GOHNET NEWSLETTER NO. 21
June 2013 Edition

IMPROVING WORKERS' HEALTH WORLDWIDE:
Implementing the WHO Global Plan of Action on Workers' Health

Dear Reader,

The WHO delivered its first report on the implementation of the *WHO Global Plan of Action on Workers' Health* (GPA), 2008-2017, to its Executive Board in January and to the World Health Assembly in May this year. In addition, the Global Occupational Health Programme organized a side event on universal health coverage and two resolutions on non-communicable diseases were passed. One was the *global action plan on the prevention and control of non-communicable diseases*, and the other the *comprehensive mental health action plan*. This edition reports on these resolutions and outlines the links to workers' health that could be established.

In addition, and like in the last edition of the Newsletter, you will find selected global and local news items in the area of workers' health related to the GPA, more updates from WHO and from the Global Network of Collaborating Centres for Occupational Health and other partners, about on-going projects and upcoming events that support the implementation of the objectives of the WHO GPA.

Emails are provided for the purpose of networking and collaborating.

We hope you enjoy this issue. If you would like to send feedback, you can use the email indicated below.

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Universal health coverage for workers: Why we care?

(Introductory remarks to the workers' health side event at the 66th World Health Assembly, 22 May 2013, Palais des Nations, Geneva)

Dr Pakishe Aaron Motsoaledi, Minister of Health, Republic of South Africa

In 2007 at the 60th World Health Assembly we endorsed the resolution on the Global Plan of Action on Workers' Health. We are all committed to work toward full coverage of all workers with essential interventions and basic health services for the prevention of occupational injuries and work-related diseases.

There are effective interventions and occupational health services, both basic and specialized that do this. However, access of workers to health protection and preventive services is limited mostly to workers in large enterprises in the formal sector with decent jobs and social protection benefits. The working poor and informal sector workers do not have insurance cover or services for occupational injuries and diseases.

Currently about one billion workers – nearly one in three – live below the poverty line of US$2. Such people often work in hazardous conditions. They suffer work-related diseases, injuries, and disabilities. They lose their capacity to work and to earn their living. In poor communities, when the breadwinner falls sick and cannot work anymore, the whole family suffers and there is no social protection to help. This is the vicious circle of persistent poverty. For example in our country, silicosis, TB and work injuries take a much larger toll in poor communities.

With the current job crisis and the reduction of the employment opportunities in the formal sector and the changing patterns of employment, we see more persons entering the informal sector which has been the norm in many developing countries.

Can we move towards universal health coverage without addressing the specific health needs of workers? Their health is an essential prerequisite for sustainable economic development - it is a national capital. But do health systems support this capital?

As with many other countries, we are now reforming our health system in South Africa and we are re-engineering our primary health care. We want to end the exclusion of poor workers and we want to make our health services to contribute more efficiently to sustainable economic development.

Furthermore, can we address the enormous burden of noncommunicable diseases and mental ill health on sickness absence and social security without linking occupational health services to primary and community care?

The traditional occupational health and safety systems and services are not fit for the new realities! I believe we need new models of organizing primary health care services so that all workers can benefit.

We need new ways of financing such services. We need to remove the barriers faced by informal workers and vulnerable workers in the formal sector in accessing social security and the health system.

This is the reason that we wanted to open this discussion at the Assembly this year. We will hear several different perspectives and experiences here. However, we hope that this discussion will continue outside these walls and that it will provide inspiration for others!

Universal health coverage for workers, side event at the 66th World Health Assembly, 22 May 2013, Geneva

Under the Global Plan of Action on Workers' Health 2008-2017, WHO has been working with countries to increase the coverage of all workers with essential interventions and basic health services for prevention and control of occupational and work-related diseases and injuries. Particularly concerned are workers in agriculture, the informal economy, small enterprises, and migrant workers. Several developing countries, such as Thailand, Indonesia, Sri Lanka, South Africa, Colombia, Brazil, the Philippines, and Tanzania started working toward this objective by integrating interventions for protecting workers' health into their primary care services particularly for working populations not covered by company occupational health services, social health protection and insurance for occupational diseases and injuries. Industrialized countries, such as Italy, The Netherlands, the UK and the USA are concerned with the impact of the growing burden of chronic diseases and mental ill health on the sickness absenteeism, social security and productivity.

This side event was convened by the World Health Assembly (WHA) delegation of South Africa in collaboration with WHO to highlight the experience in addressing the health of workers at the primary care level and to discuss the challenges for working towards universal health coverage of workers. The event was co-chaired by Dr Barry Kistnasamy, Commissioner for Occupational Health at the Ministry of Health of South Africa and Dr Maria Neira, WHO, Director for Public Health and Environment.

Dr Pakishe Aaron Motsoaledi, Minister of Health of South Africa addressed the participants and explained why his country convened the event. (See above the text of the ministerial speech)

Professor Dame Carol Black from the Department of Health of England highlighted the impact of chronic diseases on workers' productivity in her country. Good work is considered also good for health and for those with chronic conditions. Work can be also promote recovery and rehabilitation. Particular challenges are chronic mental disorders and these require co-ordination between primary care services, occupational health advice and employers. Chronic conditions, such as common mental health problems, musculoskeletal disorders,

M. Zungu, W.Sawasdivorn, I.Heath, Minister P.A. Motsoaledi, B.Kistnasamy, M.Neira, Dame C.Black

cardio-vascular and respiratory diseases, diabetes and cancer, all require vocational rehabilitation, flexibility and adaptation to the workplace. The keys to success are good primary and secondary clinical care by work-conscious healthcare professionals, well informed patients and support from charities. In 2009, the UK started supporting family doctors to understand workers health problems through education, training and information (online, telephone and face-to-face). In 2010, the UK introduced a "fit note" instead of a "sick note" considering partial capacity and not full incapacity. A 2012 survey of general practitioners (GPs) found that 90% of respondents considered helping patients to stay in or return to work as an important part of their role. 68% said that GPs had a responsibility to society to facilitate a return to work, and 76% agreed that staying in or returning to work was an important indicator of success in the clinical management of people of working age. However, only 19% indicated that there were good services locally available to which they could refer their patients for advice on return to work and fewer GPs (10%) reported they had received training in health and work within the past 12 months (Department for Work and Pensions, Research Report No 835). In 2014, a special state-funded service will provide specialist work-related assessments and advice to GPs and employers regarding workers' health. It will include: (1) assessment by occupational health professionals for employees who are off sick for four weeks or more, (2) initial telephone triage with case management for employees with complex needs who require on-going support to enable return to work, and (3) an online job search service for employees who are able to work, but unlikely to return to their current employers. Both GPs and employers will be able to refer to this service based in the community.

Dr. Winai Sawasdivorn, Secretary General of the Thai National Health Security Office spoke about the experience of his country in providing health services to all workers. Thailand introduced a medical welfare scheme for low income people in 1975 when gross national income (GNI) per capita was only 390 USD. A community-based health insurance scheme was introduced in 1983 when GNI was 760 USD, and achieved universal coverage in 2002 with GNI per capita of less than 2000 USD. The Thai example shows that universal health coverage is not only for rich countries and that reaching it is a real political and financial commitment. By 2012 almost all the population (995) was covered by three schemes – Universal Coverage (75%), Social health Insurance (15%) and Civil Servants' Medical Benefit Scheme (10%). Services by all three schemes are free at the point of delivery. The benefit package is comprehensive and ranges from the low cost such as outpatient services to high cost care such as chemotherapy, haemodialysis and open heart surgery. All services cover medicines. This results in a very minimum level of catastrophic health expenditure and prevents impoverishment from paying medical bills. Half of the total population are workers (36 million) and nearly two-third (24 million) work in the informal economy, such as farming and fisheries (59%), services (19%), and crafts (7%). About 12% encounter occupational problems including chemical effects (67%) or hazards from equipment (20%). The interventions for occupational health and rehabilitation by the primary care units are covered by the universal health coverage scheme. These interventions include: (1) outpatient services such as simple and common occupational disease recognition and case management, maintaining records about work in patient cards, and disease reporting, and (2) outreach services in communities, including farm or workplace survey, participatory data analysis, health screening (e.g. cholinesterase tests for exposure to pesticides) and communication of results with workers for joint problem solving. The challenges are to expand the services for occupational health nationwide, to strengthen the role of sub-district local governments, to add the interventions for primary prevention in the benefit package, and to develop a system for monitoring and evaluation.

Dr Muzimkhulu Zungu, Medical Director of the National Institute of Occupational Health of South Africa spoke about the challenges and initiatives for addressing workers' health in the policies for primary health care in his country. The population of South Africa is 53 million and 65% are of working age (15-64 years). The economically active population is 17.7 million of which 13.3 million work in the formal

sector and 4.4 million in the informal economy. In 2009, the top ten diseases related to work were: noise-induced hearing loss, mental health problems, tuberculosis, trauma, shock, allergies, skin diseases, asthma, asbestosis, and musculoskeletal disorders. In the mining sector the mortality from silicosis and active tuberculosis are increasing. The governance of occupational health is shared between the Departments of Health, Mineral Resources, and Labour. The occupational health legislation was recently amended and a programme was developed to expand coverage to informal workers in the context of the national initiative for primary health care reengineering – moving to community-based care, health promotion and disease prevention by primary care teams, district outreach, district specialists and school health. Healthcare for workers is transitioning from the traditional occupational health, limited to workplaces mainly in the private sector, focused only on problems directly related to work of permanent employees under employers' responsibility to a public health-based care where action goes beyond the workplace to address all health determinants, among all workers (formal and informal) with the involvement of all stakeholders. The model for workers' health services includes: (1) community level – primary care nurse, environmental health officer and community health workers; (2) district hospital – specialists in family medicine, occupational nurses and hygienist; (3) general specialized hospital – specialist in occupational medicine; and (4) central hospital – academic and reference units in all disciplines of occupational health. The next phase of the programme foresees to establish integrated social protection system for workers, to develop infrastructure and human resources for workers' health and to ensure appropriate funding. The challenges include availability of human resources, a curative focus of primary care, fragmented service delivery and insufficient quality assurance.

