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#### PLAN OF ACTION ON WORKERS' HEALTH

##### Introduction

1. This document presents the new Plan of Action on Workers' Health for the period 2015-2025, which aims to address the current situation resulting from the challenges and changes that the world of work imposes. The new Plan of Action is consistent with the WHO Global Plan of Action on Workers' Health 2008-2017 (1). It is based on the Pan American Health Organization (PAHO) conceptual framework on health and human rights (Resolution [CD50.R8](#) [2010]), regional guidance on the social determinants of health (2), the Plan of Action on Health in All Policies (Resolution [CD53.R2](#) [2014]), the new United Nations Sustainable Development Goals, the PAHO Strategic Plan 2014-2019 (Resolution [CD53.R3](#) [2014]), and the Strategy for Universal Access to Health and Universal Health Coverage (Resolution [CD53.R14](#) [2014]).

2. The Plan contains strategic lines of action, and specific objectives and indicators aimed at protecting workers'<sup>1</sup> lives and promoting their health and well-being, with emphasis on workers in inequitable conditions of employment and those exposed to hazardous working conditions. It seeks to reduce occupational risks<sup>2</sup> and noncommunicable diseases, targeting actions in certain critical economic sectors, as well as to address access to health and universal health coverage and the social determinants related to workers' health.

##### Background

3. The Regional Plan on Workers' Health (Document [CD41/15](#) [1999]) was formulated after the 1992 Earth Summit (3), where the concept of sustainable development arose, and the 1995 Pan American Conference on Health and Environment

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<sup>1</sup> In this document, the term "workers" refers both to male and female workers.

<sup>2</sup> Occupational risks include workplace injuries, occupational diseases, and deaths that occur in the workplace.

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in Sustainable Human Development (4). It was based on the mandates of the PAHO Governing Bodies on workers' health, as stipulated in Resolution CSP23.R14 (1990) (5); on the Declaration on Occupational Health for All (6); and on the Global Strategy on Occupational Health for All (7); and took into account WHO's general health policies and PAHO Strategic and Programmatic Guidance 1999-2002 (8). These mandates call for protecting and promoting workers' health, and preventing occupational risks.

4. The evaluation of the activities of the previous regional plan, carried out in 1999-2006 (9, 10), served as the basis for its initial adjustment, taking into account the PAHO Strategic Plan 2008-2013 (*Official Document 328* [2009])<sup>3</sup> and the WHO Global Plan of Action on Workers' Health 2008-2017. Between 2007 and 2012 its actions had greater impact with the implementation of initiatives that reached a larger number of Member States. These include the initiative to protect the health of healthcare workers in 17 countries (11), the regional strategy to eliminate silicosis in five countries (12), and advances made in the plan for the prevention and control of occupational and environmental cancer in 16 countries (13). The support of the network of PAHO/WHO Collaborating Centers in Occupational Health was crucial to achieving these results. Nevertheless, the plan was not uniform in scope, since it was not possible to reach all the countries of the Region.

5. In 2008, the report of the WHO Commission on the Social Determinants of Health (14) recognized that employment<sup>4</sup> and working<sup>5</sup> conditions are social determinants of health, that they provide well-being and economic stability, and that although employment and work can favor sustainable human development, they can also contribute to health inequalities. The multidimensional global study conducted by the Employment Conditions Network, which analyzes the relationships between employment and work on one hand, and health inequalities on the other, concluded that unequal employment conditions<sup>6</sup> and hazardous working conditions contribute to inequalities (15). The final report urges the formulation of policies and interventions to improve employment and working conditions; address the health conditions and well-being of workers; promote decent (16), healthy, and productive work; and improve comprehensive care for workers.

6. For these reasons, the progress report on the Regional Plan on Workers' Health presented during the 52nd Directing Council ([CD52/INF/4](#) [2011]) recommended that it

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<sup>3</sup> Strategic Objective 8: "To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health."

<sup>4</sup> Employment conditions: Conditions or circumstances in which a person perform a job or occupation. This often involves an agreement or relationship between an entrepreneur who hires a worker and an employee who offers his/her labor. Source: Glossary of employment and working conditions. Appendix. (15).

<sup>5</sup> Working conditions: The general working conditions that in many ways determine people's work experiences. These are the variables that define the completion of a given task and the setting in which it is completed, determining three aspects of workers' health: physical, psychological, and social. Source: Glossary of employment and working conditions. Appendix. (15).

<sup>6</sup> Unequal employment conditions refer to underemployment, unemployment, and informal work.

be updated, taking into account the impact of workers' health on the productivity of the countries and the Region, and on the health sector.

### **Situation Analysis**

7. *The regional workforce and employment conditions.* According to the International Labor Organization (ILO) (17), the Region's workforce is made up of 484.7 million workers, who represent 49.9% of the total population (974 million) of the Region. Latin America and the Caribbean contribute 62.3% (302.1 million) and North America (United States and Canada) 37.7% (182.6 million) (18). Globalization, economic crises, and changes in the world of work caused a deceleration in regional development, resulting in slower growth for Latin America and the Caribbean (only 1.1% at the end of 2014) (19). From 2013 to 2014, workforce participation rates declined (from 60.3% to 59.9%) and employment rates (from 56.5% to 56.2%), due to the buoyancy of the economy and the lack of new jobs, which affected women and young people in particular, with an increase in informal work and other forms of vulnerable employment.

