On 16-18 March 2011, the World Health Organization (WHO) held an International Consultation on Healthy Workplaces at the South-East Asia Regional Office (SEARO). It was attended by 63 participants representing governments and businesses from 18 countries from all six WHO Regions. This included

- 17 occupational health & safety experts
- 11 government officials
- 21 business representatives
- 4 representatives of NGOs, and
- 10 representatives of various United Nations agencies.

The meeting was an excellent example of WHO Headquarters and a WHO Regional Office collaboration in concert with the International Labour Organization (ILO) and other UN agencies. The SEARO Regional Director who inaugurated the meeting, and the Assistant Regional Director who also attended the meeting, showed their support for the initiative.

The impetus for the meeting was the Global Plan of Action for Workers’ Health (GPA), which set out the mandate for the healthy workplace initiative when it stated, “Mechanisms need to be established to stimulate the development of healthy workplaces, including consultation with, and participation of, workers and employers.”

The purpose of the Consultation meeting was:

1. To increase awareness of the business community, workers, occupational health experts and policy-makers on the benefits of the comprehensive
approach to improving workers’ health, as well as on the risk assessment and management model to reduce the health impact of hazardous, unsafe and unhealthy working conditions;

2. To collect good examples of workplace practices from different sectors and differently-sized companies that cover the full cycle of assessment and management of workplace risks; and

3. To increase ease of use and ownership of the business community to comprehensive healthy workplace programmes.

Over the past three years, WHO has developed a framework and model for healthy workplaces that emphasizes the need for leadership engagement and worker participation at each step of the process. A Healthy Workplace website has been established by WHO and a global Healthy Workplace Network of currently 170 members was set up to support the adaptation, development, implementation and evaluation of healthy workplace programmes.

In 2011, the intention is to begin to develop a global document on good practices and tools. This International Consultation was the first step in achieving these objectives. Employers, trade unions, and government representatives were invited to attend this Consultation to provide case studies and to discuss the needs of these stakeholder groups.

The meeting included a pre-conference Workshop on the 4th Avenue*, Enterprise Community Involvement (see Annex 1 for details of the Workshop). The main meeting included 24 case studies from government, business, OHS experts and NGO leaders, as well as many opportunities for networking and group discussions.

Key conclusions of the meeting were as follows:

1. There is a high degree of support and a strong expressed need for WHO to develop practical, hands-on guidance for enterprises to help them apply the information provided in the earlier documents.

2. There is strong support for a WHO International Consultation on healthy workplaces in the informal economy, also called micro-enterprises.

3. In addition to generic practical guidance, there is a need for gender-specific, sector-specific, and culture-specific documentation. WHO will develop the generic materials, which will be adapted by healthy workplaces network members and other stakeholders.

4. While Small and Medium Sized Enterprises (SMEs) and Micro and Small Enterprises (MSEs) are badly in need of guidance documents, large multinational corporations can often be the conduit to reaching these enterprises.

5. As the WHO healthy workplace model is aimed at the enterprise level (workplace parties such as management and workers), the model was felt to be appropriate for application by policy makers in developing countries.

6. There is support to pilot, adapt, implement and evaluate the global guidance in different regions, at different levels (national, sectoral, organizational, workplaces), and levels of intervention with local expert support.

7. There is support to collect & develop suitable training packages to enhance the implementation of comprehensive healthy workplace programmes.

8. The WHO Healthy Workplace network is a critical part of spreading knowledge and expertise globally.

9. There are four common misunderstandings of the WHO Healthy Workplace model and framework that must be addressed and emphasized in future documents (clarified below).

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* See the Introduction, next page, for an explanation of the four “Avenues of Influence” through which employers and workers can impact the health, safety and well-being of workers and the enterprise.
Introduction

WHO recognizes that workers’ health, safety and well-being are vital concerns to hundreds of millions of working people world-wide. But the issue extends even further beyond individuals and their families. It is of paramount importance to the productivity, competitiveness and sustainability of enterprises, communities, and to national and regional economies.