Dr Iona Heath from the World Federation of Family Doctors (Wonca) argued about the importance of people-centred care for workers. She reminded that originally the primary health care movement enshrined in the Alma Ata Declaration from 1978 was based on social justice. The best health systems are based on primary care. Most health care – including for occupational health – can, should and does happen in primary care. Primary care is especially concerned with knowing the person and context. People do best when primary care and occupational health care professionals work well together. Primary care professionals should know as much as possible about the workplace and what can be done for work-related diseases and health risks. The global conference "Connecting health and Labour" held in the Hague in 2011 provided a road map for integrating occupational health in primary health care. The major barriers for action include communication between occupational health and primary care experts, the additional time for primary care providers to act on work-related problems and the complexity of occupational health.

Dr Maria Neira, WHO, Director for Public Health and Environment reminded according to the definition adopted by the UN General Assembly in 2012 that "universal health coverage" implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population…" (UN General Assembly, Resolution on Global Health and Foreign Policy, 201s2).

 A WHO global survey among 120 countries carried out in 2008/2009 found that still two thirds of countries have very low coverage of workers with occupational health services and one fourth of countries do not even know their actual coverage level. There are three ways of expanding coverage. The first way is by increasing the proportion of costs that are covered to ensure that workers do not have to pay for prevention, diagnosis, treatment and rehabilitation of occupational diseases and injuries. This requires expanding of insurance schemes for occupational diseases and injuries. The

second way is by increasing the number of interventions, for example, by adding primary prevention of occupational risks and promotion of work capacity to the diagnosis and treatment of occupational diseases and injuries. And the third way is by expanding the groups of workers who have access to basic interventions for workers' health. There are good examples about covering workers in the informal sector, small enterprises, farmers and migrant workers. The interventions for protecting health at the workplace encompass most stages of the life cycle.

Unfortunately there are still working children, often in hazardous conditions, women in vulnerable work situations, adults in the informal sector and dangerous activities, the elderly, helping the family or trying to meet the ends. The global conference "Connecting health and Labour" was held in the Hague with kind support of the Dutch Ministry of Health. For the first time occupational health and primary health care experts discussed the ways of addressing the specific health needs of workers and identified the essential interventions at the primary care level. These interventions include: (1) primary prevention of occupational risks incluidng providing advice for improving working conditions, for example, through workplace visit, information materials and training of workers, (2) secondary prevention through early detection of occupational diseases and injuries, their referral, reporting, and eventually treatment and rehabilitation, and (3) tertiary prevention to promote working capacity and return to work and to reduce sickness absence. These interventions are not expensive. WHO studies in five countries show that the cost of the interventions per workers served vary between 14 and 83 PPP Dollars. Currently, WHO is developing a methodology for assessing the costs to health systems from the delivery of essential occupational health interventions at the primary care level. We are finalizing a special module on workers' health under the international OneHealth costing tool. This will allow countries to integrate these interventions in their national health accounts and mobilize additional resources, for example, through social security or pooling together private funds. We need to work together to build the capacities of health systems to deliver these interventions to the largest possible number of workers, particularly in the informal sector, small scale work settings and migrant workers. Health systems should support people to maintain their work and income earning potential, not to get sick because of their work or stay home on sick leave.

In the ensuing discussions participants spoke about the challenges to provide health coverage for informal sector workers, about the need to address workers' health in the global forums on public health and development, and about the potential to involve civil society in the efforts to move towards universal health coverage for workers.

The 66th World Health Assembly satisfied with progress made on the Global Plan of Action on Workers' Health

The 60th World Health Assembly in 2007 endorsed the Global Plan of Action on Workers' Health (2008-2017) and requested the WHO Director-General to report back to the Assembly in 2013 and 2018 on the progress made in the implementation. The progress report presented to the 66th Health Assembly in May 2013 covered the activities by the WHO Secretariat along the five objectives of the GPA. The highlights of WHO work on workers' health in the period 2008-2013 include:

1 Committee B of the 66th WHA reviewing the progress made on workers' health – 27 May 2013

- strengthening national policies through global campaigns for elimination of asbestos related diseases and for immunizing healthcare workers against hepatitis B;
- protecting and promoting workers' health - tools for management and control of occupational risks – chemicals, radiation, and psychosocial factors, healthy workplace programmes and guidelines for HIV and TB control at the workplace;
- increasing access to occupational health services - essential interventions for workers' health and models for their delivery and costing at the primary care level;
- creating evidence base for action - incorporating occupational diseases in the 11th revision of ICD, developing diagnostics and exposure criteria for occupational diseases;
- integrating workers' health in all policies – indicators measuring workers' health in sustainable development, green economy and extractive industries.

These activities have been supported by the global network of WHO collaborating centres for occupational health and most of them were carried out in collaboration with ILO.
During the discussion at the World Health Assembly countries expressed satisfaction with the progress made and asked WHO to continue its actions on protecting and promoting workers' health worldwide. Speaking on behalf of all countries in the WHO African Region, the delegation of Liberia argued for recognizing the need for workers' health in the framework of health service delivery. Legislation and policies in many African countries did not protect workers sufficiently and, therefore, assistance was needed to strengthen the capacities of ministries of health and to develop national action plans on workers' health. Indonesia stressed that industrialization, global free markets and competition were not always favourable for the health of workers. Occupational health was included in the national health law and such policies should be based on evidence and centred on people. Quality occupational health services should be able to anticipate technological development. There was also a need to develop standards for occupational health protection. Therefore, Indonesia urged WHO to give more attention to workers' health in primary health care. The delegations of Italy and Australia encouraged WHO to continue its global campaign for the elimination of asbestos-related diseases in the direction of raising awareness that all forms of asbestos cause cancer, recognizing the most efficient way to eliminate these diseases is to stop using asbestos, linking the relevant international conventions to implementation, and avoiding influence of vested interests. The Russian Federation and Kazakhstan shared their specific experience with controlling health risks in the use of chrysotile asbestos.

The future work of WHO on workers' health will be directed to:

- scaling up access to essential interventions for prevention and control of occupational and work-related diseases and injuries
- strengthening national and local governance for workers' health
- setting global standards for workplace health protection
- stimulating work settings in different contexts to protect and promote health, and
- measuring and monitoring workers' health globally.

The next progress report on the implementation of the WHO Global Plan of Action on Workers' Health will be presented to the World Health Assembly (through the Executive Board) in 2018.

The 66th World Health Assembly endorses the Global action plan for the prevention and control of noncommunicable diseases (2013–2020)

An estimated 36 million deaths, or 63% of the 57 million deaths that occurred globally in 2008, were due to noncommunicable diseases (NCDs), comprising mainly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes. The biggest concern is that large number of these deaths (14.2 million) occur in the in the working age 30-69 years. The four major NCD groups share some behavioural risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol), as well as environmental and occupational risks (air pollution, carcinogens, psycho-social stress and some physical hazards).

In his 2011 report to the UN General Assembly the Secretary-General Ban Ki-moon stressed the link between occupational risks factors and NCDs and argued for regulations to prevent exposures to such risks and multi-sectoral actions. Furthermore, with Resolution 66/2 the UN General Assembly called upon the private sector "to promote and create an enabling environment for healthy behaviours among workers, including by establishing tobacco-free workplaces and safe and healthy working environments through occupational safety and health measures, including, where appropriate, through good corporate practices, workplace wellness programmes and health insurance plans."

The Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013–2020)

was endorsed by the 66th World Health Assembly in May 2013 as a road map for implementing UN Resolution 66/2. It urges countries, the WHO Secretariat and international partners to stimulate international cooperation, to strengthen countries' response, to reduce modifiable risk factors, to re-orient health systems, to foster prevention research, and to monitor trends with the goal to reduce the preventable and avoidable burden of morbidity, mortality and disability due to NCDs. The major actions relevant to occupational health in this plan include developing programmes for healthy workplaces, connecting occupational health services to primary health care and addressing occupational NCDs.

The workplace is seen as one of the key settings for action on prevention and control of NCDs. There are many workplace interventions addressing the behavioural risk factors, such as 100% smoke-free workplaces, smoking cessation, modifying work environment and organization for combatting sedentary work, walking and cycling to work, healthy and balanced diet at the workplace, and workplace policies for alcohol. These interventions are likely to be more successful if combined with occupational health and safety programmes for prevention of air pollution, substitution of carcinogens, and improving work organization. The WHO Healthy Workplaces framework is an evidence based model for health action at the workplace addressing occupational risks, work organization, behavioural factors and corporate social responsibility.

The NCD action plan also recognizes that connecting occupational health services to primary health care is an innovative and effective model of care for meeting the needs for long-term care of people with NCDs. This includes close collaboration between occupational health experts and primary care providers for assessing working capacity, stimulating the return to work and modifying the work environment of people suffering from NCDs. Such collaboration is essential for early recognition of the

relation between non-communicable diseases and occupational risks. The WHO global conference "Connecting Health and Labour", held in 2011 in the Hague, provided strategic directions for collaboration between occupational health and primary health care.

Certain non-communicable diseases are globally recognized as occupational diseases. The ILO list of occupational diseases includes a number of diseases that are also among the priorities under the global NCD action plan - different forms of pneumoconiosis, asthma, chronic obstructive pulmonary disease (COPD) and occupational cancer. According to WHO, estimates annually amount to 634,000 deaths due to NCDs, are attributed to several occupational risks - 177,000 cancer deaths are related to occupational exposure to selected carcinogens and 457,000 deaths from pneumoconiosis, asthma and COPD are related to occupational exposures to airborne particles, fumes and allergens. The NCD action plan urges countries to facilitate access to preventive measures, treatment and vocational rehabilitation, as well as financial compensation for occupational NCDs, consistent with international and national laws and regulations on occupational diseases.

Countries will be expected to develop and implement national multisectoral policies and plans on NCDs. It is very important to link these policies to the national plans of action and programmes dealing with the health of workers. The 2008/2009 WHO country survey showed that 63% of existing national action plans on workers' health already include some measures regarding the prevention of NCDs, and that about 50% of national NCD programmes have workplace components.

Finally, the NCD action plan will probably result in new international partnerships and initiatives on NCDs. Such partnerships can also foster actions at the workplace as well as prevention and control of occupational NCDs. There is room for more interaction between the occupational health networks, such as ICOH, IOHA, IEA, PEROSH and the global network of WHO collaborating centres for occupational health with the networks for prevention and control of NCDs, such as the Global NCD alliance, the World Federation of Family Doctors (Wonca) and the Global Noncommunicable Disease Network (NCDnet).