8. *The informal sector.* In 2011, the informal sector constituted more than 54% of the Region's workforce (20). The statistics on the informal economy ([ILO, 2012](#)) indicate that the countries with proportions of informal<sup>7</sup> employment greater than 60% at that time were Bolivia (75.1%), Ecuador (60.9%), El Salvador (66.4%), Honduras (73.9%), Nicaragua (65.7%), Paraguay (70.7%), and Peru (69.9%). That same year, the countries with proportions of people in the informal<sup>8</sup> sector higher than 45% were Bolivia (52.1%), Colombia (52.2%), El Salvador (53.4%), Honduras (58.3%), Nicaragua (54.4%), and Peru (49%). The informal economy includes low-income groups, a high proportion of which live below the poverty line. Also in 2011, the First Central American Survey on Working Conditions and Health (21) was conducted with a representative sample of 12,024 formal and informal workers in Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. It was found that in Central America as a whole, the most common type of employment was self-employment (37%); that 8% of the surveyed population lacked employment contracts; and that 74% was not covered by social security (22). These results shed light on employment conditions and informal work.

9. *Exposure to hazardous working conditions.* The First Central American Survey on Working Conditions and Health also revealed a high prevalence of exposure to hazardous working conditions (high temperatures, solar radiation, etc.), discrimination, and workplace violence (3-4%). Other surveys conducted between 2007 and 2009 in Argentina, Colombia, Chile, Guatemala, and Nicaragua indicated exposure to various

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<sup>7</sup> Informal employment refers to the total number of people whose main job is informal. Employment is informal when it lacks basic social or legal protections, or social benefits. It can be found in the formal and informal sectors, and in domestic work.

<sup>8</sup> Work in the informal sector refers to the total number of people in informal production units, which are characteristically unorganized; produce goods or services for sale or exchange; they lack official registries, are small in size, have unregistered workers, and do not keep worker records.

hazardous conditions (chemical, physical, and biological agents; ergonomic and psychological stressors; and unsafe conditions) (23), whose effects may be aggravated by other phenomena, such as climate change in agricultural work (heat, drought, etc.) and increasing urbanization, which creates short-term, low-wage employment without opportunities for improvement through professional development or higher remuneration.

10. *Occupational injuries.*<sup>9</sup> Exposure to workplace hazards is the cause of the silent global epidemic of occupational diseases (according to WHO, 140 million new cases every year), injuries, and occupational deaths (2.4 million every year according to the ILO) (18). In 2007 it was estimated that in the Region there were at least 7.6 million occupational injuries (20,825 a day), of which nearly 11,343 were fatal; and they were more frequent in men than in women. A total of 5,232 deaths occurred in Latin America and the Caribbean. Construction, mining, agriculture, and transportation are the sectors with the highest number of fatal accidents (24). Although the causes and consequences of the occupational injuries are easily identifiable and are reported almost immediately, the figures do not fully reflect the situation in the Region, since they exclude the population not affiliated with social security systems, in addition to high underreporting in the countries. In 2009, Chile estimated 38% underreporting of occupational injuries (376,078 cases) (25). In 2008, the Committee on Education and Labor of the United States House of Representatives reported that nearly 69% of occupational injuries and illnesses were not registered in the Survey of Occupational Injuries and Illnesses of the Occupational Safety and Health Administration (OSHA), as a result of which stricter recordkeeping requirements were to take effect in 2015 (26).

11. *Occupational disease* is greatly underreported due to its long latency period, making it difficult to identify. This means that it remains invisible among the records of non-occupational diseases. In 2007, PAHO recognized that the mixed profile of occupational pathologies is not reflected in the official statistics of the Region (18). Only 1–5% of occupational diseases are reported (27), due to the low coverage of health systems and workers' compensation systems, the scarcity of occupational health and safety services (<30%), and the lack of visibility of the informal sector and rural workers. The lack of knowledge of health professionals (especially in Latin America and the Caribbean) and deficient information, surveillance, and recordkeeping systems in the countries are the main causes of underreporting (28). The study of the global burden of disease in 2010 (29) showed the existence of premature death attributable to occupational risks and years of productive life lost due to disability by occupational diseases. Occupational low back pain is the leading cause of disability (the highest rates of loss of disability adjusted life years per inhabitant), increasing by 22% as a risk factor between 1990 and 2010 (30). The WHO Global Health Observatory (31) has estimated that occupational risks contributed nearly 15% of the global burden of disease.

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<sup>9</sup> The English term “occupational injuries” corresponds to “*accidentes de trabajo*” or “*accidentes laborales*” in Spanish.

12. *Communicable and noncommunicable diseases.* Working-age adults (18-65 years) are exposed to communicable diseases at or outside of work, and to conditions that put them at risk of noncommunicable diseases, which are the leading cause of death in the Region (Resolution [CSP28.R13](#) [2012]). Both jeopardize health in the middle of the life course or are caused by work (occupational diseases), requiring comprehensive health surveillance by monitoring exposure to occupational risks and the risks of everyday life. It is necessary to address pathologies with high morbidity and mortality, such as chronic kidney disease of nontraditional origin, which affects agricultural workers in Central America (Resolution [CD52.R10](#) [2013]). Etiologic studies of this disease are not yet conclusive, but suggest known occupational causes and aggravating environmental factors. Accordingly, studies continue on exposure to the factors that cause kidney damage and on actions to mitigate it.

