. Global media coverage of workers' health issues (means of measurement needed); and
9. Incidence of occupational diseases and injuries, global and by country.

Developing targets for 2017 will require further consultation with countries and regional offices.





**WHO Global Plan of Action on Workers' Health (2008-2017):  
Baseline for Implementation**

**Global Country Survey 2008/2009**  
Executive Summary and Survey Findings