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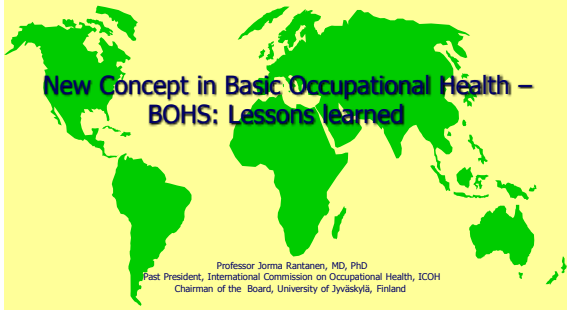

New Concept in Basic Occupational Health – BOHS: Lessons learned

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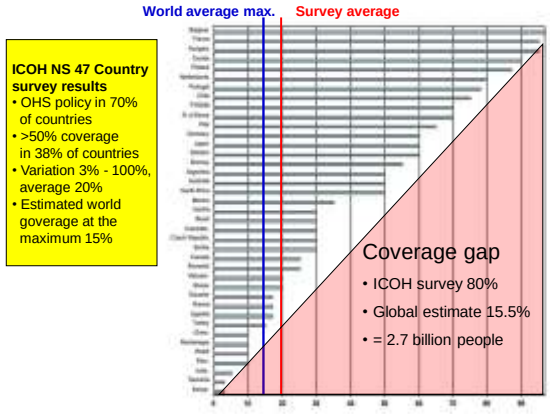
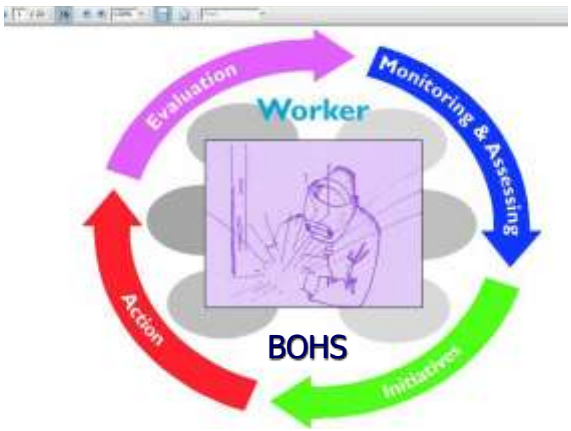


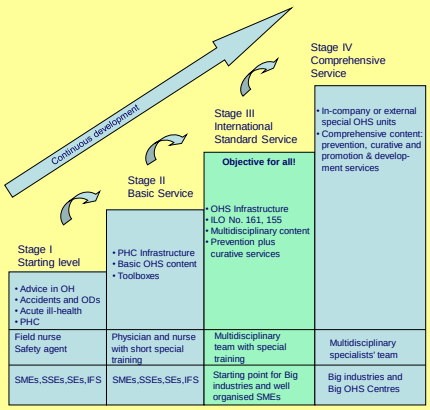
Workers of the world (total 2.7 billion)

Group	Number (mill)	% of world total	OBS
Developed economies	470	15	25% in hazardous jobs
Informal workers	1600	50	Most in South Asia and SSA
Working poor	1200	38	Most in South Asia and SSA
Agricultural workers	1300	41	91% in developing countries Women account for almost half of the agricultural workers
Economically vulnerable workers	1528	48	a) Own account workers and b) Unpaid family workers
Workers in high-risk and hazardous jobs	2200	70	Majority of workers in the less and least developed economies
SMEs	1056	30	OECD 132 Country Survey: 125 Mill formal MSMEs

International and national policy on BOHS

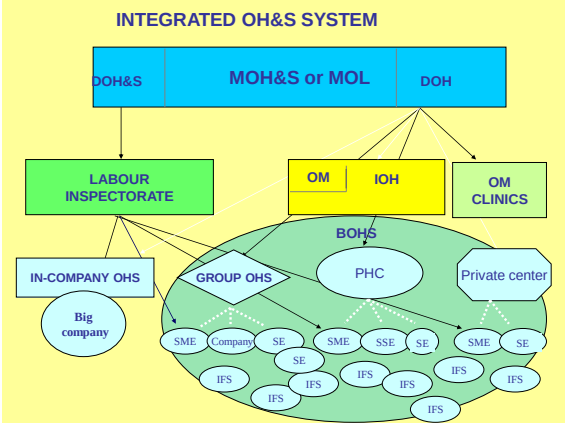
- ILO/WHO 13th Joint Committee on Occupational Health December 2003
- WHO Global Plan of Action: Workers Health 2007 (WHA)
- ILO Governing Body 2004 (GB289-STM-7-2004-01-0323-1-EN.Doc)
- WHO EMRO, EURO, PAHO and WPRO organized region-wide meetings for BOHS strategies in the Regions. Practical pilot projects have been supported byt the Regional Offices.
- Several countries included BOHS in either OSH or Health strategies (Serbia, Montenegro, Macedonia, China, Thailand, Turkey)
- Many governments expressed wish to implement and ask for support
- In the ICOH NS survey 29 Countries (62% of respondents) reported on some level of implementation of BOHS in their OHS system.





