executive committee of the directing council

working party of the regional committee

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

111th Meeting
Washington, D.C.
June-July 1993

Provisional Agenda Item 4.6

CE111/13 (Eng.)
21 May 1993
ORIGINAL: SPANISH

WORKERS' HEALTH

The purpose of this document is to report on the achievements of the Program on Workers' Health and to outline its future orientations. The document underscores the political, social, and economic importance of workers' health, discusses the resolutions and other instruments that have guided actions, and analyzes the situation, changes, and advances in the countries in recent years.

It also contains information on the composition of the economically active population, data on occupational accident rates and social security coverage, and information on graduate courses and the National Plans for Workers' Health.

The document gives consideration to various factors that influence workers' health and that must be taken into account in order to define future orientations and plan activities under the Initiative "Workers' Health for Development" up to the year 2000.

This report is being presented to the Executive Committee as the basis for the recommendations that it is asked to make to the Directing Council on this subject.

CONTENTS

1. Introduction

The countries of the Americas are undergoing periods of change and adjustment in an effort to cope with various social and economic problems. These processes have been triggered not only in the Region of the Americas, but on other continents as well; some are the result of upheavals in political processes, others of shifts in the changing geographical emphasis of international assistance and cooperation. These problems have a strong impact on the health of workers, whose situation is aggravated by financial restrictions, combined with the need to increase production, which entails enhancing the abilities and skills of the working population.

The changes and adjustments have been especially profound in Latin America and the Caribbean over the past decade; the postponement of social solutions, even more than economic decline, caused the 1980s to be described as the "lost decade." The application of programs of structural adjustment and budgetary restrictions was felt above all in the Ministries of Health and Labor. Other negative factors for workers' health should also be emphasized: ignorance of the severity of the situation[1]; working conditions[2]; limited resources for properly informing and training workers[3]; the health vulnerability of the working-age population[4]; the limited interest of the health sector in prevention[5]; and the shortage of experts in occupational health[6].

More activities have been carried out in the Region in recent years as a response to this situation, including widespread consciousness-raising and the movement to better understand the actual situation and to find the most appropriate solutions in the area of workers' health. It is in this context that the Ministers of Health of the Member Governments have made the decision to study the situation, for which purpose they have requested cooperation from PAHO, first in Central America and in the Andean Area and

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[1] Due to the inadequate mechanisms for reporting and recording work-related pathology and also to the limited resources for investigating and diagnosing work-related injuries, diseases, and disabilities

[2] Characterized by the concurrence of obsolete work practices and the use of technologies that entailed new, little known, and poorly monitored risk factors that call for more sophisticated preventive measures

[3] A necessary condition for achieving the expected increase in production from these new technologies and for developing a preventive consciousness and promoting self-care, as well as the ability to participate in the programming, execution, and evaluation of health programs in the workplace

[4] Related to poverty and inadequate health service coverage

[5] The modest number of units and experts devoted to accident and disease prevention, to the maintenance of workers' health, and to the control of risk factors in the workplace contrasts with the steady development of curative medical care, whose costs are steadily rising

[6] In some countries, occupational health units in Ministries of Health are staffed by only 1 or 2 experts, and their position in the organizational chart does not accord them their due importance and visibility, the same applies to Ministries of Labor and social security institutions

later throughout the Region; this has permitted the identification of the most important factors that have a bearing on the situation and the definition of the priority lines of action to be pursued.

2. Frames of Reference

In 1990 the XXIII Pan American Sanitary Conference analyzed the report on the situation of workers' health[7] and, taking into account that good health is desirable and necessary so that a population can be creative, produce more, and have a better chance to integrate into development processes[8], defined workers' health as one of the eight priority program areas for the development of health programs during the quadrennium 1991-1994[9]. In addition, in Resolution XIV on Workers' Health it set forth the needs and forms of cooperation, recommended the principal program lines for the Member Countries, called for the identification of additional mechanisms for mobilizing resources, and designated 1992 as the Year of Workers' Health[10].