13. *The costs of the burden of occupational risks (occupational injuries, diseases, and deaths).* Occupational risks impose high costs, amounting in 2007 to 4.4% of regional GDP (10) and in 2012 between 1.8% and 6% of GDP in countries worldwide (averaging 4%, according to the ILO). This figure rises to 15% of GDP when losses due to involuntary early retirement are considered (32). In the United States, the burden of occupational risks was estimated at 250 billion dollars in 2007 (27% due to medical expenditures and 73% due to the indirect costs of injuries and diseases) (33). This amount was equivalent to the cost of cancer treatment programs, but workers' compensation systems covered only 25% of the cost of occupational risks.

14. *Prevention of occupational risks as a cost-containment strategy.* The preceding figures suggest that the burden and costs of providing health services are assumed by health systems through their budgets, despite the fact that employers and workers' compensation systems are responsible for these costs. There is an imbalance between the investment made in occupational health and safety and the high cost of the consequences of not making such investments. Prevention programs cost less than providing care, making them a sound cost-containment strategy for health systems.

15. *Workers' rights:* The aim is to support countries in their promotion and protection of workers' rights, including from the perspective of the right to health where nationally recognized, or promoting the right to the enjoyment of the highest attainable standard of health, and to address the ILO Declaration on Fundamental Principles and Rights at Work.<sup>10</sup>

16. *Lessons learned and successful projects.* The Member States have carried out successful activities that serve as examples, including the following: a) the creation and

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<sup>10</sup> ILO Declaration on Fundamental Principles and Rights at Work: Adopted in 1998, it commits the Member States to respecting and promoting principles and rights in four categories, whether or not the relevant conventions have been ratified: freedom of association and freedom to form unions and recognition of the right to collective bargaining; the elimination of all forms of forced or compulsory labor; the abolition of child labor; and the elimination of discrimination in respect of employment and occupation. Source: <http://www.ilo.org/declaration/thedeclaration/lang--en/index.htm>

strengthening of national intersectoral committees and commissions on occupational health, in which various social actors and even national networks took part in addressing local conditions (34); *b*) the development of standardized research methodologies, such as the aforementioned surveys, to paint a clear picture of workers' health in the countries and the Region (22); *c*) the creation of communities of practice with an ecosystem approach in Canada, Central America, the Andean area, and the Southern Cone, which has also helped to address workers' health issues (35); *d*) the development of educational materials and courses to disseminate information for the prevention of cancers of occupational and environmental origin; *e*) the participation of PAHO in the Inter-American Conference of Ministers of Labor (ICML) of the Organization of American States (OAS), which raised the ministers' awareness of the regional profile of occupational morbidity and mortality, and led to the inclusion of workers' health and well-being in their Action Plan 2014-2015, as well as the promotion of dialogue with the ministries of health.

17. *Some options to address existing problems.* Preventive interventions in the workplace aimed at protecting and safeguarding workers' health and lives require collaborative actions coordinated with all economic sectors. The ministries of health play a key role in strengthening public policies and regulations on workers' health in the countries, with a view to implementing intersectoral policies and strategies in close coordination with the ministries of labor and other sectors of interest (environment, education, mining, and agriculture). Access to adequate, comprehensive, integrated, health services should be expanded, including primary care services and referral services (all of these being consistent with PAHO's Strategy on Universal Access to Health and Universal Health Coverage, WHO's global plan of action on workers' health,<sup>11</sup> and the Sustainable Development Goals).

## **Plan of Action**

### **Goal**

18. The goal of this Plan of Action is to strengthen the health sector's response, in coordination with other stakeholder sectors, in order to provide comprehensive workers' health services, improve work environments, increase efforts to promote workers' health, and reduce health inequalities by implementing updated policies, plans, and regulations.

19. To achieve this goal, Member States will strengthen their technical and institutional capacities; their initiatives to prevent and control the conditions that cause occupational injuries, diseases, and deaths; and the promotion of health and well-being in the workforce. The leadership of the health authorities, in harmony and collaboration with the ministries of labor and other economic sectors, will make it possible to lay the

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<sup>11</sup> WHO. *Workers' health: Global plan of action*. 60th World Health Assembly, May 2007 (Resolution WHA60.26). Available from: [http://www.who.int/occupational\\_health/publications/global\\_plan/en/](http://www.who.int/occupational_health/publications/global_plan/en/).

groundwork of health in all policies, close the inequality gaps in workers' health, and improve universal access to health and universal health coverage for all workers.

### **Strategic Lines of Action**

20. In order to address the issues highlighted in the situation analysis, the plan proposes the following strategic lines of action to support Member States, as appropriate, taking into account their context, needs, and priorities:

- a) Develop and update legislation and technical regulations on workers' health.
- b) Identify, evaluate, prevent, and control hazardous conditions and exposures in the workplace.
- c) Increase access to and coverage of health services for workers.
- d) Promote health, well-being, and healthy work in the workplace.
- e) Strengthen diagnostic capacity, information systems, epidemiological surveillance, and research in the field of occupational diseases, injuries, and deaths.

#### ***Strategic Line of Action 1: Develop and update legislation and technical regulations on workers' health***

21. It is necessary for the public health policy agenda of the ministries of health to make workers' health a priority. The health-in-all-policies approach facilitates an intersectoral approach to this. National occupational health committees, councils, and commissions that have served as multisectoral forums have a key role in defining, updating, and following up on policies and legislation.