In 2007, the World Health Assembly endorsed the Workers’ Health: Global Plan of Action (GPA) to provide impetus for action by Member States. To move towards achieving its objectives, especially Objective 2 (To protect and promote health at the workplace), WHO developed the WHO Healthy Workplace Framework and Model: Background and Supporting Literature and Practices, and a summary version titled Healthy Workplaces: a Model for Action, both of which are available on the WHO website. The target audience for the first document is occupational health experts, while the target audience for the second is the workplace parties – business owners, managers and workers in enterprises.

The WHO healthy workplace model is illustrated below. It centres around ethics and values, and certain key principles that include worker involvement and leadership engagement. It suggests that approaches to a healthy workplace should consider four “Avenues of Influence” through which employers and workers can have an impact on the health, safety and well-being of workers and the enterprise. These four Avenues are:

1. The physical work environment (traditional health & safety, considering physical, chemical, biological, mechanical, electrical, and ergonomic hazards in the workplace);
2. The psychosocial work environment (the non-physical hazards that may exist in the workplace, including organizational culture, work organization, and the way people are treated in the workplace by managers and co-workers);
3. Personal health resources – finding ways to create a supportive work environment that encourages healthy lifestyles, to remove any workplace barriers that may prevent workers from adopting healthy habits;
4. **Enterprise community involvement** – going beyond legislated mandates to consider voluntary actions that impact the health of workers, their families, and members of the community.

The model also stresses that the process of moving towards a healthy workplace is as important, if not more important, than the content of the programmes implemented. It describes eight steps:

1. Mobilize – mobilize key commitments and resources, including leadership and workers or their representatives;
2. Assemble – bring together a team to work that includes workers or their representatives, both genders and other stakeholders;
3. Assess – determine the current situation in the workplace, the ideal situation, and the gap in between. Ensure that workers are consulted in determining needs;
4. Prioritize – in discussion with workers, determine the priorities among all the issues identified;
5. Plan – develop a 3-5 year plan based on the assessments and the priorities;
6. Do – carry out the action plans;
7. Evaluate – collect information and measure the outputs and outcomes of the process, and consult workers or their representatives on what is working well and what isn’t;
8. Improve – based on the evaluations, make necessary changes and recognize success.

After developing the framework and model, WHO determined that more practical guidance and case studies of good practice are required to assist employers and workers to implement the model with their healthy workplace programmes. For that reason, employers, trade unions, OHS experts and government representatives were invited to attend this International
Consultation on Healthy Workplaces, to provide case studies and to discuss the needs of these stakeholder groups.

**Special Workshop on Enterprise Community Involvement**

It is recognized that the Enterprise Community Involvement (ECI) is the least familiar Avenue of Influence, and the one with the fewest tools available. In addition, it is often not associated with workplace health, safety and well-being, and may operate in isolation from other healthy workplace activities. Therefore WHO saw it as important to devote half a day to exploring this Avenue to clarify its role in the model.

The Workshop consisted of a presentation about the Avenue, followed by three company case studies that illustrated their implementation of this concept. Participants were then given the opportunity to discuss the following four questions:

1. How can Enterprise Community Involvement (ECI) drive the promotion of workers’ health?
2. To what extent can ECI drive the promotion of workers’ health in the absence of legislation?
3. How can ECI and OH&S issues be mainstreamed into business strategy?
4. What support do enterprises need to promote health through responsible business practices?

Details of the presentations and discussions are included in Annex 1.