In 1992, at its XXXVI Meeting, the Directing Council of PAHO reviewed the advances made during "1992: Year of Workers' Health" and supported the Plan of Action for this initiative and the Declaration of Washington, prepared by the Organizing Commission. It called on Member Governments[11] to confirm and maintain their political decision to implement the national plans for workers' health and to identify and mobilize resources for workers' health.

Also in 1992, the Ninth Meeting of the Inter-American Conference of Ministers of Labor discussed the subject of workers' health and emphasized the importance of intersectoral cooperation in the governmental sphere (health, labor, social security,

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[7] Document CSP23/4 of the Pan American Sanitary Conference on Workers' Health

[8] Concept embodied in the definition of the primary health care strategy, at the Alma Ata conference, as part of total coverage, high priority was assigned to the special needs of women, children, high-risk worker populations, and underprivileged segments of society The need to bring health care to the places where individuals live and work was also pointed out

[9] Resolution XIII of the XXIII Pan American Sanitary Conference, September, 1990

[10] Resolution XIV identifies the following specific program lines the formulation and evaluation of policies, coordination among national institutions, the development of various institutional forms of primary health care for workers (health education and promotion, primary health care, incorporation of occupational health into health services and local or municipal health systems), community participation (by employers and workers), training of the human resources needed to expand coverage, inclusion of occupational health activities in health programs, establishment of information and epidemiological surveillance systems, and participation by workers in the development of healthy lifestyles

[11] Resolution XXII of the XXXVI Meeting of the Directing Council of PAHO

education, etc.) and of collaboration between employers and workers. Guidelines for action were also approved on this occasion[12].

The Latin American Parliament also discussed the subject and produced an agreement on workers' health[13]. The same occurred at meetings of social security institutions, union confederations, and employers' organizations.

All these instruments which originated in the Region of the Americas are compatible with the international instruments previously adopted by WHO and ILO[14], as well as with the material resulting from the meetings of the ILO/WHO Joint Committee on Workers' Health[15].

These frames of reference took into account the recognition of the political, social, and economic importance of workers' health. The relationship between health conditions, working conditions, and productivity, and the influence of good workers' health on individual productivity and national production show that ensuring workers' health is a profitable investment. The shift that is under way at the international level from a classical economy to one that is concerned with effectiveness and efficiency is founded on the development of the individual capacity of the worker, which includes self-care. Therefore, workers' health is indispensable to the production of safe, high-quality goods and services that meet the safety requirements posed by international markets and envisaged in free trade agreements.

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[12] Resolution 4 (IX/92) on workers' health reaffirms support for the Declaration on Workers' Health, manifests the political decision to give priority to the implementation of national plans and programs, requests collaboration from international agencies, urges the creation and strengthening of mechanisms to integrate work, health, and social security, and supports the continuation of the workers' health initiative as a catalyzing framework

[13] First Meeting of the Permanent Commission on Health, Labor, and Social Security Havana, Cuba, 24 to 27 March 1992

[14] WHA30 43, 1977 " the main social target should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life " The Alma Ata conference in 1978 prioritized high-risk worker populations and recommended bringing health care as close as possible to the place where people work Also worthy of note are ILO Convention 161 and Recommendation 171 of 1985 on health services in the workplace, Convention 155 and Recommendation 164, both of 1981, on workers' safety and health and the working environment, Convention 148 and Recommendation 156 of 1977 on the protection of workers against occupational hazards due to air pollution, noise, and vibration in the workplace, and Resolution WHA40 28, May 1987

[15] Worthy of special mention are the 1st Meeting of the ILO/WHO Joint Committee in 1950, at which Workers' Health was defined by its objectives, and the 11th Meeting in 1992, at which information on the initiative on workers' health" in the Region of the Americas was presented and considered

3. Analysis of the Workers' Health Situation in the Countries

3.1 *Recent General Advances*

Despite the existing differences between countries it is easy to identify positive changes, including the following, which have taken place as part of the stages of preparing and developing the workers' health initiative:

- The declarations, decrees, and resolutions confirming political decision and institutionalizing mechanisms of intersectoral coordination and cooperation,and the collaboration of the various social actors.