<b>Objective</b>	<b>Indicator</b>	<b>Baseline (2014)</b>	<b>Target (2025)</b>
<b>1.1</b> Develop and update legal instruments to monitor compliance with policies and technical standards for surveillance and control of conditions that jeopardize workers' health, well-being, and lives, in accordance with international conventions of the International Labor Organization (ILO), human rights instruments applicable to health, and public health standards	<b>1.1.1</b> Number of countries with regulations on occupational safety and health, updated in accordance with ILO conventions and WHO international health recommendations	9	20
	<b>1.1.2</b> Number of countries with lists of occupational diseases, updated in accordance with the ILO list	4	20

Objective	Indicator	Baseline (2014)	Target (2025)
1.2 Strengthen national coordination and capacity to effectively address workers' health in countries	1.2.1 Number of countries with national workers' health plans integrated into national public health plans	6	20
	1.2.2 Number of countries with functioning national committees or councils on occupational health	9	25
	1.2.3 Number of countries with functioning networks of occupational health <sup>12</sup> committees (34)	1	10

***Strategic Line of Action 2: Identify, evaluate, prevent, and control hazardous conditions and exposures in the workplace***

22. The primary prevention approach makes it possible to identify the sources, means of transmission, and magnitude of occupational risks or risk factors (chemical, physical, biological, psychosocial, and hygienic factors, and ergonomic stressors) that can negatively impact health, and to identify, evaluate, and control them through the use of occupational health sciences (hygiene, safety, ergonomics, and occupational medicine). In order to focus actions, certain critical economic sectors were identified because of their high rates of injury, disease, mortality, and inequality (the informal sector, mining, agriculture, and health). Other current initiatives that address chronic exposures with long-term effects (silica, asbestos, carcinogens, etc.) will be continued.

Objective	Indicator	Baseline (2014)	Target (2025)
2.1 Strengthen the capacity of the Member States to develop and implement initiatives that identify and control hazardous agents and other conditions of risk and inequality in the workplace	2.1.1 Number of countries implementing training programs on occupational health	14	24
	2.1.2 Number of countries with occupational health research centers devoted to research on workers' health and its social determinants	16	30
2.2 Develop and implement comprehensive health programs that identify and control hazardous agents and	2.2.1 Number of countries with programs on workers' health and well-being implemented in the informal sector	9	20

<sup>12</sup> Occupational health: The set of multidisciplinary activities aimed at promoting and maintaining the highest degree of physical, mental, and social well-being of workers in all occupations, promoting the adaptation of work to the person and each person to his/her job. Synonyms: occupational health and safety; workplace health and safety. Source: Joint ILO/WHO Committee on Occupational Health, 1950.



Objective	Indicator	Baseline (2014)	Target (2025)
other conditions of risk and inequality in selected critical economic sectors	<b>2.2.2</b> Number of countries with comprehensive workers' health and well-being programs implemented in the health sector	15	25
	<b>2.2.3</b> Number of countries with comprehensive workers' health programs established in the mining sector	9	15
	<b>2.2.4</b> Number of countries with comprehensive occupational health programs implemented in the agriculture sector, with emphasis on exposure to pesticides	16	26
<b>2.3</b> Advance with programs to prevent occupational diseases, in particular those related to asbestos, silica, carcinogenic agents, ergonomic stressors, and psychosocial risks	<b>2.3.1</b> Number of countries participating in the silicosis elimination initiative <sup>13</sup>	6	15
	<b>2.3.2</b> Number of countries that have developed programs for the prevention of occupational cancer and matrices for occupational exposure to carcinogens (CAREX) <sup>14</sup>	7	16
	<b>2.3.3</b> Number of countries implementing asbestos-related disease prevention programs <sup>15</sup>	15	25
	<b>2.3.4</b> Number of countries with programs for the prevention of musculoskeletal disorders <sup>16</sup>	6	15
	<b>2.3.5</b> Number of countries with developed and implemented programs for the prevention of psychosocial risks and for the control of workplace violence <sup>17</sup>	6	15

<sup>13</sup> ILO/WHO Global Programme for the Elimination of Silicosis. [Americas Elimination of Silicosis Initiative](#).

<sup>14</sup> PAHO Initiative for the prevention of occupational cancers (2014).

<sup>15</sup> [Americas Asbestos Atlas Project](#) (2012-2015).

<sup>16</sup> It is understood that it includes control of ergonomic stressors.

<sup>17</sup> Framework Guidelines for Addressing Workplace Violence in the Health Sector, ILO/ICN/WHO/PSI 2002.

***Strategic Line of Action 3: Increase access to and coverage of health services for workers***

23. Given the estimated magnitude of the damage to workers' health, it is necessary to strengthen access to and coverage of comprehensive health services. To achieve this, WHO proposes integrating basic occupational health services into primary healthcare services. It is expected that doing so will increase access and coverage, especially for workers in the informal sector, while at the same time facilitating access to specialized occupational medicine services and other clinical specialties.