Links:
Secretary General's report to the UN General Assembly
Resolution 66/2
The Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013–2020)
WHO Healthy Workplaces framework
"Connecting Health and Labour"
ILO list of occupational diseases
WHO NCD burden of disease data
2008/2009 WHO country survey

A comprehensive mental health action plan: 2013-2020

The vision of the action plan is a world in which mental health is valued and promoted, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

A resolution on the mental health action plan for the next 8 years was endorsed by the 194 WHO member states in May at the World Health Assembly, the supreme decision making body of the WHO. The plan sets four major objectives:

1. strengthen effective leadership and governance for mental health;
2. provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. implement strategies for promotion and prevention in mental health, and
4. strengthen information systems, evidence and research for mental health.

The plan sets important new directions for mental health including a central role for provision of community-based care and a greater emphasis on human rights and it also includes prevention and promotes action at the workplace. It was constructed to be multisectoral approach whereby services support individuals, at different stages of the life course and, as appropriate, facilitate their access to human rights such as employment including return-to-work programmes, housing and educational opportunities, and participation in community activities, programmes and meaningful activities. It also provides opportunities for synergies with other programmes of the UN system, UN interagency groups and intergovernmental organizations. Therefore, it has close conceptual and strategic links to other global action plans and strategies endorsed by the Health Assembly, including the global plan of action for workers' health, 2008–2017, but also the global strategy to reduce the harmful use of alcohol, the action plan for the global strategy for the prevention and control of noncommunicable diseases, 2008–2013, and the draft global action plan for the prevention and control of noncommunicable diseases (2013–2020).

The action plan also covers mental health, which it defines as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. It also covers mental disorders which are used to denote a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems (Tenth revision). These include disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism.

Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports among others.
This is well demonstrated by the current global financial crisis which provides a powerful example of a macroeconomic factor leading to cuts in funding despite a concomitant need for more mental health and social services because of higher rates of mental disorders and suicide as well as the emergence of new vulnerable groups including the young unemployed.

In addition, in many societies, mental disorders related to marginalization and impoverishment, domestic violence and abuse, and overwork and stress are of growing concern, especially for women's health. Because of stigmatization and discrimination, persons with mental disorders often have their human rights violated and many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health.

Broad strategies for mental health promotion and the prevention of mental disorders across the life course may focus on anti-discrimination laws and information campaigns that redress the stigmatization and human rights violations all too commonly associated with mental disorders; promotion of the rights, opportunities and care of individuals with mental disorders; the nurturing of core individual attributes in the formative stages of life; early intervention through identification, prevention and treatment of emotional or behavioural problems, especially in childhood and adolescence; provision of healthy living and working conditions, which includes work organizational improvements and evidence-based stress management schemes in the public as well as the private sector.

Objective 3 specifically focuses on the promotion of participation in work and return-to-work programmes for those affected by mental and psychosocial disorders, as well as the promotion of safe and supportive working conditions, with attention to work organizational improvements, training on mental health for managers, the provision of stress management courses and workplace wellness programmes and tackling stigmatization and discrimination. Lastly, it promotes workplace initiatives for suicide prevention.

Link to the complete plan of action: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_10Rev1-en.pdf

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Tackling electronic waste issues to bring health to vulnerable populations

The amount of electronic waste (e-waste) produced over the last two decades is considered one of the fastest growing global waste streams. These wastes are 'recycled' to developing or emerging industrialized countries, but only a substantial amount of the equipment is actually recycled. E-waste is normally dismantled and valuable elements such as gold and copper are regained through primitive recycling procedures (e.g. burning cables, acid baths). The results are higher risks of injury and exposure of an unknown number of adult workers, pregnant women and children to high levels of a variety of chemicals contained in the materials. These may include lead, cadmium, chromium, brominated flame retardants, and polychlorinated biphenyls, which are known to pose health risks.

E-waste has, therefore, become a major concern also from a human health point of view. In many countries, e-waste dismantling and recycling activities are home-based and family-run with highly insufficient occupational hygienic conditions. Furthermore, children are reported to be living, playing, attending school near dumps containing e-waste, or living or working near recycling activities, which makes them more vulnerable to potential health effects of chemicals in e-waste. They can be exposed to high levels of cadmium, lead and brominated flame retardants (BFRs), by inhaling (indoor) fumes or ingesting chemical-enriched house dust and soil. The burning or disposal of e-waste can also eject toxic gases as well as hazardous combustion products (such as dioxins) into the environment.

As a result of the Busan Pledge for Action on Children's Environmental Health in 2009, and the 3rd International Conference on Chemical Management (ICCM3) held in Nairobi 2012, the WHO was urged to promote the recognition, assessment and study of environmental factors that have an impact on health, with a specific mention on the emerging area of e-waste. In response to this concern and need, the WHO Children's Environmental Health team has recently started working on e-waste issues.

In the next few months, WHO will be collaborating with different partners such as the WHO collaborating centres, other UN organizations, the Partnership for Action on Computer Equipment (PACE) and the Solving the E-waste Problem (StEP), to advocate and create networks to improve and promote safer and healthier environment for families and children who are engaged in e-waste activities or living close to e-waste sites. This initiative will have several initial components, including assessing information and meeting with experts and key stakeholders. The overall goal is to advance the work towards better defining the exposures and related factors that can lead to health risks to allow identification of potential measures to protect children and other vulnerable populations from environmental health risks in e-waste. In addition, a training module for the health sector and for children is being prepared on e-waste to raise awareness and provide health workers with a "train the trainers" tool.

Links:
Global Plan of Action for Children's Health and Environment:
http://www.who.int/ceh/global_plan/en/index.html
Training Package for Health Care Providers on Children's Environmental Health:
http://www.who.int/ceh/capacity/trainpackage/en/index.html
International Conference on Chemical Management (ICCM):
http://www.saicm.org/index.php?option=com_content&view=article&id=96&Itemid=485
Solving the E-waste Problem (StEP) : http://www.step-initiative.org/

Contributed by Marie-Noel Brune Drisse, Children's Environmental Health, Interventions for Healthy Environments, Department of Public Health and Environment

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Action to create healthy workplaces in the Pacific islands

A healthy workplace is a workplace that promotes health through improving the physical and psychosocial work environment; personal health resources and enterprise involvement in the community. Improving healthy workplaces is a priority for Pacific Island Countries and the WHO Division of Pacific Technical Support (DPS) is taking action to assist Pacific Island governments to develop and implement healthy workplace initiatives. The Pacific is in a crisis due to the increasing burden of non-communicable diseases (NCDs). NCD mortality and the prevalence of NCDs risk factors such as overweight and obesity, diabetes, hypertension and physical inactivity are among the highest in the world. The NCD burden is not only a challenge for the health system, but has become a threat for socio-economic development in the region as well.

Workplaces constitute an important setting for health promotion and health protection in the Pacific. WHO promotes settings-based approaches to prevent and control NCDs and creating and promoting healthy workplaces has been identified as an important means to address the NCD crisis.

In line with the Western Pacific Regional Guidelines for the Development of Healthy Workplaces and the WHO Model for Action on Healthy Workplaces, WHO DPS in collaboration with Auckland University

of Technology (AUT) is developing a practical framework for action on healthy workplace. The framework is designed to assist Pacific Island governments in developing and implementing healthy

workplace initiatives based on a review of best practices and lessons learned from the Pacific and the overall Western Pacific Region. The framework will take into consideration the uniqueness of the Pacific setting and identify interventions and strategies that can be implemented to improve the physical and psychosocial work environment, personal health resources as well as enterprise community involvement.

It is expected that the work in the Pacific will contribute to the work on improving workers' health which has recently been initiated by the WHO Western Pacific Regional Office (WPRO). As part of the NCD and health promotion work by the Regional Office, a review of work on workers' health in the

Western Pacific region will be carried out and an expert consultation is being plan to review best practices of workplace interventions that address NCDs. The purpose of the Expert Consultation will also be to identify priority actions to strengthen efforts related to the prevention and control of NCDs through workplace settings.

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Regional occupational and environmental health standards and indicators for accrediting hospitals and other health care facilities in the Arab Gulf:

On 22 May 2013, the Health Minister's Council of the Cooperation Council for the Arab States of the Gulf adopted occupational and environmental health standards and indicators for accrediting hospitals and other health care facilities. WHO together with the regional office of the Eastern Mediterranean (EMRO) held two regional consultations in June and December 2012 to develop the Core Set of occupational and environmental health standards and indicators. During the course of the consultation, main achievements, challenges and lessons learnt in positioning and developing occupational health standards in accreditation systems of hospitals and other health care facilities were identified and discussed along with best integrative and innovative approaches for developing and fulfilling occupational health standards in accrediting hospitals and other health care facilities.

The resulting occupational health standards align with the draft WHO-ILO Global Framework for National Occupational Health Programmes and include three categories of standards: *Critical*, *Core* and *Developmental*. *Critical standards* are those considered critical for the health and safety of health workers and are fundamental for safe practice. As such they are compulsory in the accreditation systems where they are adopted. *Core Standards* are an essential set of standards with which a HCF should comply to protect and promote the health of its employees but are not compulsory. *Developmental standards* are based on capacity and resources for health services organizations and aim at continuous improvement as other standards are fully implemented.

There are eleven domains identified in the occupational health standards with actions and indicators for every domain. The domains include the following:

OH1. Organizational set up,
OH2. Occupational health (OH) services,
OH3. Employee health program,
OH4. Occupational health risk management,
OH5. Employee health and physical assessment,
OH6. Information, Education, training, and awareness aspects of OH issues,
OH7. Prevention and control measures,
OH8. Treatment, rehabilitation and compensation services,
OH9. Incident/ accident investigation, analysis and/ or OH surveillance system,
OH10. Suitable documentation and record keeping, respecting confidentiality and blame- free removing barriers for reporting, and
OH11. Review, monitoring and evaluation of the OH programme.