- The affirmations of a generation of professionals who are involved in the development of a new economy, with concern both for increasing production and gaining access to new markets by ensuring optimal training of human resources, thus simultaneously ensuring health and social well-being.

- The incorporation of the issue of workers' health into the agendas of labor organizations.

- The updating of legislation resulting from discussions of the subject by technical groups, representatives, and legislators.

- The considerable number of congresses, seminars, workshops, and other events that have helped to disseminate information, knowledge, and experiences.

- The involvement of the mass media and the production of diverse promotional materials that contributed to heightened awareness and concern among the public at large.

- The increase in and strengthening of graduate courses for training specialists.

- The preparation, discussion, and enhancement of national plans for workers' health that call for the inclusion of occupational health in primary health care programs (Annex I).

3.2 *Current Situation in Latin America and the Caribbean*

The economically active population in the Region of the Americas rose in 1990 to 304 million, accounting for 42% of the total population (data on 32 countries) (Annex II, Table 1). Minors are part of the work force and in some countries are estimated to account for between 20% and 25% of the active population. The number of children who work is increasing, not only in absolute terms but also as a proportion of the child population, according to the ILO. In Latin America surveys show that in countries like Brazil 18% of children from 11 to 14 years of age work. Data on the participation of children aged 10 to 14 in the work force are shown in Table 2. The number of workers under 10 years of age is unknown.

The participation of women in the work force in Latin America and the Caribbean has increased in recent years; in 1990 they accounted for 26%, and by the year 2000 this percentage is expected to be around 27 (the IDB estimates 53 million as of 1990) (Tables 3 and 3-A). Considering the many women who do not have formal work contracts, the percentage of women who actually work is likely to be much higher than these figures indicate.

Presented below is a summary of various issues relating to the workers' health situation in Latin America and the Caribbean:

Occupational accidents, which are easily identifiable and have a causal link that can usually be clearly established. The ILO statistics on occupational accidents, which usually record information from social security institutions, whose average affiliation is estimated for Latin America and the Caribbean at 40%, indicate that approximately 2 million people a year are injured (based on data for the period 1982 to 1991, Table 4). Projecting this value to the total number of workers makes possible an estimate of 5 million disability-producing accidents a year; the data that has been collected indicate that each Andean worker suffers 3 occupational accidents[16] in 45 years of his/her working life and that at the Regional level every worker suffers from 2 to 4 accidents on the average during his/her working life. Based on these figures, during one workday there are 17,500 occupational accidents, 36 per work minute. For the purpose of obtaining more complete, updated, and realistic information, data from social security institutions are being gathered in collaboration with the CIESS (Annex III).

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[16] From the subregional project "Development of Workers' Health," documents 2 and 3 of PLANSAT ANDINO (the Andean Area plan for workers' health)

Mortality from occupational accidents in Latin America and the Caribbean is four to five times higher than that reported by the developed countries (Table 5); and the disproportion is even greater when certain groups engaged in similar economic activity are compared. For example, in agriculture the rate can be up to 10 times higher; in mines and quarries, up to 18 times; and in construction, up to 12 times (Table 6).

There is one permanent disability for each 39 occupational accidents, and in some countries the rate of disability has doubled in relatively short periods (for example, in Brazil).

Based on data from 14 countries in Latin America and the Caribbean (ILO), an estimated 12 to 14 million workdays are lost per year (Table 7). Given the number of reported occupational accidents--630,460 in 1986--it can be calculated that every accident causes the loss of 19 workdays. Several studies that compare the average number of days missed for treatment show that in the countries of Latin America this period can be up to three times longer than in the industrialized countries. In Uruguay, the Banco de Seguros del Estado reports an average of more than 26 days.