Objective	Indicator	Baseline (2014)	Target (2025)
3.1 Improve access to and expand coverage of comprehensive occupational health services integrated into national health systems	3.1.1 Number of countries with basic occupational health services integrated into primary health care services	3	15
	3.1.2 Number of countries with primary health care professionals trained and certified in basic occupational health skills	3	15
3.2 Strengthen specialized occupational medicine services and other clinical specialties, as well as referral and cross-referral systems	3.2.1 Number of countries with functioning referral and cross-referral systems providing access to specialized occupational medicine services and other clinical specialties	4	12

***Strategic Line of Action 4: Promote health, well-being, and healthy work in the workplace***

24. The goal is to implement activities promoting workers' health, well-being, and quality of life, focusing on healthy and respectful work environments and workplaces, as well as quality of life at work, in order to contribute to the comprehensive care of adult workers; promote protective factors for noncommunicable diseases; promote employee assistance programs and return-to-work programs; and expand access to workers' compensation insurance and health insurance.

Objective	Indicator	Baseline (2014)	Target (2025)
4.1 Implement the initiative for healthy and respectful jobs and	4.1.1 Number of countries that have incorporated the WHO healthy workplaces model <sup>18</sup>	5	25

<sup>18</sup> [WHO Healthy Workplaces: a model for action](#) (WHO, 2010).

Objective	Indicator	Baseline (2014)	Target (2025)
workplaces, and for quality of life in the workplace	<b>4.1.2</b> Number of countries with comprehensive programs that promote workers' health and prevent noncommunicable diseases	2	25
	<b>4.1.3</b> Number of countries with networks of healthy workplaces	2	25
<b>4.2</b> Strengthen comprehensive health care for working-age adults in the workplace	<b>4.2.1</b> Number of countries that have incorporated periodic medical occupational evaluations in the working adult population (18-65 years old)	1	20
<b>4.3</b> Develop knowledge management mechanisms to translate the results of initiatives for health promotion, well-being, and quality of life in the workplace—as well as statistical data on occupational diseases, injuries, and deaths—into policies and regulations for prevention.	<b>4.3.1</b> Number of countries with publications that reflect the results of successful activities and experiences in health promotion, well-being, and quality of life at work	3	20
	<b>4.3.2</b> Number of countries with technical regulations issued based on results of activities and experiences in health promotion, well-being, and quality of life at work	0	15
	<b>4.3.3</b> Number of countries with publications that reflect the results of activities on the diagnosis, registration, and epidemiological surveillance of occupational diseases, injuries, and deaths in the workplace	8	14

***Strategic Line of Action 5: Strengthen diagnostic capacity, information systems, epidemiological surveillance, and research in the field of occupational diseases, injuries, and deaths***

25. The silent epidemic of occupational diseases and their associated high costs for health services indicate that it is urgent to improve and stimulate registration and information systems on workers' health, and to focus on preventive actions. It is necessary to improve diagnostic and registration capacities, as well as epidemiological surveillance of occupational risks, and to create or strengthen information systems on workers' health.

Objective	Indicator	Baseline (2014)	Target (2025)
<b>5.1</b> Strengthen and develop information and surveillance systems for occupational diseases, injuries, and deaths in the workplace	<b>5.1.1</b> Number of countries with functioning registration, and reporting systems for occupational diseases, injuries, and deaths in the workplace	6	15
	<b>5.1.2</b> Number of countries with occupational epidemiological surveillance systems functioning at the national level	5	15
<b>5.2</b> Develop and implement protocols or guidelines that facilitate the identification and diagnosis of occupational diseases	<b>5.2.1</b> Number of countries with implemented protocols or guidelines for the diagnosis of occupational diseases	4	15
	<b>5.2.2</b> Number of countries with complete statistics on occupational injury, morbidity, and mortality rates, distributed by sex, age, ethnic group, economic sectors, and rurality	6	20
<b>5.3</b> Establish national research agendas to determine working and employment conditions and related inequalities; and generate practical solutions, knowledge, and evidence for decision and policy makers	<b>5.3.1</b> Number of countries with an established national research agenda on working conditions, health, equity, and occupational diseases	8	20
	<b>5.3.2</b> Number of countries with research protocols and guidelines for interventions or preventive actions to control dangerous exposures <sup>19</sup>	7	14
	<b>5.3.3</b> Number of countries that have conducted surveys on working conditions, health, and equity (21, 22)	10	27
	<b>5.3.4</b> Number of countries with intervention or action protocols to minimize the occurrence of chronic kidney disease from nontraditional causes in Central America	1	6

### Monitoring and Evaluation

26. The proposed objectives and indicators will serve as a reference for monitoring and evaluating the progress made in 2015-2025. Progress will be evaluated at the end of each biennium to identify weaknesses and specific threats in the countries and the Region, and to evaluate the strengths and opportunities for moving forward in each country. At the end the first five years (2020), a progress report will be prepared for the

<sup>19</sup> Dangerous exposures are dangers or high-risk factors to which workers are exposed and which pose a high risk to workers' health and lives.

Governing Bodies, in which successful outcomes will be shared and priority actions reviewed. Furthermore, at the end of 2025, a final report on the results of the Plan of Action will be prepared.

### **Actions by the Pan American Sanitary Bureau**

27. These will focus on technical cooperation with the countries and subregions, in collaboration with WHO and the Network of Collaborating Centers in Occupational Health, in order to: advocate for and promote the Plan of Action; facilitate and support the implementation processes with guidelines, protocols, and other relevant instruments; disseminate, adapt, and develop courses, tools, and programs to facilitate institutional strengthening and capacity-building in the ministries of health in the countries; and disseminate the results on all the areas that the Plan addresses, to help translate them into policy tools and legislation in the countries.