**International Consultation on Healthy Workplaces: The Presentations**

Some highlighted points during the presentations were:

- Many multinationals are working to improve conditions in their workplaces and communities, and are influencing SMEs who work with them as suppliers or contractors.
- Multinationals in Africa have clearly documented the fact that managing HIV/AIDS in their employees and employees' families is not just a “nice thing to do” but is essential to their sustainability. Especially in medium and low prevalence countries (such as Ghana) is has been shown, that an expansion from HIV Workplace Programs to comprehensive Employee Wellbeing Programs is very effective.
- Government agencies, either from the Ministries of Labour/Manpower, Ministry of Health, or Ministry of Railways (in India) can have a big impact on SMEs by influencing and enforcing healthy workplace practices.
- Many large enterprises have been implementing programmes in 3-4 of the Avenues of Influence long before WHO developed the model. However, they tend to be somewhat fragmented and not integrated.
- Both business leaders and government presenters emphasized repeatedly the importance of involving workers at all stages of implementing healthy workplace programmes.
- Several presentations mentioned very positive return on investment (ROI) data, but all agreed that measurement and evaluation is often lacking.
The Working Groups

There were several opportunities during the three days when participants had the chance to work on assigned questions in small groups.

Participants were asked: “What have been your drivers for developing & implementing healthy workplace programmes?”

Participants answered:
- Rising awareness of all stakeholders (including increased public expectations) – increased knowledge
- Increasing incidence of specific diseases, problems, lifestyle issues
- Company policies – meeting and going beyond legal requirements
- Benchmarking, recognition schemes/awards, accreditation
- Reputation, image
- Morally and ethically the thing to do
- Business case - linked with profits and productivity, sustainability
- Pressure (community, customers/clients, competitors)
- Changing working environment (globalization, ageing, technological changes, business functions – manufacturing to service sector, laws etc.)
- Meeting existing standards and legislation
- Partnerships/networks
- Aligning with international initiatives – ILO, WHO etc.
- Addressing employee requests
- Aligning with management and organisational systems
- Reducing sickness absence
- Improving Social aspects, work-life balance
- Reducing risks
- Reducing expenditures – high healthcare cost
- Lack of access to public health care
- Reducing injury and illness (road safety, HIV/AIDS)
- Addressing liability concerns from management
- Being employer of choice (benefit)
- Reducing premiums (insurance)
- Aligning with public policies
- Achieving increased product quality.

Participants were asked, “Who are the key stakeholders in this process?”

Participants answered:
- Internal:
  - Employees and their representatives
  - Employer-managers-supervisors
  - OSH experts/professionals
  - Sub-contractors and their workforce
  - Shareholders
  - Owners
  - Developers
  - Human resource department and officers
- External:
  - NGOs, media, government, society at large, service providers, other businesses, customers, transporters, suppliers
  - Supply chain – contractors, distributors
  - Trade unions
  - International organizations
  - Training and education providers (medical schools, business schools, engineering schools)
  - Insurance providers, social security agencies
  - Lawyers
  - Business consultants
  - Accreditation bodies
  - Professional associations
  - Academia
  - Banks and money lenders
Participants were asked, “What are the key indicators of success?”

Participants answered:

- Increased share market performance – profits
- Reduced employee turnover
- Reduced work-related injuries, occupational diseases, food poisoning, deaths, insurance premiums
- Reduced presenteeism, absenteeism
- Reduced medical costs
- Improved working conditions
- Increased worker engagement
- Increased safety performance (reduction in unsafe conditions and unsafe behaviours)
- Healthy workplace: wellness parameters (employees and business), climate in the company
- Business reputation, benchmarking
- Increased productivity and innovation
- Participation rates in programmes offered
- Reduced near misses (near hits)
- Reduced disability
- Increased awareness in OHS, health practices
- Behaviour change/lifestyle practices
- Employees satisfaction/job satisfaction/morale
- Health risks/status
- Reduced OHS risks
- Increased cost avoidance through employee training
- Productivity: increased profits, increased quality of products, competitiveness
- Healthier workforce: decreased rates of illness/chronic health risks, condition relative to community.
- Improved survey results on Company reputation: “Best place to work”
- Recognition by government, clients, NGOs, accreditation agencies.
- Improved customer satisfaction.