The standards will be presented during a preconference on surveillance systems for health worker occupational health to be held on 22 September 2013 as part of the International Commission on Occupational Health (ICOH) 9th International Conference on Occupational Health for Health Care Workers joint conference together with the 1st International Conference on Occupational Infectious Agents, the International Conference on Occupational Health and Development and International Conference on Occupational Nursing . See http://www.healthcareworkers2013.com/pre-conference-courses/

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GOHNET — The Global Occupational Health Network

World Health Organization

Healthy workplaces, toolkits and good practices

The first Global Healthy Workplace Awards & Summit was launched in London

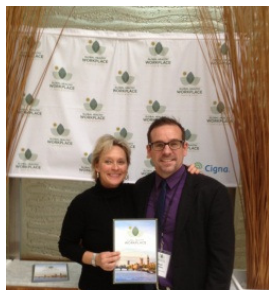Dame Carol Black providing the scientific context from the UK Perspective

The motto of the first Awards Ceremony was *Good Health is Good Business.* The award is based on the criteria of the WHO Healthy Workplace Model outlined in the 5 keys for healthy workplaces. The Summit attracted more than 100 organizations of all sizes, health system leaders, universities, and NGOs. The results were so positive and encouraging that the organizers plan on having more events in subsequent years, which is an excellent

opportunity for raising increased awareness about the need to protect and promote the health of workers.

Organizations of all sizes were encouraged to share their approaches to healthy workplaces. The search for the healthiest workplaces in the world was sponsored by the Cigna Foundation and hosted by the Global Knowledge Exchange Network (GKEN) together with International Health Consulting and i-genius, whose common goal is to promote awareness of emerging better practices in health promotion and wellness in the workplace. Six finalists who exemplified leadership in these areas were chosen to present their programmes in London. Alexandra Health, Royal Dutch Shell and Toyal America won the competition which considered companies of all sizes from 29 countries. The programmes provide good practice examples of how the workplace can serve as the entry point for improving global health and wellness. A very good example of a healthy workplace by an SME was provided by Lebanon, who rely on the premise that profit should not be the driver of their company, but that profit will come as the applause received from satisfied customers when they are served by highly motivated people.

Submissions were reviewed by an international panel of public health experts from five continents who judged the workplace programmes for the first time through the lens of the World Health Organization addressing the physical and psychosocial work environment, personal health resources and the enterprise-community involvement. The judges included Dame Carol Black, the UK National Director for Health and Work. Carol is also the Chairman of the Nuffield Trust and she established the famous review of the health of Britain's working age population *Working for a healthier tomorrow*. The other judges included Georges Benjamin, the

> *"The model for action of the WHO is not rocket science, and it does not need training or advanced know-how to implement it. All it needs is a proper culture and set of values which will drive the model for action. Tony Haddad, CEO Technica, Lebanon*

Executive Director of the American Public Health Association; Alberto Ogata, the President of the Brazilian Association of Quality of Life (ABQV); Annie Ling, the Director of the Adult Health Division of the Health Promotion Board in Singapore; as well as Tracy Kolbe-Alexander, Senior Lecturer from the University of Cape Town. Efforts were made to represent the globe with the judges chosen as well as the speakers, who included Dame Carol Black herself, Jorma Rantanen, Stavroula Leka, Shyam Pingle, Valentine Douala-Mouteng and others.

GOHNET — The Global Occupational Health Network — World Health Organization

The editor with Wolf Kirsten at the Summit

Lastly, we would like to congratulate Wolf Kirsten of International Health Consulting, for being instrumental in taking up the WHO work and putting it into practice with his partners in the international employer community.

Links:
WHO Healthy Workplace Model for Action
Global Healthy Workplace Awards and Summit

Implementing Healthy Workplaces in SMEs: a pilot project in three countries of Latin America

The Healthy workplace model was launched in 2010 by the WHO as an innovative approach to workers' Health protection and promotion. The model is built on three pillars: i) a multidimensional approach to workers' health; ii) management and workers following a continuous process for improvement of workers' health; iii) collaboration of employers/managers and workers, with a focus on protection and promotion of health, safety and well-being for all workers, and on sustainability of the workplace.

Small and medium size enterprises (SMEs) are the main provider of employment in Latin America and they make a great contribution to the Gross Domestic Product. Many of them are in the informal sector, but also a significant number of SMEs are formalized through labour relationships protected by labour laws and social security.

The multidimensional approach of the healthy workplace model is an opportunity to manage workers' health in SMEs, as it can be tailored to their size, needs and heterogeneity. Social working relationships inside the SMEs can facilitate collaboration and agreements for change.

This pilot project, currently under implementation and commissioned by WHO, is aimed at adapting the healthy workplace model to the specific needs of SMEs in three countries of Latin America, namely Chile, Perú and Colombia. In each of these countries there is a WHO collaborating centre for occupational health (recognized or candidate) that provides support for advancing the project. The regional WHO office (AMRO) supports involving country offices to help build networks.

The phases of the pilot follow a common line, but they are adapted to differences among countries. They include:

a) Inviting key institutions - In addition to WHO collaborating centres, institutions in charge of the OHS social security are being invited, as they have the capacity to provide technical advice to

their SMEs affiliates. In some cases, representatives of Ministries of Health and Labour, and Universities, are also invited to be part of the network.
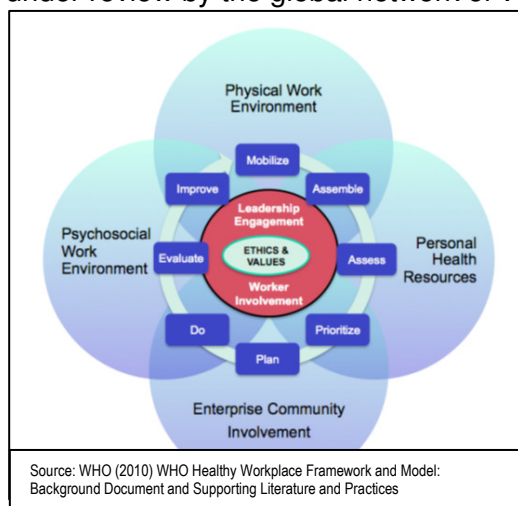
b) b) Building a network of collaborating institutions and professionals - Training in the basics of the healthy workplace model is provided to professionals of the institutions, by online and face-to-face activities. The networks are expected to promote and develop the model, and to suggest tools for its practical implementation.

c) Implementing healthy workplace programmes in enterprises - At least three small enterprises in each country are to selected to implement a comprehensive model to manage their workers' health problems, with the support of the network participants. An action plan will be designed for each, based on their specific needs. Each action plan will contain activities to improve the physical and psychosocial working environments, personal resources for health and enterprise-community relationships, following a continuous improvement process.

The pilot will produce also a network of professionals and potential champions trained in the WHO model and a blueprint to implement changes in other sites.

Contributed by Dr Manuel Parra Garrido, Consultant commissioned by WHO for this project. Physician, specialist in OSH and in Psychiatry. Teacher of the International Master of Science in OSH of Ludwig-Maximilians Universität of Munich.

Developing an indicator tool for the Healthy Workplaces Model

Since the launch of the Healthy Workplaces Model in 2010, the tools and work surrounding the model have been growing steadily. In the 20th edition of the GOHNET newsletter it was reported that an audit tool was in development to assess progression towards healthy workplaces on the basis of the Healthy Workplaces Model. A first draft of this audit tool commissioned by WHO has been completed by the Centre for Organizational Health and Development, University of Nottingham. The tool is currently under review by the global network of WHO collaborating centres for occupational health.

Source: WHO (2010) WHO Healthy Workplace Framework and Model: Background Document and Supporting Literature and Practices

The Healthy Workplaces Model provides eight steps for the implementation of a continual improvement process on the basis of key principles in four avenues of influence. As such the starting point in the development of key indicators was the cyclical process and its eight steps (mobilize, assemble, assess, prioritize, plan, do, evaluate, and improve). A search was conducted using several keywords to identify existing audit tools in the four avenues of influence. From this pool of over 150 audit tools and checklists, criteria were established to select appropriate existing tools on which to base the development of indicators on. Only tools that were underpinned by a cyclical process of improvement, similar to that in the Healthy Workplaces Model, that took a multi-faceted approach to healthy workplaces, tackling several elements of the environment, were considered. Eleven such tools were identified as appropriate.

A mapping exercise of the key themes and indicators in these tools, on to the eight steps in the Healthy Workplaces Model was undertaken. A gap analysis was then conducted assessing any gaps in these emerging indicators with what was envisaged by WHO, as described in the background literature to the

HWM. On the basis of this, the research team (involved in the conception of the healthy workplaces initiative) developed items which addressed this gap. The items were then reviewed and compiled to form an audit tool for large scale enterprises and a shortened, simpler, tool for small and medium-sized enterprises.

It is envisaged that these two audit tools will aid organizations understand what good practice in developing a healthy workplace is and assist them in implementing this process of good practice on the basis of defined indicators. It is also expected that these tools will be revisited and refined once the audit tools have been used and tested across WHO regions.

Link: http://www.who.int/occupational_health/healthy_workplaces/en

Contributed by Stavroula Leka, PhD, and Nicholas Andreou, MSc, Centre for Organizational Health & Development, University of Nottingham, WHO collaborating centre for occupational health, Stavroula.leka@nottingham.ac.uk, Nicholas.andreou@nottingham.ac.uk


A WHO/IEA toolkit to reduce the risk of work-related musculoskeletal disorders

Musculoskeletal injuries and disorders (MSDs) are a major occupational health problem worldwide. They include a very diverse group of conditions, and clinical diagnosis can be a complex process. However, in 2012 the International Commission on Occupational Health released a consensus document concluding that at *workplace* level the focus of MSD risk management should simply be to reduce levels of musculoskeletal discomfort and pain, regardless of any individual diagnoses.

This apparently simple goal nevertheless presents major challenges to occupational health practitioners around the world, because of the large, diverse and interacting set of workplace hazards that can affect MSD risk. In most workplaces, MSD risk management focuses primarily on physical hazards arising from manual handling work tasks. Many checklists and other simple tools have been developed for use in assessing risk from such hazards, and there is wide recognition of risk control measures such as adjusting workstation height, and avoiding repeated lifting or carrying of heavy loads. However, there is now a large body of research demonstrating that MSDs risk is *also* affected by 'psychosocial' hazards arising from *how work is organised* and *how people are managed.* The extent to which psychosocial hazards affect MSD risk is variable, but usually very substantial. For example, a recent review of a large number of research studies reported that psychosocial hazards were responsible for between 14% and 63% of risk to the back, and for MSDs of the upper body and arms they accounted for 28% to 84% of risk (Marras, 2008).