### **Financial Implications**

28. The estimated cost of implementing the Plan for the 10-year period (2015-2025) is US\$ 1,000,000, which will cover the costs of technical cooperation to prepare and implement the Plan. This amount considers maintaining current personnel, as well as the focal points that work in activities related to workers' health and health in all policies. It is estimated that there will be a funding gap of 30% of the total budgeted amount, corresponding to the operating costs of technical cooperation with the countries and the necessary temporary contracts for expert support in specific activities. It is expected that the Member States will prioritize the issue and allocate resources to improve their workers' health programs and services. It will be important to forge partnerships with all organizations, institutions, and collaborating centers, and to identify donors who support the Plan in order to obtain the necessary resources to meet its targets.

### **Action by the Directing Council**

29. The Directing Council is requested to review the information provided in this document and to consider adopting the resolution presented in Annex A.

Annexes

### **References**

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## 54th DIRECTING COUNCIL

### 67th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 28 September-2 October 2015

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CD54/10, Rev.1  
Annex A  
Original: Spanish

### ***PROPOSED RESOLUTION***

#### **PLAN OF ACTION ON WORKERS' HEALTH**

##### ***THE 54th DIRECTING COUNCIL,***

Having reviewed the *Plan of Action on Workers' Health* (Document CD54/10, Rev. 1);

Recalling the specific mandates of the Governing Bodies of PAHO on workers' health and, in particular, Resolution CSP23.R14 of the 23rd Pan American Sanitary Conference (1990), which urges the Member States to increase the development of different institutional workers' health care arrangements in order to promote the attainment of universal coverage, and Resolution CD41.R13 of the 41st Directing Council (1999), which urges the Member States to include in their national health plans, as appropriate, the Regional Plan on Workers' Health contained in Document CD41/15, which proposes specific programmatic lines for the action of the Member States and for international cooperation;

Considering Resolution WHA49.12 (1996) of the World Health Assembly, which endorsed the Global Strategy on Occupational Health for All, and Resolution WHA60.26 (2007), which adopts the Global Plan of Action on Workers' Health 2008-2017, with its principal objectives, targets, and indicators, and requests the Director-General of WHO to step up collaboration with the International Labor Organization (ILO) and other relevant international organizations for the implementation of the global plan at the national and international levels;

Taking into account the document *The Future We Want*, of the United Nations General Assembly, in particular its recognition that health is a precondition for the three dimensions of sustainable development and is both an outcome and an indicator of those dimensions, and the document's call for participation by all relevant sectors in coordinated multisectoral action to urgently address the health needs of the world's population;

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Recognizing that work and employment are health-related human rights and social determinants of health; that the Rio Political Declaration on the Social Determinants of Health calls for the design and implementation of robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards, and programs across the social gradient, that go beyond economic growth; and the importance of promoting the health in all policies approach, led by the ministries of health;

Recognizing that increases in migration, aging populations, and occupational and noncommunicable diseases are very important trends shaping the profile of health in the Americas; and that health benefits have not been shared equally among and within the countries of the Region, meaning that inequality remains one of the greatest challenges facing workers' health and sustainable development in the Region of the Americas;

Aware that health systems are assuming the burden and costs of providing health services to formal and informal workers as a result of occupational diseases, which remain invisible due to the lack of diagnosis and adequate registration, and due to low investment in programs to prevent damage to workers' health, which would help the public sector contain these costs;

Aware of the large social, economic, and health-related inequalities and inequities that affect workers' health, especially in the informal sector, and recognizing that workers' health and healthy work environments are essential in order to achieve individual and community health and well-being, which are crucial for the sustainable development of the Member States;

Considering the Strategic Plan of the Pan American Health Organization 2014-2019 and, especially, the principles of category 3, on the determinants of health and promoting health throughout the life course,

***RESOLVES:***

1. To approve the *Plan of Action on Workers' Health* for the period 2015-2025.
2. To urge the Member States, as appropriate, and taking into account their national context, priorities, and financial capacity, to:
  - a) advocate for equality and the promotion of workers' health as a priority, and adopt effective measures to control employment and working conditions as social determinants of health, increase universal health coverage, and strengthen health systems and health equity;
  - b) adopt effective measures, including, where appropriate, measures involving current legislation, structures, processes, and resources in order to establish public policies that take into account impacts on workers' health and equity in workers' health; and implement mechanisms to measure and monitor working and employment conditions that impact workers' health;