Participants were asked, “How do you evaluate these key indicators of success?”

Participants answered:

- Surveys (awareness, behaviour change/lifestyle practices, employee satisfaction)
- Employee health screening (health risks/status)
- Audits (safety behaviour, level of compliance, OHS risks)
- Available data (Injury, mortality, avoided life threatening events, near misses, illness rates, event/program participation rates, disability, retention/turnover, presenteeism)
- Employee interviews, exit interviews (retention/turnover)
- Cost-benefit analysis – Return on Investment
- Accreditation: internal and external audits, third party certification
- Feedback from society and customers (stakeholders)
- Replicability
- Client claims: decreased failure rates/rejection.
- Media reports, national community
- Statutory fines, penalties.

Advice for the Guidance Document

The WHO’s current plans for the development of the next document were then outlined for participants. The intention is to target workers and employers with guidance that is very practical. Participants discussed the forthcoming document and provided the following advice:

- Include emphasis on meeting legislation first.
- Living document
- Include indicators for what companies can do at each of the 8 steps for each of the 4 avenues. Then a check list for the whole thing.
Separate worker and management views.
Clarify that psychosocial hazards don’t just affect mental health, but also affect physical health and safety.
Global guidance is needed to stimulate all 4 avenues in SMEs.
We need hands-on tools and checklists.
Include grading system to enable companies monitor their performance in the 4 avenues of influence; enabling WHO to collate national scores for assessing effectiveness of national and WHO initiatives.
Need to reinforce the process along with the tools. The new document should provide practical approaches & good practices that will serve as basis for adaptation to different contexts.
Include case studies from small companies.
How to address psychosocial factors in small companies? Information is needed, as this is a priority emerging issue in developing countries.
The informal sector is important – we need unique toolboxes for different workplaces eventually.
Translate theory into general principles that apply everywhere.
Provide a hands-on approach for district health managers (e.g. public health nurses in Sri Lanka) on how to approach a small enterprise.
Include substance abuse as well as HIV/AIDS issues in the workplace.

Key Conclusions

1. There is a high degree of support and a strong expressed need for WHO to develop more practical, hands-on guidance for enterprises to help them apply the information provided in the more theoretical Background documents (WHO Healthy Workplace Framework and Model: Background and Supporting Literature and Practices) and Model for Action (Healthy Workplaces: a Model for Action). Nevertheless, these previous documents, which are both freely available on the WHO website contain many practical examples that can assist both SMEs and larger enterprises to apply the information, and which can already be applied in the current absence of further guidance.

2. There is strong support for a WHO International Consultation on healthy workplaces in the Informal and illegal sectors, also called micro-enterprises. The vast majority of workers world-wide, and in particular in developing countries, operate in these sectors, which are so different from larger formal enterprises that they must be addressed separately.

3. In addition to generic practical guidance, there is a need for gender-specific, sector-specific, and culture-specific documentation. WHO will develop the generic materials, which will be adapted by healthy workplaces network members and other stakeholders.

4. While SMEs and MSEs are badly in need of guidance documents, large multinational corporations can often be the conduit to reaching these enterprises. Multinationals, for example can:
   - act as mentors for small enterprises in their communities;
   - provide support for the development, implementation and evaluation of healthy workplace programmes, and
   - require their supply chains and contractors (who are often SMEs or MSEs) to attain a minimum level of healthy workplace standards and practices before doing business with them.

5. While the WHO healthy workplace model is aimed at the enterprise level (workplace parties such as management and workers), the model was felt to be appropriate by policy makers in developing countries to develop and implement policies as part of the national OHS policies. There is a need for a subsequent document to guide policy
developers to include health system needs and mechanisms of support to implement healthy workplace policies and practices.

6. There is support to pilot, adapt, implement & evaluate the global guidance in different regions, at different levels (national, sectoral, organizational, workplaces), and levels of intervention with local expert support.