The potential for interactions between hazards means that risk assessment on a hazard-by-hazard basis can be unreliable, because the effect on MSD risk of a particular observed hazard level is likely to depend on the type and severity of other hazards experienced by workers in that job. For occupational health professionals familiar with hazard-focused procedures for assessing and controlling risk from particular hazardous substances or energy sources (e.g. control banding methods), the need for a more holistic approach in the case of MSD risk management may not be obvious. However, the importance of this is clear also from conclusions of research evaluating the effectiveness of various workplace interventions intended to reduce risk, from which the following key requirements for effective MSD risk reduction have been identified:

- *a multi-pronged approach ...* addressing psychosocial hazards concurrently with manual handling hazards
- *participation by workers and their representatives, along with other stakeholders including supervisors and key managers*
- *management commitment ...* ensuring that workers have the time needed to participate in risk management processes and that risk controls are implemented as fully as practicable.

Figure 1. A model of hazards affecting risk of work-related musculoskeletal disorders.
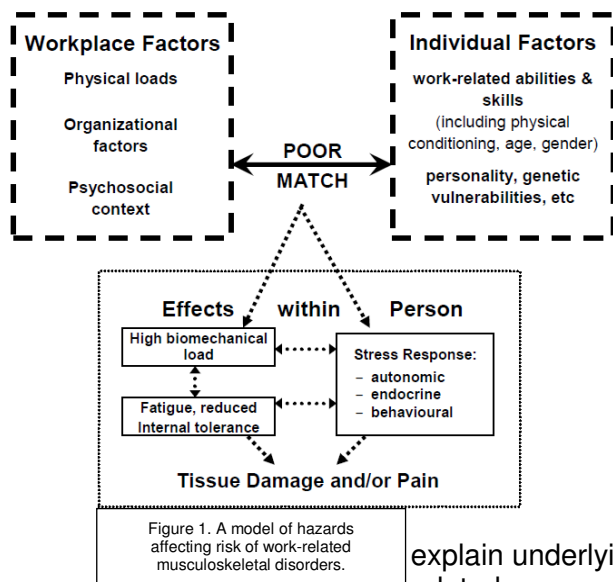
To assist workers, their managers and others to meet these requirements, the WHO network of collaborating centres for occupational health, in liaison with the International Ergonomics Association (IEA), is working to produce a MSDs Risk Management Toolkit. This work is being coordinated by Professor Wendy Macdonald of the Centre for Ergonomics & Human Factors at La Trobe University in Melbourne, Australia (a WHO Collaborating Centre), on behalf of both the WHO secretariat and the IEA. The conceptual framework adopted for this project is shown in Figure 1.

Based on this framework, a draft toolkit has been formulated in accord with WHO toolkit guidelines for healthy workplaces. The first parts of the toolkit explain underlying risk management principles and outline the work-related causes of MSDs, including an explanation of 'psychosocial' hazards. The main sections then detail a series of workplace procedures, with associated tools, following the risk management cycle shown in Figure 2.

Getting Started entails formation of a MSDs risk management team, including representatives of workers and of their supervisors/managers. The team reviews current workplace documentation (if any) on MSD hazards and incidence, and uses toolkit training materials to enhance their own understanding of MSD risk management requirements. Having agreed on the particular jobs to be targeted, they undertake a *Risk and Hazard Assessment*.

Figure 2. MSDs Risk Management Framework
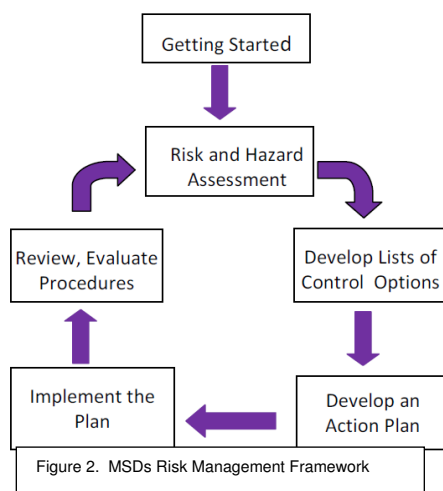
The assessment process is based on ratings by workers of a full range of potential hazards, and of their own physical discomfort or pain levels. These ratings can be obtained either by individual questionnaires or by small group discussions and 'body mapping',[9] using the tools provided. The set of psychosocial hazards rated might first need to be customised, using guidelines provided. Analysis of the ratings can be done manually, or by using a simple software package (under development, along with guidelines for its use).

Guided by toolkit instructions and templates, the ratings are then used to identify and prioritise possible risk control options for both physical ('manual handling') hazards and psychosocial hazards. On this

basis, an action plan is developed and implemented, and the effectiveness of the action plan is evaluated by hazard and risk ratings obtained during the first stage of the next risk management cycle.

Undertaking this basic MSDs risk management cycle does not require use of any *task*-focused analysis methods (of the kind familiar to many ergonomists) for assessing the severity of manual handling hazards. However, the toolkit provides guidance on the possible uses of such methods, along with links to online resources providing further information. Development of these online resources is being supported by the International Ergonomics Association.

A project based at La Trobe University's WHO collaborating centre is planned to implement the toolkit in a range of different workplaces and evaluate its effectiveness in reducing MSD risk. Opportunities for more widespread implementation and evaluation of the toolkit will be sought through the wider WHO network of Collaborating Centres, the International Ergonomics Association and the Healthy Workplace network.

Contributed by Wendy Macdonald, Centre for Ergonomics & Human Factors, La Trobe University, Australia, WHO collaborating centre for occupational health   W.Macdonald@latrobe.edu.au

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The " *Happy 8* ": A Holistic Approach towards a Healthy Organization

In general, the well-being of an organization, which is a measure of a *"healthy organization"* only refers to productivity and profitability. However, this should also include another essential factor: the *health* and *the work and life quality* of its employees. This concept can also be viewed in the framework of WHO's definition of health dimensions, which comprises of the physical, mental, social and spiritual, as well as the more recent WHO comprehensive healthy workplace framework.

To become a "healthy organization", an organization must focus on developing its human resources (HR). A prerequisite is that a team effort among executives, HR managers and employees is established. Today, it is no longer adequate to simply find the right people for the right jobs, but it is also necessary to enhance the quality of the employees' work and life balance. This can be achieved through the " Happy 8 " concept, which includes eight dimensions of human "happiness" that are essential for creating and monitoring the balance between professional and private life (work and life balance) and between the intelligent and emotional quotient (IQ and EQ).

The **"Happy 8"** conceptual framework is proposed here to help *create* work and life balance for employees and monitor these at three distinctive levels: *self, family,* and *society*. Its adoption can transform any organization into a healthy one.

The " Happy 8 " framework is composed of eight actionable pillars, namely:

1) *Happy Body*   Enjoy good health in one's body and in one's mind.
2) *Happy Heart (Relationships)* Show kindness and sympathy for oneself and for others, and be generous.
3) *Happy Relaxation*   Able to relieve stress from work and in daily life.
4) *Happy Brain*   Improve one's knowledge through learning.
5) *Happy Soul (Spirituality)* Possess a good sense of moral.
6) *Happy Money*   Manage personal finances well.
7) *Happy Family* Create understanding and a stable environment in one's family.

8) *Happy Society* Support one's community at work and at home. Promote social harmony.


Fig.1   Happy 8   conceptual framework

The **"Happy 8"** are classified into three distinct levels: happiness for oneself (Happy Body, Happy Heart, Happy Soul, Happy Relaxation, Happy Brain and Happy Money), happiness in one's family (Happy Family), and happiness in one's workplace (Happy Society).

Fig.2 Happy 8 three levels

The outcome of adopting the **"Happy 8"** approach is the increase of employee engagement, leading to happy people (self), happy home (family) and happy workplace (society), all of which are key indicators of a healthy organization. To adopt **"Happy 8"**, an organization must first communicate to its employees a clear corporate policy and a corresponding set of goals in becoming a "*healthy organization.*" Next it must prioritize and design *activities* along the eight clearly defined principles of Happy 8, which are aligned with its own *vision, culture* and *context*.

Upon a successful adoption of **"*Happy 8*"**, individual employees will be able to manage their work-life balance with the support of their organization. They will become *healthy employees*, who are not only effective and efficient in their work, but who also develop a good sense of ethics, constantly striving to improve themselves, and who are able to take care of themselves, their family, and their workplace thereby becoming responsible citizens to their communities and society as a whole. Through its happy workforce, the organization itself becomes healthy. Creative and content workers can contribute more value and thereby enhance the organization's overall competitiveness.
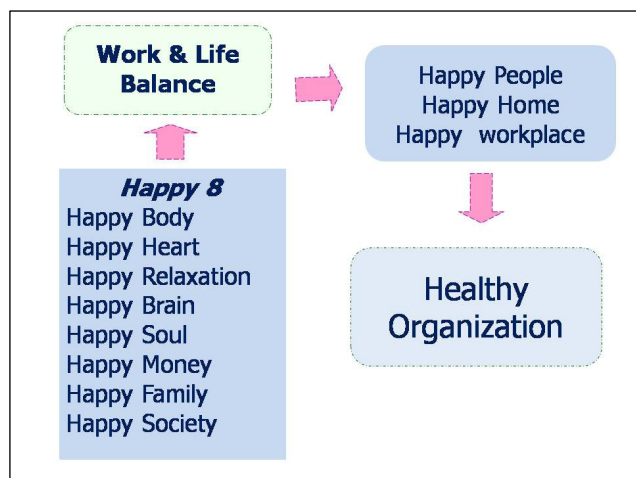
A *"healthy organization"* can be achieved if it places importance on HR development for healthy, which implies happy, employees. The outcome of a healthy organization is that it is resilient to shocks and to local and global challenges because its workforce is able to adapt to new changes. One way to achieve this outcome is through the proposed Happy 8 framework, which rests on the fundamental premise of promoting workers' management of work-life balance in the eight dimensions of happiness.