The very concept of BOHS: Is it needed, is it feasible?

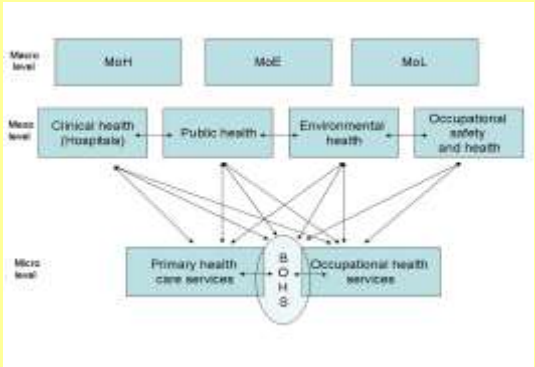
- BOHS cycle: As such feed-back supportive
- Feasibility: Stepwise development OK. Practically feasible if adjusted
- The principal idea of the BOHS: OHS for all including underserved groups and going to the grassroots levels seems to be strongly supported
- Pragmatic approach appreciated



BOHS and relationship to OSH system

The relationship varies between countries:

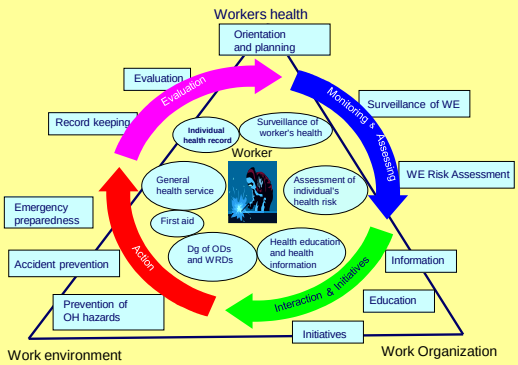
- In some countries OSH system highly interested and wants to collaborate
- In some countries so called "legal persons" see competition in risk assessment
- In some countries government organized close collaboration between OHS and OSH at the national governance level
- In some countries BOHS included into OSH strategies



BOHS and health system

- Numerous BOHS pilots have been implemented or are ongoing (see below)
- In some countries BOHS has been adopted by the Ministry of Health as a model for filling the gap in OHS coverage
- Some problems in some countries concerning the profile of occupational medicine vs. BOHS
- Some OM communities have felt threat that BOHS will dilute the traditional strong OM position
  - In some countries the authorities have misunderstood the idea of BOHS and thought OHS can be straigthforward delegated to GPs or family doctors
  - Some Public health/Primary health care authorities and institutions have presented position that OHS in general and also BOHS will add inequality by providing special services to workers
  - Public health theorists (and partly WHO) see OHS as a vertical system, which does not fit to the present integrated system doctrine on health services system
- Some health systems have absorbed BOHS very well as a part of the system and found benefit from it (Thailand, China, Turkey etc)

The BOHS cycle

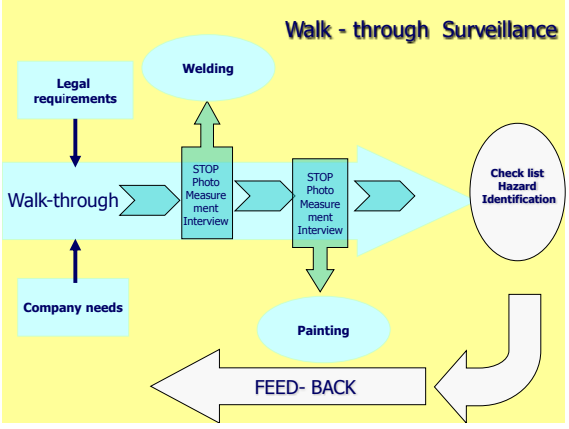


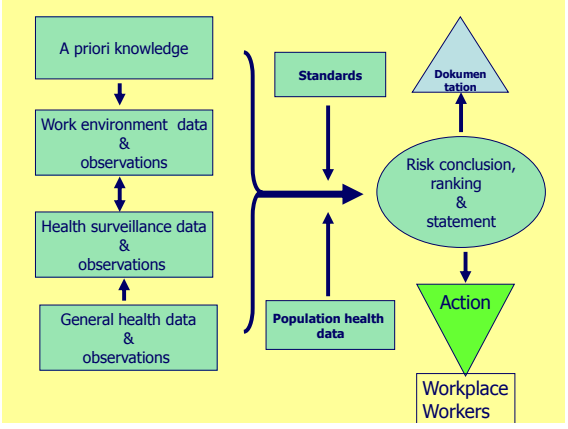
BOHS content and activities

- The ***BOHS cycle*** follows the ILO Convention 161 and Recommendation 171 principles and several well established good practice guidelines
- The ***content needs adjustment*** to national and local conditions and in the end of the day to individual workplaces' needs
- The ***users of the guidelines*** report back on positive impact in systematization of their work (even very senior ones)
- The BOHS practices need further support and several requests for ***advisory help*** have been presented
- The need for ***support from the secondary level*** is obvious. This means that either IOH or ministry or faculty should be available for provision of back-up support for fron-line workers. In some countries the institutions have taken this role very seriously with good results (e.g. Thailand Ministry of Health or Macedonia NIOH, Turkey Ministry of Health)
- ***More tools for BOHS practices*** have been requested