7. There is support to collect & develop suitable training packages to support the implementation of comprehensive healthy workplace programmes.

8. The WHO Healthy Workplace network is a critical part of spreading knowledge and expertise globally.

9. There are four common misunderstandings of the WHO Healthy Workplace model and framework that must be addressed and emphasized in future documents:

   - There is a natural tendency to assume that the Physical Work Environment is the “most important” Avenue for enterprises in developing countries to address, and to ignore the other Avenues until that one is dealt with. In reality (a) the other avenues, especially the Psychosocial Work Environment, often contribute in major ways to injuries that on the surface seem to be due only to physical hazards; and (b) while physical hazards may be a top priority, when looking for root causes of injuries or illness, and preventive solutions, all Avenues must be considered. For example, if construction workers are being injured or killed from falling off roofs, this is a physical injury resulting from (on the surface) a physical workplace hazard. However, contributing root causes may include unreasonable workloads and bullying supervisors or colleagues, which result in workers not taking the time to use fall arrest systems. The solution to the problem therefore not only includes providing the appropriate protective equipment, but making workloads reasonable and training supervisors (i.e., psychosocial interventions)

   - The Psychosocial Work Environment remains the least understood, despite many resources developed by WHO in this area. There is a tendency to think that psychosocial hazards only affect feeling, emotions, and mental health, while in reality they also contribute to physical health or non-communicable diseases, such as heart disease, depression, back pain, diabetes, and others. Interest was high and support and more information was requested by some participants to develop this component.

   - The Personal Health Resources Avenue is frequently misunderstood to mean emphasizing only individual health practices, and encouraging workers to change their lifestyles, based on data from medical examinations or health risk assessments. In reality (a) employers must also attempt to create a supportive environment, in order to remove barriers to healthy lifestyle changes; and (b) worker input and opinions are as important to decide priorities as are demographic or medical data. For example, tobacco avoidance programmes are not likely to have a high success rate if workers do not wish to stop using tobacco, and/or if tobacco use is allowed on the job. Programmes will have a higher cost-benefit ratio if workers have input into the programme priorities, and resources and a supportive environment are provided to assist in helping workers make changes that they wish to make.

   - The process of developing a healthy workplace is as important as the content, and sometimes more important. For example, it is quite common to involve workers in the assessment process only, and then to simply “inform” them of later work. It is critical to involve workers or their representatives in meaningful ways at every step of the process, in order to ensure buy-in of workers and relevance of programmes and policies developed. Similarly, leadership must be
engaged at each step of the process, not merely asked for permission in the beginning.

Next Steps

WHO will move forward with the Guidance document(s) and the further improvement of tools. Recommendations and advice provided by participants in this meeting will be taken into consideration. The intention is to hold another International Consultation meeting in a year’s time to consider the progress to date and the way forward at that time. Any readers of this report who would like to be involved and/or to remain aware of activities in this area are invited to join the WHO Healthy Workplace Network. This can be done by going to the WHO extranet at: https://extranet.who.int/datacol/survey.asp?survey_id=1355 and log in with the Username healthy workplaces (with a space between the two words) and the password healthy.

Annexes (Appendices)

Annex 1: Special Workshop on Enterprise Community Involvement
Annex 2: Agenda
Annex 3: List of Participants
Annex 1: Special Workshop on Enterprise Community Involvement

Wednesday, 16 March 2011
09:00am – 12:30 pm

Facilitator: Aditya Jain, Nottingham University Business School

Dr. Salma Burton, Regional Advisor, Occupational Health, for the South-East Asia Regional Office (SEARO) extended a warm welcome to all participants.

Evelyn Kortum, Technical Officer, Interventions for Healthy Environments, Department of Public Health and Environment, World Health Organization (WHO) Headquarters presented an overview of WHO’s healthy workplace activities. She reviewed the WHO Healthy Workplace model, explaining each of the four Avenues of Influence, as well as the 8-step continual improvement process that is used to implement the model. She stressed the healthy workplace work has been based on a tripartite approach, although trade unions were unable to be represented at this meeting. She noted that this work is an ongoing consultation. In introducing the Special Workshop, she emphasized that in the fourth avenue (currently called Enterprise Community Involvement) the main focus is not in external community but rather the internal aspects of what is sometimes called Corporate Social Responsibility.