Fig.3 The " Happy 8 " Framework towards a Healthy Organization

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Certifying healthy workplaces in Spain and Latin America

Reducing the frequency and seriousness of occupational risks in a sustained way, requires implementation of an occupational health and safety management system. Such a system can help an organization develop risk prevention activities in a structured and coordinated manner, integrated with all day-to-day activities and decisions. It can also bring real cultural change, where management and employees share positive values and beliefs about occupational health and safety. With this in mind, many companies have begun demanding a management model, with a guide to implementation. The result is growing adoption of models of occupational health and safety management system standards (not developed by ISO), which offer the possibility of certification.

Promoting and protecting health in the workplace is one of the most important objectives defined by the WHO Global Plan of Action. There is much data that shows that companies that promote and protect the health of their workers are among the most successful and competitive over the long term and also have the highest retention rate of employees.

For this reason, AENOR (a private, independent, non-profit Spanish entity dealing with the development of standardization and certification), together with the European Institute of Health and
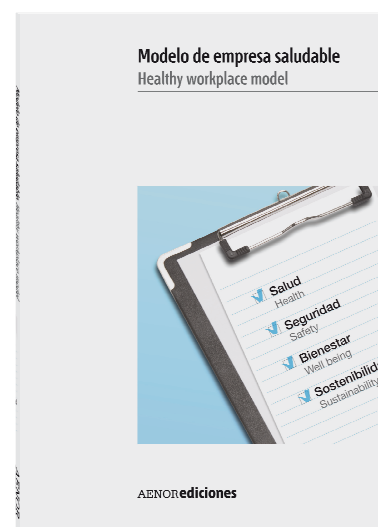
Social Welfare, a collaborating centre for occupational health in Spain, and the FREMAP Prevention Society, have put together this publication (see on the right) that proposes a global model for the identification, planning, execution and evaluation of the essential activities needed to protect and promote health in any size or type of organization.

This model establishes the requirements of a healthy workplace management system for organizations committed to the principles and recommendations existing on healthy workplaces (in particular, the contents of the WHO healthy workplace model), and which seek to promote and protect workers' health, safety and well-being and the sustainability of the work environment on a continuous basis.

On the basis of the criteria contained in the WHO model and the extensive literature that exists on this matter, this model establishes an occupational health and safety management system based on the Plan-Do-Check-Act (PDCA) methodology, which is equivalent to the WHO risk assessment and management cycle proposed in the model. The basis for this approach is shown in the Figure below.

As in the case of other management systems, this system contains auditable requirements that ensure the continuous improvement of the occupational safety and health management system. However, no absolute requirements are established in relation to health, safety, wellbeing and sustainability, beyond the following:

HEALTHY WORKPLACE MANAGEMENT SYSTEM
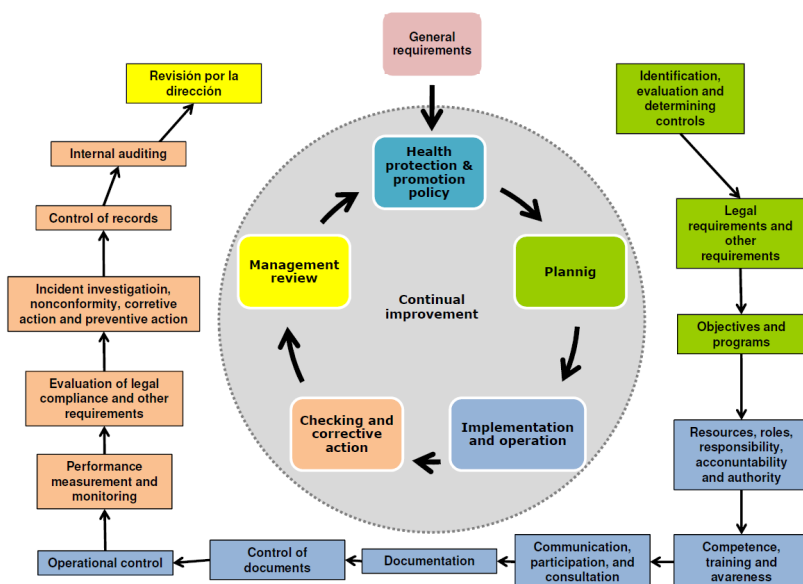
• The legal duties incumbent on an organization.

• The requirements of the management system contained in this model and any other requirements adopted or established by the organization.

• The aims established by the organization itself.

Aim and scope of application: This model specifies the requirements in order to define, implement, maintain, and improve a Healthy Workplace Management System (HWMS) with the aim of integrating healthy work environments throughout the organization.

The following should be taken into account in the implementation and evaluation of an occupational safety and health management system:

- The characteristics and size of the organization, in particular when it is a small or medium-sized enterprise (SME).
- The process for implementing a healthy workplace program recommended by the WHO.

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In addition, the implementation and evaluation shall take into account its compatibility with other management systems.

Links**:**

➕ WHO Healthy Workplace Framework and Model. Background and Supporting Literature and Practices : http://www.who.int/occupational_health/healthy_workplace_framework.pdf

➕ Healthy workplaces: a model for action : http://www.who.int/occupational_health/publications/healthy_workplaces_model_action.pdf

➕ Modelo de empresa saludable: http://www.aenor.es/aenor/normas/ediciones/fichae.asp?codigo=9818

Contributed by Agustín Sánchez-Toledo Ledesma, Gerente de Seguridad y Salud en el Trabajo, Madrid, AENOR, asanchezt@aenor.es

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Changes in the world of work: increase of mental workload in machine operators in Mexico

One of the objectives of the "WHO healthy workplace model: a comprehensive way of thinking and acting" is to address *work-related physical and psychosocial risks* in an integrated way. In this context, the authors of this article are conducting investigations into the workload-fatigue relationship among AMT operators in companies located in central Mexico, in Celaya City. The study shows that in Mexico the implementation of Advanced Manufacturing Technology (AMT) has increased significantly, especially in the automotive industry. The inclusion of the semi-automatic Computer Numerical Control machinery in these industrial processes has brought changes to the nature of tasks that operators have been familiar to. The physical dimension of their perceived workload now includes a mental dimension, which sometimes is perceived even higher than the traditional physical one.

Traditional tasks performed by AMT operators that involve making physical efforts primarily are "loading and unloading parts to machines", "moving parts from/to conveyors" and "taking pieces from containers". Tasks that engage mental efforts primarily include "control panel operation" and "inspection". However, these two tasks also include components of physical efforts largely caused by the manipulation of heavy inspected parts. Also, the physical dimensions of this machinery and its control panel were designed for populations with different anthropometric dimensions to the Mexican population, which points to the need for adjustments.

Recent ergonomics research has shown that overall workload perceived by AMT workers has had higher values than before, and workers are experiencing higher levels of mental workload than physical workload. The situation presented a few years ago was the reverse. Studies show that significant correlations exist between workload and fatigue. Lack of energy is the most important factor followed by physical discomfort and sleepiness, which poses an additional safety hazard. Musculoskeletal

disorders most commonly found in these studies are those related to the neck, right hand, right shoulder and feet.

Healthy workplace programmes that aim at re-designing the job to maximize worker wellbeing for both the physical and mental working environments need to provide simple and practical guidance to safeguard the health of machine operators.

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More news from WHO collaborating centres and partners

Activities in the UAE University

Several recent activities were organized by the United Arab Emirates University relevant to the WHO Global Plan of Action on Workers Health 2008-2017. These included local, regional and international collaboration:

a) A 5-day training course for capacity building for occupational health practitioners in March 2013. Twenty-seven doctors and nurses from the UAE and neighbouring countries in the Middle East (Qatar, Oman, Bahrain), and participants from Australia, Nigeria and the UK attended a course on the theory and practice of occupational health. The aim of the course was to provide knowledge and skills in order for the participants to use these to better develop preventive programs for their own organizations in their countries. Similar training was delivered by UAE University in Oman (Feb 2013); and an introductory module on case studies and projects is scheduled for India in April 2013.

b) On April 16th 2013, the UAE University collaborated with Medicine Sans Frontiers to deliver a workshop on an important area of health of healthcare workers – tuberculosis. The workshop was attended by healthcare workers from the university and several hospitals in the area, and was provided at no cost to attendees.

c) At the end of 2012, UAE University participated in a WHO sub-regional workshop on Occupational and Environmental Health Standards for Accrediting Hospitals and other healthcare facilities. The event was held in Doha, Qatar over 3 days, and contributed to recommendations on developmental, core and critical standards. Delegates included WHO personnel and advisers, and invited experts from the USA, UAE, Egypt, Bahrain, Kuwait, Yemen, Saudi Arabia, Oman and Qatar. This effort on recommended standards will benefit healthcare workers in the region.

Occupational health training at the United Arab Emirates University

Contributed by Tar-Ching Aw, Institute of Public Health, UAE University, WHO collaborating centre for occupational health, United Arab Emirates   tcaw@uaeu.ac.ae

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The Toolkit for eliminating asbestos-related diseases

The 2.5-year-long project undertaken to develop a toolkit for eliminating asbestos-related diseases has finally been completed. The endeavour started in September 2010 based on a contract with the Rotterdam Convention Secretariat (RCS); the University of Occupational and Environmental Health, Japan (UOEH) acted as the lead organization, and the Occupational Safety and Health Research Institute (OSHRI) of the Korean Occupational Safety and Health Association acted as the co-lead organization. It was Dr Ivan Ivanov of the WHO, who, after attending the Second International Seminar of the Asian Asbestos Initiative (AAI-2) in Bangkok, extended the invitation. He remarked on "the progress made and the capacities being built in Asia for dealing with asbestos" and the need "to prepare an asbestos toolkit for use in …Asia." We were fortunate to have already built up a degree of confidence in our collective capacity via networking, so we embarked on the project.

The toolkit was developed to serve as a concise and easy-to-use source of knowledge, technologies and information related to eliminating asbestos-related diseases (ARDs). The traditional public health approach of addressing the three levels of prevention was considered a basic means for tackling ARDs. It is a sad reality that many countries, especially rapidly developing countries, continue to use asbestos at alarming levels. The developing countries in Asia are at the forefront of this trend, so we intend for the administrators, practitioners and researchers of Asian countries to be the primary beneficiaries. However, we hope that any concerned party will benefit from this toolkit.