- c) develop and maintain, as appropriate, adequate and sustainable institutional capacity and competencies to achieve, through action in all sectors, better outcomes from the perspective of workers' health and equity in workers' health;
  - d) use the relevant tools to identify, evaluate, mobilize, and strengthen participation and multisectoral activities to promote workers' health, including, as appropriate, the work of the interministerial committees and the analysis of impacts on health;
  - e) strengthen due diligence and accountability and increase transparency in decision-making and commitment to action;
  - f) involve, as appropriate, workers and labor unions, employers and sectoral organizations, local communities, and other civil society actors in the formulation, implementation, monitoring, and evaluation of policies in all economic sectors, especially those identified as priorities, including mechanisms for community and public participation;
  - g) contribute to the preparation of the post-2015 sustainable development agenda by emphasizing that policies in sectors other than the health sector have significant impacts on health outcomes; and determine the synergies between policy objectives in the health sector, the labor sector, and other sectors;
  - h) promote active participation of the health authorities with other sectors when implementing the strategy of health in all policies.
3. To request the Director to:
- a) promote and support the dissemination and implementation of the integrated approach to action proposed in the *Plan of Action on Workers' Health*;
  - b) pay special attention to the development of institutional partnerships, both in the national and international contexts, including the mobilization of extrabudgetary resources to implement intersectoral activities that facilitate the design and consolidation of preventive activities within the framework of the integrated approach to prevention;
  - c) continue to support the ministers of health in their efforts to promote and improve workers' health and well-being;
  - d) continue to promote and support the development of the network of PAHO/WHO Collaborating Centers and scientific institutions in order for them to contribute to the strengthening of the technical, scientific, and administrative capacity of institutions and programs in the field of workers' health;
  - e) promote and support cooperation among countries in the field of workers' health.

## Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

### 1. Agenda item: 4.7 - Plan of Action on Workers' Health

### 2. Linkage to Program and Budget 2014-2015:

a) **Categories:** 3, Determinants of health and health promotion throughout the life course.

b) **Program areas and outcomes:**

Program area 3.5, Health and Environment.

OCM 3.1.7, Number of countries with increased access to and coverage of periodic medical occupational evaluations of the adult working population (18-65 years of age).

OCM 3.5.4, Number of countries with the capacity to address workers' health, with emphasis on critical economic sectors and occupational diseases.

### 3. Financial implications:

a) **Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities):**

Technical and financial cooperation is required with all the organizations, institutions, and collaborating centers that PAHO works with to disseminate and implement the new Plan of Action on Workers' Health. It is calculated that \$1,000,000 over a 10-year period (2015-2025) will defray the costs of technical cooperation to implement this Plan. This amount considers maintaining current staff, as well as the focal points who work in related activities in the four subregions. The Pan American Sanitary Bureau will use its technical capacity to promote technical cooperation among countries, as well as the strengthening of networks in the Region with a view to obtaining the resources needed to meet the targets of this Plan of Action. These costs will be reviewed every biennium and details will be included in the respective biennial work plans.

b) **Estimated cost for the 2016-2017 biennium (including staff and activities):**

A total of \$11,555,000 has been allocated to program area 3.5 (Health and the Environment) for the 2014-2015 biennium, which includes workers' health.

c) **Of the estimated cost noted in b), what can be subsumed under existing programmed activities?**

Currently available financing for workers' health can be allocated to the Plan of Action from the PAHO regular budget, WHO contributions, and extrabudgetary sources. Efforts will also be made to mobilize resources to support the implementation of the Plan.

**4. Administrative implications:**

- a) Indicate the levels of the Organization at which the work will be undertaken:**  
The Plan of Action on Workers' Health will be implemented at the regional, subregional, national, and subnational levels, in close collaboration with the ministries of health, and will spread to other sectors of government, particularly the ministries of labor and their social stakeholders: workers, employers, and civil society.
- b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):** In order to implement this Plan, PAHO will maintain current staff, as well as the focal points who work in activities related to workers' health in the four subregions. The Pan American Sanitary Bureau will use its technical capacity to promote technical cooperation among countries, as well as the strengthening of networks in the Region with a view to obtaining the resources needed to meet the targets of this Plan of Action.
- c) Time frames (indicate broad time frames for the implementation and evaluation):**
- January-March 2015: prepare and draft the Plan of Action in close collaboration and consultation with the different areas of PAHO and with the network of PAHO/WHO Collaborating Centers for Occupational Health.
  - April 2015: hold high-level regional consultations on the draft Plan of Action.
  - June 2015: present the Plan of Action on Workers' Health to the Executive Committee.
  - June-September 2015: hold final consultations with countries and partners to finalize the Plan of Action on Workers' Health.
  - September 2015: present the Plan of Action on Workers' Health to the Directing Council for consideration.
  - September-December 2015: prepare a work plan to implement the Plan of Action on Workers' Health.
  - 2015-2020: first quinquennium of implementation of the Plan of Action on Workers' Health.
  - 2020: prepare and submit a progress report on the implementation of the Plan of Action on Workers' Health to the Directing Council.
  - 2025: prepare a final evaluation of the Plan of Action on Workers' Health and present it to the Directing Council.

## ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.7 - Plan of Action on Workers' Health

2. **Responsible unit:** Special Program on Sustainable Development and Health Equity (SDE)

3. **Preparing officer:** Dr. Julietta Rodríguez-Guzmán

4. **Link between Agenda item and Health Agenda for the Americas 2008-2017:**

The Plan of Action on Workers' Health is an important linchpin for public health in the 21st century, improving the quality of life of the Region's workforce. The multisectoral efforts that the Plan proposes will make health systems more effective, equitable, and accessible to all workers.

The Plan addresses several of the areas of action established in the Health Agenda for the Americas 2008-2017, namely:

- a) Strengthen the national health authorities, promoting and supporting the ministries of health.
- b) Address the determinants of health, in particular work and employment.
- c) Reduce inequities in workers' health among and within countries.
- d) Reduce the risk and burden of disease associated with occupational and noncommunicable diseases.
- e) Strengthen the management and development of health personnel.

5. **Link between Agenda item and the [PAHO Strategic Plan 2014-2019](#):**

This Plan of Action is linked with Category 3, "Determinants of Health and Health Promotion throughout the Life Course."