Given the number of occupational accidents that may be occurring every year in Latin America and the Caribbean (2 million reported), it can be estimated that 38 million workdays are lost annually. If this figure is extrapolated to the total population--the data correspond only to insured workers (nearly 40%)--the days of work lost would be on the order of 95 million per year.

Occupational accidents and occupational illnesses cost the equivalent of 10% of the gross domestic product in the developing countries. In one country alone (Colombia), where there were 105,468 occupational accidents in one year, the Institute of Social Security spent US$2.3 million on curative medical care. The overall cost of these events to social security and to industry was estimated at $19 million, i.e., $180 per occupational accident.

Occupational diseases represent an important public health problem. Despite underreporting that is even worse than for occupational accidents, studies indicate high prevalences of occupational cancer, lung disease, metal and pesticide poisoning, neurological and behavioral disturbances, hearing losses, and skin and osteomuscular problems caused by work-related risk factors.

Occupational diseases can cause, besides human suffering, very high expenditures on medical care, major disabilities, and the resulting loss of many years of working life.

Work-related diseases are multifactoral health impairments triggered, aggravated, or accelerated by risk factors, improper conditions, and occupational exposure. Of particular importance are infectious and parasitic diseases, zoonoses, malaria, psychosomatic disturbances, cardiovascular diseases, musculoskeletal disorders, digestive disturbances, chronic respiratory diseases, and several types of cancer.

Health personnel must recognize these diseases and study their multifactoral causes, since in all cases they can be avoided by means of primary prevention and health interventions in the workplace.

Coverage of workers' health programs and services. Given that the available services do not cover all workers and fewer than 10% have access to benefits that include health promotion and maintenance, prevention in the workplace, and curative and rehabilitative medical care, the countries have been pursuing efforts to formulate and implement national plans for workers' health whose objective is the steady extension of basic occupational health care with an epidemiological approach.

With regard to social security coverage, three groups of countries can be distinguished: those with coverage of over 80% of the economically active population, only 5 countries; those with coverage of between 50% and 80%, 6 countries; and those with coverage of less than half the working population, 9 countries (Table 8). Coverage is also uneven across the various areas of economic activity. It is generally very low for workers in rural areas, agriculture, mining, construction, and the informal sector. Also, the percentages of coverage are lower in the case of women and practically nonexistent among working children.

Legal framework. There is a basic legislative framework and in some cases a relatively extensive system of laws and regulations on medicine, hygiene, and safety in the workplace, but appropriate ways of monitoring their enforcement have not been established, and the degree to which they are complied with has not been determined, although it is known to be low. One can also detect a lack of consistency and clarity among the responsible authorities, as a result of which mechanisms of consensus are not available for their preparation and promulgation.

Availability of trained personnel. In the last five years the number of people trained in workers' health has increased, and 12 countries have intensified their efforts to train specialists. At present at least 32 courses are being conducted at the graduate level, and most of them, 22, have received PAHO technical

cooperation. Mechanisms have been established with universities in industrialized countries[17].

Factors that limit available coverage and care

- Limited incorporation of specific policies into national social and economic plans.
- Dilution of responsibilities between the company and the health and labor sectors, and social security.
- Limited involvement of unions in this area.
- Inefficiency of coordination mechanisms.
- Inadequate implementation of national intersectoral, concerted, and participatory plans.
- Absence of uniform criteria for programming.
- Quantitative and qualitative deficiencies in coverage (high percentages of uncovered workers): concentration of efforts on curative care and on certain areas and labor categories.
- Limitations in human, technical, and budgetary resources.
- Large gaps in knowledge and lack of a thorough diagnosis of work and health conditions, especially among underserved labor groups.
- Transfers of technologies that fail to take into account the sociocultural environment, the size, the physical make-up, and the training of the workers who will utilize them in the recipient countries.