The chapters are descriptively entitled: 1) Asbestos exposure assessment, risk identification and substitutes; 2) Asbestos-related legislation and regulations; 3) Diagnostic tools for ARDs; 4)
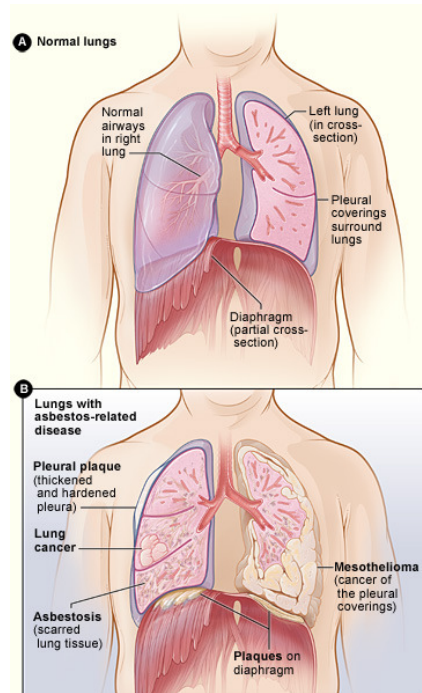
Economic cost/burden incurred by asbestos exposure and ARDs; and 4) Risk communication. The print version of the toolkit comprises two full volumes; the first is a compendium of "factsheets," and the second is a compendium of "originally developed references." A very unique feature is the structure of the factsheets, which provide not only the usual bibliographic information (e.g., an abstract), but offer added value in items such as "Asian context," "critical appraisal" and "annotations." A total of 190 such factsheets (380 pages) are included, along with 200 pages of originally developed reference documents.

The toolkit's contributors include 25 authors and editors originating from eight countries and regions, all of whom pitched in with their effort and time to achieve a common goal. Several world-class experts supported our efforts as advisors, and the RCS-UNEP, WHO and ILO oversaw the entire process. Although space limitations preclude me from acknowledging each name here, I am deeply indebted to all. Lastly, our efforts will be meaningless if the toolkit is not utilized by stakeholders. We will thus be distributing the print and CD-ROM versions to as many concerned parties as possible. The following website provides a comparable version: http://envepi.med.uoeh-u.ac.jp/toolkit/index.html

Contributed by Ken Takahashi, Director of the WHO Collaborating Center for Occupational Health, IIES, University of Occupational & Environmental Health, WHO collaborating centre for occupational health, Japan, ktaka@med.uoeh-u.ac.jp

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Campaigns, competitions and ongoing projects in Brazil

SESI's Safety Annual Campaign - April 28th, 2013 : SESI organized a national event, by videoconference, offering to representatives from Brazilian Chamber of Construction Industry, Construction Trade Union, Employers, Government representatives and OHS professionals, the educational toolkit "100% Safe" Series with 100 educational movies with 3-5 minutes each and 100 educational short films with 90 seconds each. The 100 educational programs with 3-5 minutes each were written in Portuguese, with subtitles in Portuguese, English and Spanish. These materials aim at promoting safety behaviours and preventing occupational accidents in the construction industry.

Links:

Toolkit: http://www.portaldaindustria.com.br/sesi/canal/pnsstic

Videos: http://www.portaldaindustria.com.br/cni/imprensa/2013/04/1,12892/sesi-lanca-na-internet-videos-sobre-seguranca-na-industria-da-construcao.html

28th April celebrations: http://www.portaldaindustria.com.br/cni/imprensa/2013/04/1,12922/sesi-vai-atender-quatro-milhoes-de-trabalhadores-ate-2014.html

OSH at work competition for young people: http://www.portaldaindustria.com.br/cni/imprensa/2013/04/1,12953/sesi-premia-projetos-sobre-seguranca-e-saude-no-trabalho.html

OHS National Programme for the food industrial sector – Slaughterhouses: SESI implemented a National Programme for Slaughterhouses and the Mining industrial sectors. A broad study for OHS prevention in slaughterhouses was finalized and it is being prepared to be published.

Stage of Return on Investment – Goetzel's Lecture : On 11 April 2013, the national meeting with superintendents of SESI's units, that work together to the industries of each state, Professor Ron Goetzel, director of the Institute for Health and Productivity Studies at Emory University, presented a series of surveys and intervention studies which indicate that quality of life is good for worker's health. The impact can be beyond and be positive for corporate financing, with a return on investment. According to Goetzel, in the case of Citibank, every dollar invested in programs of quality of life has an average return of US$4.70, with reduced medical costs, absenteeism, among other expenses.

Link: http://www.portaldaindustria.com.br/cni/imprensa/2013/04/1,12400/investimento-em-qualidade-de-vida-reduz-custos-medicos-e-faltas-ao-trabalho.html

Industrial National Vaccination Programme : With the aim to prevent worker illness and absenteeism caused by Influenza, SESI promoted a vaccination programme for industrial workers, subsidizing 2/3 of the whole value, vaccinating 900,000 industrial workers.

Training for OHS Committees in chemical companies: SESI is launching a training course for employees of Internal Committees for Accident Prevention of chemical companies, petrochemical and steel companies that produce or handle benzene. This 20-hour long educational programme promotes worker awareness of health and safety hazards from potential exposure to this agent, identifying preventive actions, such as monitoring their health by clinical examinations, the importance of environmental assessments, action towards emergencies, and the use of personal protective equipment. We conducted a first pilot in three companies, empowering 70 employees and in total we plan to reach more than 1.500 workers.

Health and healthy lifestyle assessment tool at the workplace : In 2012, SESI applied a diagnostic tool named "Health and Lifestyle Diagnostic" in industrial companies distributed in 27 states, which reached 418.440 workers: 73.4% men; 59.8% up to 34 years. This diagnostic identified that 16.4% of the workers are obese; 26.3% had abnormal blood pressure in which 20.6% of them did not have a previous hypertension medical diagnosis. 7.4% indicated to have depression and anxiety disorders in which 6.2% of them did not have a previous mental disorder medical diagnosis.

Contributed by Sylvia Yano, MSc. OHS Specialist, SESI, WHO collaborating centre for occupational health. Quality of Life Unit. Brazil sylvia.yano@sesi.org.br

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OSH advances in Nepal

Occupational Safety and Health (OSH) issues are being fruitfully discussed these days in Nepal. On 28 April 2013, the World Day for Safety and Health at Work, a rally was organized in the main streets of Kathmandu Valley bearing the slogan 'Prevention of Occupational Diseases' and "Human Rights at Work". This rally was one among several OSH activities initiated by the OSH Project, Department of Labour under the Ministry of Labour and Employment to celebrate the 13th National Occupational Health and Safety Week in Nepal.

 An interaction programme on "Occupational Safety and Health Promotion" was organized by the OSH Project and Nepal Public

Health Foundation with support from the Danish NGO Dialogos. Relevant stakeholders participated, including Nepal Ministries of Health, Agriculture, Environment and Labour, alongside Universities, Unions, Employer Associations, the ILO and WHO. Three opening presentations were provided on the following topics: a)'*Globalisation and OSH'* delivered by Occupational Physician Erik Jørs from Dialogos/ICOEPH/ Department of Occupational Medicine in Denmark, b) '*National Perspectives on Occupational Health and Safety Promotion in Nepal*' delivered by Occupational Physician Sunil Kumar Joshi from Kathmandu Medical College in Nepal, and c) '*Role of Stakeholders on OSH in Nepal'*, delivered by Engineer Barun Kumar Jha from the Ministry of Labour and Employment in Nepal. Dynamic discussions among all the present stakeholders followed, leading to the following recommendations:

- A multi-stakeholder approach should address OSH issues
- A national OSH policy should be prepared and endorsed by the government
- Issues of non-formal workers' rights should be stated in the future
- Female trade unions must be discussed
- Curricula in medicine, public health and nursing studies need to incorporate OSH
- Criteria for compensation related to occupational diseases have to be clearly defined
- OSH must be included into the current governmental preparation of a health plan for Nepal.

The discussions provided clarity about a common path for future initiatives on OSH in Nepal and gave the Nepal Public Health Foundation a kick off to advocate for the development of OSH issues and services in Nepal. The stakeholders expressed their willingness to support future actions in this area, which is absolutely necessary if occupations in Nepal are to be improved and the country as a whole to be included in the increasing globalization and production developmental process. The commitments expressed by government representatives, the ILO and WHO during various meetings conducted during the 13th National Occupational Health and Safety Week were uplifting as these stakeholders will be major key players in improving the OSH field in Nepal.

With its partners in Denmark, ICOEPH and the Department of Occupational Medicine in Odense University Hospital, Dialogos will support the development of the OSH field in Nepal as far as possible now starting with a project on 'Farmers' Health'. In the coming three years, this project will focus on the prevention of pesticide intoxications among vegetable farmers in the Chitwan District of Nepal by means of training, research and awareness raising activities. The Nepal Public Health Foundation is Dialogos' local implementing partner in the project.

In addition to consensus among all stakeholders on Nepal lacking sufficient legislation, effective monitoring, healthcare and research studies in the field of OSH, the fact that all stakeholders could be gathered in one room and have rich discussions resulting in concrete recommendations, signifies hope for future safe and healthy occupations for Nepali workers.

Contributed by Anshu Varma, cand.scient.san.publ (1,2,5), Dinesh Neupane, cand.scient.san.publ (2), Gajananda Bhandari, MD, MPH (2), Sunil Kumar Joshi, MD, MPhil, PhD (6) and Erik Jørs, MD MIH(1,2,4)

1.Dialogos, Denmark
2.International Centre for Occupational, Environmental and Public Health (ICOEPH), Denmark
3.Nepal Public Health Foundation, Nepal
4.Department of Occupational Medicine, Odense University Hospital, Denmark
5.Department of Occupational Medicine, Copenhagen University Hospital, Denmark
6.Kathmandu Medical College, Nepal

Conference Reports

3rd International Strategy Conference on Occupational Health and Safety: Networking for a sustainable prevention culture

Networking of policy areas was the focus of the 3rd International Strategy Conference on Occupational Health and Safety - Networking as a driving force for a culture of prevention that took place in Dresden from 6-8 February, 2013. The event provided 135 participants from 29 countries with opportunities for cross-policy exchange of ideas on the topics of "Accidents/Vision Zero", "Health and Well-Being at Work" and "Diversity".