Aditya Jain, Lecturer in Human Resource Management, Nottingham University Business School, UK, chaired the Special Workshop. He opened by doing a presentation on the Avenue of Influence currently called Enterprise Community Involvement (ECI), noting that the name may be changed shortly to avoid confusion with other work that WHO is doing in community health. He described various definitions of Corporate Social Responsibility (CSR) and explained that CSR includes both an external and internal components; ECI is focused on the internal dimension of CSR which focuses on stakeholders within the enterprise, i.e. employees. It focuses on voluntary internal initiatives that enterprises can engage in to improve the health and well-being of their employees, above and beyond the law. Examples could be providing a safe and healthy working environment for employees at work; insisting on fair trade practices among suppliers to ensure health and safety of workers in other enterprises; sharing best practices with SMEs; going beyond local legislated requirements for occupational health & safety (OSH), and encouraging suppliers to do the same.

Dr. Ingrid Christensen, Senior Specialist on Occupational Safety and Health, International Labour Organization (ILO) stated that Decent Work is a core objective for ILO. Enterprises can create Decent Work regardless of their location by going beyond local legislation and implementing healthy and safe work practices that conform to or exceed ILO conventions and recommendations. CSR is a common focus for large enterprises, but small and medium sized enterprises (SMEs) can also show CSR, but in different ways.

Two employers provided case studies, illustrating how their enterprises demonstrate the ECI dimension:

Dr. Gan Siok Lin, Ministry of Manpower, Singapore: Dr. Gan outlined the work of the Ministry of Manpower, which encourages enterprises to comply with local workplace safety and health legislation. She described how the BizSAFE programme, a capability Programme, was developed by the Singapore Workplace Safety and Health Council. BizSAFE focuses on a step-by-step approach to building risk management capability. She also explained how the Ministry through this programme has created a “community of safe employers” who can be designated as partners or mentors by invitation only. These employers then support, coach and mentor SMEs in their communities and assist them to develop healthy and safe workplaces for their employees. Workplaces are recognised for their workplace safety and health efforts by the Workplace Safety and Health Council.

Dr. Clifford Panter, Mercedes Benz, South Africa: Dr. Panter outlined the many health, safety and well-being activities of Mercedes Benz in South Africa. These activities focus not only on occupational health & safety legal and corporate compliance but also on promoting
healthy work environments, safe & healthy workplaces, processes & products while contributing meaningfully to the sustainability of the corporation. They engage in many CSR projects (referred to internally as their Corporate Social Investment projects) and regard these as part of their “sustainability programme.” Examples include their comprehensive HIV/AIDS Workplace Programme, which not only focuses on their workers but also extends beyond the workplace to assist families and orphans; and their End-user Computing Learnership for People living with Disability Programme, which trains disabled school leavers in computer skills, thus making them employable.

Discussion

All participants engaged in an extended question and answer session. The presentations set the basis for further discussions which took place in focus groups.

Focus Groups

Participants were divided into four working groups to discuss the following questions:

1. How can Enterprise Community Involvement (ECI) drive the promotion of workers’ health?
2. To what extent can ECI drive the promotion of workers’ health in the absence of legislation?
3. How can ECI and OHS issues be mainstreamed into business strategy?
4. What support do enterprises need to promote health through responsible business practices?

Report from focus groups and the way forward:

Rapporteurs of the four focus groups reported back on their discussions to the plenary:

Group 1: How can ECI drive the promotion of workers health?