3.3 Economic Situation in the 1990s and its Impact on Workers' Health

It is expected that in 1993 the developing countries will achieve their highest growth rate since 1970. When the world economy grew 0.4% in 1992, the industrialized

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[17] In spite of the efforts at training, there are huge shortages of specialized personnel devoted to workers' health in Central America and the Andean Area there is, on average, one occupational health physician per 100,000 workers, one nurse per 80,000, and one industrial hygienist per 200,000 workers There are even more glaring gaps in the training of health services personnel, labor inspectors those who determine the requirements and grant authorization for industrial operations, workers, and employers

countries grew 1.5% and the developing countries 4.5%. Growth in Latin America and the Caribbean was 2%, which was lower than in previous years[18]. International trade expanded, as it has over the past nine years, rising by 4.5% in 1992. The reforms under way and international support continue to be important. The adjustment policies that have been implemented, which aim at ensuring fiscal and monetary stability, explain the cuts in public spending and the efforts to raise revenues through the privatization of public companies. The average inflation rate (excluding Brazil) declined around 25% in 1992. This slow recovery is being conditioned by a weak international economy[19].

In Decision 91/10 of June 1991, the Governing Council of the United Nations Development Program (UNDP) reiterated the importance of regional economic integration to promote economic growth and development, as well as the importance of support from the developed countries and international organizations for such integration.

There are many cooperation agreements in the Americas, including those of the English-speaking Caribbean, Central America, the countries of the Andean Pact, MERCOSUR, the River Plate area, the Amazon cooperation treaty, and the North American Free Trade Agreement between the United States, Canada, and Mexico[20]. The objectives of these multilateral and bilateral agreements are to promote production and trade, with a view to producing economic benefits and development. However, the impact that they can have on working conditions and environments, hiring practices, and technology transfer merits special attention. In order for such agreements to effectively contribute to sustainable development, their direct impact on workers' health and their indirect impact on the health of their families and of the population living near workplaces must be positive. Otherwise, they will serve only to bring in foreign exchange while reducing working capacity, which could paradoxically lead to an increase in poverty and social decline. Conditioning factors involving wages and the pace of work, and labor requirements and techniques could have undesirable consequences for health and the environment if measures that benefit health and working capacity are not taken into account. In order for these treaties and agreements to have positive results in the medium and long term, they must take account of factors relating to social development--particularly those having to do with the health and capacity of workers--as a condition for achieving the sustainable development that the countries desire.

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[18] This result was due to the recession in Brazil, which accounts for 40% of the gross product of the region, and to the nearly 4% average increase in the rest of the countries, with over 6% growth in Argentina, Chile, Uruguay, and Venezuela and a less than 3% increase in Mexico

[19] Unpublished text of the note of the Secretary General of the United Nations for the organizational meeting of the Economic and Social Council

[20] Annual Report of the Administrator for 1992 and Programme Level Activities (DP/1993/14) for the Fortieth Session 1-22 June 93, PNUD

These cooperation agreements in the Region should also function as instruments that will tie in with new high-level political initiatives, such as the presidential summits, and emerging issues like the environment[21]. In addition, they should provide for the progressive improvement of work force training and of workers' health, which are essential conditions for balance and development.

The Economic and Social Council of the United Nations (ECOSOC), which will meet in June and July 1993 in high-level session, will consider, as its main item, the Summit for Social Development, including the role of the United Nations system in promoting social development. The promotion of the health of workers and their capacities and skills will necessarily be of great importance.

4. Achievements under the Initiative "1992: Year of Workers' Health"

4.1 *General Information*

Since 1985, problems related to workers' health have been analyzed and discussed in national and international forums and, in the Americas, have been the subject of events at the highest technical and political decision-making levels in regions, subregions, and countries.