Networking was illustrated with the help of an interactive installation. The installation consisted of pillars which represented the core topics and policy areas. The participants wove ties between the core topics and the policy areas as a way of demonstrating which ties they wanted to improve during the course of the conference. Key messages from the working groups were made clearly visible for everyone in the installation.

Hans-Horst Konkolewsky, ISSA, and Walter Eichendorf, DGUV, at the 3rd Strategy

There was consensus at the conference that better integrating health into occupational safety and health (OSH) and co-operation between the policy areas of work and public health need to be taken more seriously.

Dame Carol Black got right to the heart of the issue when she said at the very start of the conference "Work is a good place for health". However, health at work must continue to be improved and its role expanded. Dame Carol Black has called for joint, multi-disciplinary health services and at the end of the day, these services should be available for everyone "whether they are entering work, seeking to stay in work, or trying to return to work without delay in the wake of illness or injury". There is a need for an "integrated prevention approach" which encompasses primary, secondary and tertiary prevention. This type of three dimensional approach links OSH with workplace health promotion and rehabilitation including return to work.

Maria Neira, WHO, at the 3rd Strategy Conference

The integrated prevention approach focuses on the person and their requirements. As such, it is particularly important when developing a culture of prevention to look at the individual lifestyle of each person. This significantly influences the occurrence of occupational diseases and especially the occurrence of non-communicable diseases (NCD). "At the same time, the work environment is also the ideal place to shape the behaviour of people and their lifestyle" (Maria Neira, WHO).

At the end of the third strategy conference, the participants agreed upon a roadmap which consisted of three action points: "Prevention Culture", "Health is good for you and for business", "Vision Zero strategy". Each of these action points was underpinned by two to three task packages. In order to ensure the sustainability of this roadmap, three milestones were set: The Third International Strategy Conference in Dresden, the International Symposium on Culture of Prevention in September 2013 in Helsinki and the XX World Congress on Safety and Health at Work 2014 – Global Forum for Prevention in August 2014 in Frankfurt.

More information: http://www.dguv.de/iag/en/veranstaltungen_en/strategie2013/index.jsp

Contributed by Dr Walter Eichendorf and Dr Ulrike Bollmann, German Social Accident Insurance (DGUV)

International seminar on ergonomics and gender for sustainable development

The CINBIOSE research centre at the Université du Québec à Montréal and the Instituto de Salud Pública of Chile, both WHO collaborating centres for occupational health, held an international seminar in March of this year in Santiago to report the results of joint projects and discuss their implications. Their current project, financed by the Canadian International Development Agency, concerns teaching, intervention and research in gender and ergonomics. It developed from an earlier joint research effort on gender and mental health at work.

The week of events started with a two-day course in ergonomic analysis and gender, taught by CINBIOSE researchers together with Chileans Pamela Astudillo and Carlos Ibarra, researchers currently being trained in ergonomic analysis at CINBIOSE. Participants, labour and occupational health inspectors, learned to identify dangerous situations in both women's and men's jobs. They discussed how to intervene to prevent injuries and illnesses, particularly musculoskeletal disorders.

Later in the week, experts in occupational health from France, Spain, Argentina, Venezuela, Chile and Canada participated in a colloquium called "Salud Ocupacional, Ergonomía y Género, realidad actual y futura" (Occupational Health, Ergonomics and Gender: Current and Future Reality).

According to the Encuesta Nacional de Empleo - Situación en la Fuerza de Trabajo of 2012-2013, the Chilean labour force is 60% male, but women are becoming more numerous in agricultural production, manufacturing, food service and even mining. Therefore, said Luis Caroca, head of ergonomics at the Occupational Health Department of the Instituto de Salud Pública, "[A gender lens] requires that we consider that women become more vulnerable if gender isn't involved in evaluation, prevention and promotion in occupational health interventions". In the words of Montserrat López of the Barcelona-based Instituto Sindical de Trabajo, Ambiente y Salud (ISTAS), it is necessary to "take into account certain morphological characteristics in (designing) tasks that men and women do, thus, understand that their risks can be different." In particular, worksite design, clothing and protective equipment conceived with men in mind should be adapted to the sizes and shapes of women's bodies.

Astudillo and Ibarra presented their research on the gendered distribution of jobs in Chile as well as the gendered distribution of tasks, risks and musculoskeletal disorders. At the colloquium they and other researchers emphasized the fact that the dangers in women's jobs remain less visible than those in men's jobs. Astudillo and Ibarra also reported on anthropometric differences between Chilean women and men: an average of 2.8 cm separates the hand width of women and men, while there is a 14 cm difference in height, implying gendered risks for those who prepare fish products for market in Chile.

The president and past president of the Chilean Ergonomics Society (SOCHERGO) participated in the

seminar, showing that gender is increasingly part of the vision of ergonomics in Chile. The University of Valparaiso and the Centro de estudios de la mujer of Santiago also participated in organizing the project.

Links :

Reports of the Joint Project (Spanish): http://www.ispch.cl/noticia/19058

Contributed by Karen Messing, Montreal, Quebec, Canada, CINBIOSE, WHO collaborating centre for occupational health

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New publications

Most recent country profile series:

German profile: http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/occupational-health/news/news/2012/12/germany-model-of-good-governance-for-workers-health

Finnish profile: http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/occupational-health/publications/2012/national-profile-of-occupational-health-system-in-finland

National asbestos profile of Japan http://envepi.med.uoeh-u.ac.jp/NAPJ.pdf

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The **five keys for healthy workplaces** are now available in eleven languages on the WHO website:

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

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WHO Global Plan of Action on Workers' Health: Baseline for Implementation – report of 2008/2009 survey among 120 countries now published on the WHO website
http://www.who.int/entity/occupational_health/who_workers_health_web.pdf

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Health indicators for sustainable development: Healthy jobs -
http://www.who.int/entity/hia/green_economy/indicators_jobs.pdf

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Health in the Green Economy: Occupational Health
http://www.who.int/entity/hia/green_economy/hgebrief_occ.pdf

Forthcoming meetings

9th Annual Forum on Health, Safety and Environment in the Energy Sector, Doha, Qatar, 30 September 2 October 2013. WHO will present its global action on prevention and control of non-communicable diseases among workers http://www.fleminggulf.com/conferenceview/9th-Annual-HSE-Forum-in-Energy/284/Programme/4504

The Third Global Forum on Human Resources for Health will be held from 10 – 13 November 2013, at the Pernambuco Convention Centre in Recife, Brazil. WHO Greening the Health Sector together with ILO Sectoral Activities and HIV/AIDS will launch the newly developed tool: Health WISE , an active participation guide to workplace improvements in the health sector. This tool, based on the ILO Work Improvement in Small Enterprises approach was developed by a tripartite working party of experts in July 2010 and piloted in Senegal, Tanzania and Thailand. Version 1 of the tool has been produced based on the experiences of the pilots and extensively revised.
 http://www.who.int/workforcealliance/forum/2013/en/

ICOH SC Joint Conference

23-26 September 2013 - SENAC University Center São Paulo, Brazil

9th International Conference on Occupational Health for Health Care Workers
International Conference on Occupational Health & Development
International Conference on Occupational Health Nursing
International Conference on Occupational Infectious Agents

WHO preconference on Protecting Health Workers 22 September 2013: Preventing occupational exposure to bloodborne pathogens toolkit.

http://www.healthcareworkers2013.com/pre-conference-courses/

This workshop with presenters from WHO, Riscobiologico- Brazil and US NIOSH will distribute and demonstrate the revised tool kit with tools for assessment and management of occupational risks, workplace walkthrough guide, selecting safer devices tools, surveillance of occupational exposures and use of data for prevention. Participants will develop an action plan for implementation of the tools and resources in their country/institution.

Also on 22 September, a separate preconference will finalize the development of surveillance indicators in health care and report on the newly developed standards from EMRO.

Link for the Conference: http://www.healthcareworkers2013.com/

International diploma in mental health law and human rights

The International Diploma on Mental Health Law and Human Rights is currently accepting applications

for the academic year 2013-14. The Diploma, now in its fourth year of existence, is a collaboration between WHO and the ILS Law College in Pune, India. The course builds the capacity of students to advocate for human rights and to influence national legislative and policy and service reform in line with the UN Convention on the Rights of Persons with Disabilities and other key international human rights standards. It is a one year Diploma and includes two residential sessions and distance learning.

Students to date have comprised health and mental health professionals, lawyers, mental health service users/survivors, government officials, social workers, human rights defenders and families and carers. The course is taught be a faculty of renowned international experts in the area.

The prospectus for the Diploma can be requested from Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse (funkm@who.int). More information about the Diploma is also available at: http://cmhlp.org/diploma

Applications can be submitted online at: http://cmhlp.org/applications-and-fees/how-to-enroll

In addition the Open Society Institute (OSI) will provide funding for two students from Central & Eastern Europe/former Soviet Union to participate in the course**.** These are fully funded fellowships and include tuition fees, travel, accommodation & living expenses for the residential sessions. If you are interested and qualify for this grant please state that you wish to be considered for the OSI fellowships in your application.

International master in mental health policy and services

The International Master in Mental Health Policy and Services, an international course promoted by the NOVA University of Lisbon in collaboration with WHO, is now currently accepting applications for the academic year 2013-2014. The main scope of the Master Degree in International Mental Health Policy and Services (MHPS) is to build capacity of mental health professionals to lead and contribute to conceiving, formulating, implementing and evaluating:
• National Mental Health Policy
• National Mental Health Legislation
• Mental Health Services and Care Delivery

The course will start on the 7th October 2013, with a two-week residential session, at the Faculdade de Ciências Médicas campus in Lisbon. A second two-week residential session will take place in Lisbon, from 31 March to 11 April 2014. Between the two residential sessions, the students will participate in e-learning teaching activities under the orientation of supervisors.

The second year of the Course will be dedicated to the development of a project and the elaboration of the dissertation, under the orientation of a supervisor. The brochure for the course can be requested from Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse (funkm@who.int). Additional information about the Course can be found at the site: http://www.fcm.unl.pt/

Useful WHO links

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

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