BOHS practices

- A few guidelines have been experimented in pilots, particularly Guideline No. 2: Surveillance of working environment and Guideline No. 5: Risk assessment.
- Combination of BOHS with ILO WISE was found very feasible
- More practical guidelines needed. Not too complicated for workplace use.
- Translation of guidelines to local languages.
- Training in the use of guidelines requested.



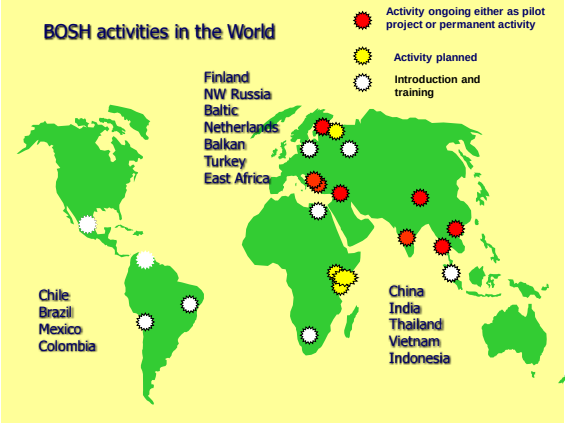


Human resources for BOHS

- Very systematic feed-back is that ***BOHS services cannot be privided without competence in occupational health***, but it does not need to be full specialist in occupational medicine
- Some bodies have seen the human resource needs for BOHS making its ***implementation impossible*** and even in the view of equity
- The working population of the world is 3.2-3.3 Billion. They account for ***61% of the population of the world***. They prioduce the whole global GDP of 70 Trillion dollars.
- The world has ***9 million doctors and 19 million nurses***.
- ***61% share of them would mean 5.5 million doctors and 11.6 million nurses***. If we would allocate to OHS no more than 10% of this mathemathical share, it would mean ***550 000 doctors and 1.16 million nurses***. Is this share inequal or unfair for taking care of health and safety of those who produce all the GDP which sustains all the other sectors and the rest of the population?

Training

- All pilot projects have asked for training regardless of the previous competence or experience
- Several levels of training requested
- Training needs to be very action-oriented and hands-on training at workplaces is expected
- Excellent training material has been collected and organized by prof. vanDijk and is available at net
- WHO and ILO Regional offices have organized training events



Examples of BOHS pilots

- ***Thailand MoH***: Intensive surveillance+training+ implemantaion pilot in selects PHC units resulting in the MoH decision on aupscaling to whole PHC system
- ***Vietnam:*** First MoH study, then practical pilot impelementation with help of Dr. Kogi and ILO Bangkok combining BOHS and WISE. Close collaboration between MoH and MOL
- ***China:*** Extensive 19 County BOHS pilot: Survey before, Profile drawing, Training, Implementation After survey, Evaluation. Result: MoH decision to expand BOHS to 49 additional Counties.
- ***Turkey:*** MoH organized three large pilot projects one in Industrial Zone of Bursa, one in large suburb of Izmir and one in suburb of Ankara alla representing different types of economies.
- ***Macedonia:*** BOHS included in the National Staregy. Pilot projects BOHS for unemployed and BOHS for agriculture (with support of a mobile OHS clinic). Result one of the few interventions in the world for ever for unemployed. Filling the gap for argricultural workers.
- ***Montenegro:*** BOHS approach included into the national strategy and into the routine activities of the PHC units with OH experts.
- ***Northwestern Russia (Karelia):*** Introduction of BOHS to the MOH and MoL of the Republic. Preparation of OHS Profile for Karelia. Preparation of BOHS interventions in the pipeline.
- ***Finland:*** Pilot syudy in municipal health centre for studying feasibility of BOHS in relatively advance OHS setting with experienced staff. Feasibility confirmed and benefits for everyday work reported.

Summary

- 29 countries have in one way or another, implemented BOHS
- About 10 pilot projects completed, ongoing or in plans. The results have led to extension
- Adjustment to local conditions needed
- Training is needed for all, even for senior OHS providers. Excellent training material has been compiled, assessed and organized by prof. vanDijk and made available in the net
- Good practice tools are requested
- Also industrialized country OHS was found benefiting from BOHS