Recognition of the importance of protecting the health of workers in order to improve production and enhance economic and social development, not just for humanitarian reasons, led to the inclusion of occupational health as a priority area in the Central American initiative "Health and Peace for Development and Democracy" and in the Andean initiative "The Andes United for Health." In this process, technical cooperation between the countries and the Pan American Health Organization has helped in the formulation of subregional plans for the development of workers' health (the Central American PLANSAT and the Andean Area PLANSAT).

As was mentioned before, workers' health was designated by the XXIII Pan American Sanitary Conference (September 1990), in Resolution XIII, as one of the eight priority program areas for the 1991-1994 quadrennium. At the same Conference, the Ministers of Health adopted Resolution XIV on workers' health, which designated 1992 the "Year of Workers' Health in the Region of the Americas."

The goal of this initiative is to achieve greater attention to the health of the working population without diminishing efforts already under way to develop projects and activities at the subregional, regional, and country level to promote articulation and

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[21] Annual Report of the Administrator for 1992 and Programme Level Activites (DP/1993/14) for the Fortieth Session 1-22 June 93, PNUD

strengthening of workers' health through a comprehensive program and a broader political spectrum. By giving high visibility to the area of workers' health, it hoped to obtain a commitment from leaders, promote the exchange of information between employers and workers on the problems and causes of work-related accidents and diseases, and foster the development of a preventive consciousness[22]. This, in turn, should result in more resources for occupational health programs and for the plans of action that have been or are being developed. It should also contribute to widespread recognition of the social and economic importance of such programs, and should contribute to the widespread recognition of their social and economic importance. Finally, it should help to bring about the necessary changes of attitude so that, even after the campaigns carried out during the Initiative have come to an end, the activities and structures will remain, increased attention will be paid to workers' health, and a new culture of workers' health will be promoted, with special emphasis on the promotion and protection of the health of workers and their ability to work and on the prevention of occupational risk factors[23].

4.2 *Achievements of the Initiative at the Regional and Subregional level*

The workers' health initiative has heightened awareness and recognition of the importance of workers' health for social progress and economic development. As a result of the new directives, PAHO has set up an Interprogrammatic Group on Workers' Health and developed a plan of action in which each program of the Organization, in its planning, has included activities specifically geared towards workers' health in areas of common interest. This plan is being carried out through the programs and centers of the Organization.

Efforts have also been intensified to obtain additional resources in the form of national professionals and associate experts, collaborating centers, and agreements with industry.

The repercussions of the Initiative include:

- The approval of frames of reference for other sectors (the Latin American Parliament, the Inter-American Conference of Ministers of Labor, and the Inter-American Council For Education, Science, and Culture).

- The approval of Resolution XXII of the XXXVI Meeting of the Directing Council of PAHO, September 1992, which provides that status reports should

[22] From the Plan of Action for the Initiative, prepared in 1991

[23] Ibid

be submitted every two years and establishes the Permanent Advisory Committee to the Organization's Workers' Health Program.

- The dissemination of the Declaration on Workers' Health prepared by former Presidents Betancourt of Colombia and de la Madrid of Mexico and other members of the Organizing Commission, which illicited broad interest and support, as expressed in the following two examples.

- The decision by the United Nations, the OAS, and the Inter-American Institute for Cooperation on Agriculture, supported by PAHO, to establish an Joint Interagency Committee on Workers' Health; and the decision by several agencies to include the area of workers' health in financial operations, in addition to the promotion of a workers' health week or day, as the Commission of the European Communities has done.

- The declaration of support by heads of state and government of the Region of the Americas and of Europe, of religious communities, of various governmental and nongovernmental agencies, and of other institutions for a dynamic process and a series of consultations to mobilize resources.

- The approval of specific resolutions at the subregional level: at the VIII RESSCA (Meeting of the Health Sector of Central America) and at the XVI REMSAA (Meeting of Ministers of Health of the Andean Area). At the level of the Caribbean an expression of support was given through a subregional meeting and a resolution of the Caribbean Labor Congress (XI Congress, November 1992). The meeting of the countries of MERCOSUR and Chile scheduled for late 1992 has been postponed to July 1993.