1. Employee health and wellbeing is part of corporate reporting and policies
2. Link between ECI and employee wellbeing is becoming stronger
3. Examples of promotion of workers health
   a. Health checks/screenings
   b. Workshops, classes, outline information/ education
   c. Employee assistance programmes (EAPs)
   d. Access to healthy foods
   e. Use of fair trade products within company
   f. Health insurance subsidies
4. Examples of promotion of workers health (other than own)
   a. Outreach to SMEs (mentoring)
   b. Via platforms (employer associations)
   c. Company’s own initiative
   d. Requirement for subcontracts (down supplier chain)
5. Included in business leader forums (where CEOs are members)
6. ECI can lead to promotion of workers health if also driven by ministries of labour and health
7. Pledge to workers health in all four healthy workplaces areas.

Group 2: To what extent can ECI drive the promotion of workers’ health in the absence of legislation

1. Context is important, and the extent to which ECI can drive the promotion of workers’ health depends on the country, culture – how much law is followed implement, economics, worker attitudes, education, population, size, number of employees.
2. ECI will lead to more worker empowerment (unionization, organisation), which in turn can lead to more sustainability, involvement than only law, community driven.
3. ECI can only drive the promotion of workers’ health within a legal framework. In absence of legal framework, community and worker driven initiatives might not be seen as legitimate.
4. Sectoral incentives (non-financial) as part of ECI can drive the promotion of workers’ health.
5. Management commitment plays a role.
6. Elaboration of the business case as well as sharing of examples of good practice.
7. Involvements and participation of all stakeholders, including tripartite agreements.
8. Corporate culture based on ethics, values can drive the promotion of workers’ health

**Group 3: How can ECI and OHS be mainstreamed into business strategy**

ECI could be divided into an internal dimension and an external dimension. ECI and OHS could be mainstreamed into business strategy as presented in the figure below.

The Internal dimension refers to:
- Setting up and enabling structures, systems and process to promote workers' health
- Aligning internal policies, vision, strategies and business objectives
- ECI policy – establishing the policy as well as assigning a person to drive ECI
- Managing supply chain

The external dimension refers to initiatives to help:
- Community
- Users of products/services manufactured/provided
- Neighbouring community and environment

The drivers for businesses to participate in CSR initiatives are:
- Increased business competitiveness
- Recognition as leader by peers and community
- Improved company image - responsible and caring organisation, doing “good thing” for community
- Reduced contribution of community factors which may adversely affect company workers’ health
The following figure represents how this is possible:

1. Recognition of good practice by giving incentives (tax breaks etc) and rewarding good companies.
2. Simple tool for calculating return on investment (like the EU-OSHA tool for risk assessment).
3. Very strong monitoring and evaluation (M&E) system – database – on the basis of which action can be targeted (Key Performance Indicators for health management – appraisal tools).
4. Inter-sectoral coordination – integration (MOH-MOL, ILO-WHO, departments of the companies).
5. Link to sustainability is important and sharing good practice will promote further good practice.
7. Development of performance parameters for regulators not just companies to promote accountability and transparency.
8. Voluntary standards where legislation does not exist
   a. Recommendation made by social partners
   b. Capacity building programmes
   c. Common validated tools for risk management
9. Acceptance ‘buy in’ from workers – active partnership
   a. Transparency in scheme
   b. Long term benefits supported by good evidence/data (evaluation is important)
   c. Empowering workers
10. Sharing good practice – interactive website – networking (so companies can replicate good practice) – with different sizes/sectors
11. Work with NGOs should be validated – CSR should be mainstreamed
12. Baseline studies – a comparison point to see effectiveness of interventions – evaluation is key. Identify priorities and key challenges
13. Regulatory as well as social partners should highlight duty of care – cannot shift responsibility when outsourcing – ethical responsibility.
14. Sensitisation and awareness raising within companies should be made mandatory.
15. Big organisations, other development organisations to mentor companies in the unorganised sector, SMEs etc.
16. Responsible business practices and social action should also be promoted in the public sector
17. Auditable standard for responsible business practices and social action/labelling scheme might engage more companies.
18. Applying research into practice
19. Awareness raising campaigns – companies highlight risk associated with products (e.g. pesticides)
20. Mainstreaming OHS into education (business, medicine, engineering) – capacity building