**Outcomes**

OCM 3.5 Reduced environmental and occupational threats to health.

**Outcome indicators**

OCM 3.1.7 Number of countries and territories increasing access and coverage of medical occupational evaluations for working adult populations (18-65 years of age).

OCM 3.5.4 Number of countries and territories with capacity to address workers' (occupational) health with emphasis on critical economic sectors and occupational diseases.



***Outputs (corresponding to PAHO Program and Budget 2014-2015)***

OPT 3.5.3 Countries enabled to develop and implement national policies, legislation, plans, and programs on workers' health.

***Output indicators***

3.5.3 Number of countries and territories with an occupational carcinogen exposure (CAREX) matrix and national information systems on occupational injuries and diseases.

**6. List of collaborating centers and national institutions linked to this Agenda item:**

- a) Ministries of health, the Inter-American Conference of Ministers of Labor of the OAS (IACML), including employers' and workers' delegates, and delegates from other sectors, including education, mining, agriculture, and environment; nongovernmental organizations of occupational health professionals (International Commission on Occupational Health [ICOH], Latin American Occupational Health Association [ALSO], Central American and Caribbean Occupational Health Federation [FECACSO], Ibero-American associations of occupational hygienists; Latin American Ergonomics Union [ULAERGO]); research networks of subregional communities of practice (CoPeLAC); Work, Health, and Equity Network; SALTRA network of Central American health and labor colleges; and other PAHO networks that promote workers' health.
- b) The PAHO network of Collaborating Centers in Occupational Health, consisting of 14 designated and five proposed institutions, is one of the two largest networks in the Organization and has been supporting the Plan of Action since its founding in 1992. The centers have carried out many collaboration, support, and research projects since then, and they wish to continue working with PAHO. They are the following entities: Fundacentro (BRA), SESI (BRA), Public Health Institute of Chile (ISPCH) (CHI), University of Quebec in Montreal (UQAM) (CAN), Canadian Centre for Occupational Health and Safety (CCOHS) (CAN), Quebec Occupational Health and Safety Research Institute (IRSST) (CAN), National Institute for Research on Toxic Substances (IRET-ONE) (COR), National Workers' Health Institute (INSAT) (CUB), St. George's University (GRA), NIOSH (USA), University of Texas in Houston (UTH) (USA), University of Illinois in Chicago (UIC) (USA), University of Massachusetts in Lowell (UML) (USA), and University of Maryland (UM) (USA). The five proposed centers are: University of Guadalajara (MEX), Autonomous University of Mexico (UNAM) (MEX), Occupational Cancer Research Centre (OCRC/CAREX-Canada) (CAN), El Bosque University (UEB) (COL), and the Occupational Health Office of the Ministry of Health of Peru (UNDER-DIGESA) (PER).
- c) Other United Nations agencies, such as the International Labor Organization (ILO), the United Nations Development Programme (UNDP), UN Women, the United Nations Food and Agriculture Organization (FAO), the Organization for Economic Cooperation and Development (OECD), the United Nations Environment Program (UNEP), and the Economic Commission for Latin America and the Caribbean (ECLAC).

**7. Best practices in this area and examples from countries within the Region of the Americas:**

- One of the most striking was the creation of national occupational health committees or commissions in the countries. Since the 1980s, these committees have proven to be an effective mechanism for consensus-building and policy-making on workers' health, safety, and well-being. They exist in countries of Central America and the Andean region and some, such as Colombia, have even created sectoral commissions to address the particular concerns of the economic

sectors and organize national networks of occupational health committees, ensuring that policies and technical standards reach all workplaces at the provincial and municipal levels.

- Another very gratifying experience was to contribute to the creation of manuals and guidelines for the prevention of Ebola during the recent epidemic that struck the African continent. In addition to the Cubans deployed there, two of our collaborating centers sent staff members from the United States and Canada to help in this effort to control the expansion of the epidemic.
- Another experience worth mentioning—one aimed at reducing the burden of cancer in the workforce, which is estimated to contribute up to 20% of the general burden of cancer in the Region—has led to several countries drafting occupational carcinogen exposure (CAREX) matrices. At this time, Canada, Colombia (in the insured population), Costa Rica, Guatemala, Nicaragua, and Panama have managed to identify the most frequent exposures to carcinogens in the workplace. Brazil has done the same only for silica and asbestos. Chile initiated activities in 2013 and Peru in 2014. Their results are expected for 2015, when activities will also begin in Argentina and Ecuador.
- Another very significant experience was an initiative to protect the health of healthcare workers in which, through the efforts of 17 countries, over 350,000 workers were vaccinated against hepatitis B, a great majority of health workers received training in preventing puncture injuries, and an epidemiological surveillance system was put in place for these events.

**8. Financial implications of this Agenda item:**

Technical and financial cooperation is required with all the organizations, institutions, and collaborating centers with which PAHO works to disseminate and implement the new Plan of Action on Workers' Health. It is estimated that US\$1,000,000 over a 10-year period (2015-2025) will defray the costs of technical cooperation to implement this Plan. This amount includes maintaining current staff, as well as the focal points who work in related activities in the four subregions. The Pan American Sanitary Bureau will use its technical capacity to promote technical cooperation among countries, as well as the strengthening of networks in the Region with a view to obtaining the resources needed to meet the targets of this Plan of Action.

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