4.3 *Achievements under the Initiative at the Country Level*

The Initiative was guided by the Plan of Action reviewed by the Organizing Commission and approved by the Governing Bodies of PAHO. The Initiative proposed two major targets[24]:

- All the countries of the Region will have formulated and approved a National Plan for the Development of Workers' Health.

- At least 10 countries of the Region will have set up mechanisms for intersectoral articulation, coordination, and cooperation through multidisciplinary

[24] From the Plan of Action for the Initiative, prepared in 1991 and revised in 1992

working groups and the organization of National Committees on Occupational Health, and they will also have initiated implementation of their National Plans for the Development of Workers' Health.

The National Plans for Workers' Health[25] envisage strategies that call for an intersectoral approach and community participation, with a conceptual breadth and projection that transcend the usual levels of tripartite coordination and participation.

Among the most significant achievements under the Initiative at the national level can be mentioned:

- All the countries of the Region have reaffirmed their political decision. In most countries this commitment came not only from the Ministers of Health but also from the Ministers of Labor. Support has also been expressed by the Ministers of Education. In some countries the commitment has been upheld by presidential decrees, many of which have established national intersectoral groups.

- National intersectoral working groups and technical commissions have been strengthened, and national councils of occupational health have been constituted.

- National councils and/or committees on which different sectors are represented have been established in 16 (85%) of the countries of Latin America, and national plans for workers' health have been prepared in the same number of countries. Half of them (8) are in the process of execution; 3 of the countries (15%) have allocated national funds.

- The countries of the English-speaking Caribbean, in keeping with the overall commitment, have begun preparing national plans.

- Only four countries of the Region did not commemorate the Initiative. In the rest activities involving various sectors were programmed, in particular specific ceremonies for launching the activity of the intersectoral groups, with publicity campaigns through television, radio, the press, publications, placards, commemorative stamps, posters, etc. These observances included Latin American, multicountry, and national congresses; seminars; courses; and workshops. Mexico, for example, held more than 500 events organized by Social Security, universities, the Ministry of Labor, and the Ministry of Health, some of which involved Mexico, the United States of America, and

[25] See Annex I

Canada. Colombia held 100 events, sponsored by various institutions[26], during the first half of the Initiative. In addition to the 39 events held by the PAHO/WHO Representative Offices or with their support, which were attended by 2,210 participants, according to the reports of the Representative Offices, mention should also be made of the participation and sponsorship of Headquarters in 20 exhibitions and other activities such as seminars and courses, attended by 2,325 participants.

- Graduate courses in workers' health were initiated in three countries, bringing to 22 the number of programs with which PAHO cooperates directly, out of the 32 with which ties are maintained.

The Initiative prompted cooperation between countries. Particularly worthy of note are the cooperation agreements established between: a) Canada, the United States, Spain, and other European countries, and b) various universities and agencies in Latin America.

5. *Organizing Commission for "1992: Year of Workers' Health"*

In order to plan for the Initiative an Organizing Commission was set up which was composed of members of political and scientific prestige, including ex-presidents of countries of the Region.

Its activities and the development of the Plan of Action led to the approval of the Declaration on Workers' Health of Washington, which was signed on 26 February 1992 and subsequently ratified by the Directing Council of PAHO and by the Inter-American Conference of Ministers of Labor. This declaration was disseminated widely among the agencies and institutions involved and facilitated the mobilization of resources and interagency and international cooperation.

The Commission promoted political commitment and the preparation or adjustment of the National Plans for Workers' Health, the establishment of national intersectoral groups, the heightening of awareness, and the fostering of a "preventive culture" in the workplace. It contributed as well to the formulation of regional, subregional, and national policy instruments that support the workers' health initiative, incorporate intersectoral concerns, and seek to promote workers' health with the broad participation of all sectors of the state, public and private companies, and workers.