Conclusions

Participants unanimously agreed that responsible business practices (presently termed ECI) can drive the promotion of workers health by encouraging employers to not only comply with legislation but by going above and beyond law. The participants highlighted the importance of context, the role played by ethics, values, stakeholder agreements, corporate culture, societal culture in relation to the extent to which ECI can drive the promotion of workers health. All participants also agreed that ECI could only drive the promotion of workers' health within a legal framework. In the absence of a legal framework, voluntary initiatives might not be seen as legitimate, and even if they are may not be recognised and replicated. Participants also discussed that for ECI and OHS to be mainstreamed into business strategy, stakeholders must focus on not just external drivers but also on internal drivers. Lastly, companies must be supported to promote health through responsible business practices by recognition of achievements in the media/reward schemes, by recognising and highlighting not only the business case but also the ethical case, by increasing cooperation and participation amongst all stakeholders, and by increasing awareness and accountability.
Annex 2: Agenda for 16-18 March 2011

PROVISIONAL PROGRAMME

Day 1: Wednesday, 16 March 2011

08:00-09:00 Registration

Special workshop on Enterprise-Community Involvement

09:00-12:30 Facilitator: Aditya Kailash Jain, Centre for Organizational Health and Development (COHD), Nottingham, UK

12:30-13:30 Lunch

Opening Session

- Welcome Address by Director, SDE/RA-OCH
- Opening Remarks by Regional Director
- Introduction of participants
- Vote of thanks – Ms Evelyn Kortum, HQ
- Group Photograph

14:15-14:45 Overview of the healthy workplaces initiative by WHO/HQ

14:45-15:30 Activities in the WHO Regions

15:30-15:45 Tea Break

15:45-16:15 Discussion on the activities of Healthy Workplaces

16:00-17:45 Companies present case studies on the four avenues of influence

17:45-18:00 Summary and closing of the day

Day 2: Thursday, 17 March 2011

08:30-10:15 Companies present case studies on the four avenues of influence

10:15-10:30 Tea Break

10:30-12:30 Continue case studies

12:30 – 13:30 Lunch Break

13:30-15:15 Work Group (various topics)¹

15:15–15:45 Tea Break

15:45-16:30 Continue group work

16:30-17:00 Group feedback, summary and closing of the day

18:00 Reception hosted by Indian Association of Occupational Health

¹ Guidance for the working groups will be developed to discuss the following topics: transferability of case studies to other sectors, companies, and countries; the draft document prepared to understand if it is complete or what should be missing to guide companies.
**Day 3: Friday, 18 March 2011**

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<th>Time</th>
<th>Session</th>
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<td>08:30–08:45</td>
<td>Plenary – Summary of day 2</td>
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<td>08:45–10:15</td>
<td>Case studies</td>
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<td>10:15–10:30</td>
<td><strong>Tea Break</strong></td>
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<td>10:30–11:45</td>
<td>Group work</td>
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<td>11:45–12:15</td>
<td>Reporting back on group work</td>
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<tr>
<td>12:15–13:15</td>
<td><strong>Lunch Break</strong></td>
</tr>
<tr>
<td>13:15–14:15</td>
<td>Discussion and comments on the draft document on good practices for healthy workplace programmes</td>
</tr>
<tr>
<td>14:15–15:15</td>
<td>Discussion on way forward</td>
</tr>
<tr>
<td>15:15–15:30</td>
<td><strong>Tea Break</strong></td>
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<tr>
<td>15:30–16:00</td>
<td>Summary and next steps</td>
</tr>
<tr>
<td>16:00–16:30</td>
<td>Closing of the Consultation</td>
</tr>
</tbody>
</table>
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