The Commission promoted wide-ranging cooperation and emphatically suggested collaboration between state organizations, employers, workers, and all social actors, also

[26] In Colombia the Initiative was observed between July 1992 and July 1993

encouraging interagency coordination at the international level and the participation of the collaborating centers concerned with occupational health in information, research, education, and the mobilization of resources.

The Commission also supported the incorporation of occupational health into the various health program areas and the development of interprogram cooperation in workers' health. In addition, it achieved an expression of support from the XXIV Regular Meeting of the Inter-American Council for Education, Science, and Culture.

Because of their impact, the Commission and its activities are to be continued[27] in the form of the Permanent Advisory Committee to the PAHO Program on Workers' Health[28].

6. Achievements of the Workers' Health Program

The main recent achievement of the Program in the framework of Initiative[29] has been to secure, with the support of the Organizing Commission and the cooperation of all PAHO Programs at Headquarters and the Representations in the countries, a solid political commitment in almost all of the health systems of the countries of the Region. particularly with respect to their current determination to establish effective workers' health programs. The countries have also recognized the need to step up efforts to make progress toward the goal of workers' health with their administrative structure and available resources.

The Program has promoted interest among ministers of sectors other than the health sector, especially labor, agriculture, and education, and among the directors of social security institutions, and emphasized the need to establish effective preventive programs.

Organized workers have, on various occasions, been made more aware of, and have come to place greater value on, their rights to health and safety in the workplace. Employers are showing that they accept this trend as positive.

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[27] Pursuant to a decision of the XXXVI Meeting of the Directing Council of PAHO, supported by the Inter-American Conference of Ministers of Labor

[28] The Committee's functions are described in section 7 3 of this document

[29] The achievements of the Program and of the Initiative should be evaluated together, taking into account the fact that the Initiative, as approved at the XXIII CSP, emerged from the action that the Program was carrying out and, in turn, heightened expectations about its performance and visibility

One of the Program's achievements has been that, by encouraging planning and the preparation of guidelines, it has fostered the drafting of national plans in all the countries. The countries have analyzed the material prepared and have taken it into account in preparing their plans.

The Program has also been successful in emphasizing the importance of training and education; and it has helped to bring specialists up to date in the various disciplines related to occupational health.

Other achievements have been: the participation of PAHO and the presentation of the Initiative at the XI Meeting of the ILO/WHO Joint Committee on Occupational Health; participation in the IX Inter-American Conference of Labor Ministers; and the incorporation of an item on workers' health on the agendas of regional meetings of Ministers of Agriculture and Ministers of Education. Communications received from international agencies and prominent individuals have expressed their agreement with and support for the Initiative.

7. Initiative "Workers' Health for Development"

During the 1990s, with a view to attaining the WHO target of health for all, it is essential to ensure that health care is available to the entire population at or near workplaces as a condition for achieving development, which will be possible only with a healthy, creative, and economically productive population. The Initiative "Workers' Health for Development," which has been endorsed by the Governing Bodies of PAHO, by Labor Ministers, and by various agencies and institutions[30], is intended to serve as a mechanism for making health coverage universal, promoting a culture of prevention, increasing cooperation, achieving the implementation of the national plans for workers' health, and contributing to greater awareness and recognition of and visibility for workers' health.

To this end, the Initiative will have the support of the PAHO Secretariat--specifically the Program on Workers' Health of the Organization--as well as the support and guidance of the Advisory Committee to the Program, the Governing Bodies of the Organization, and the network of WHO Collaborating Centers in the area of workers' health. Activities under the Initiative will be guided by the lines of action for workers' health that have already been approved by the Governing Bodies of PAHO. The Initiative "Workers' Health for Development" will lend continuity to the 1992 Initiative.

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[30] Expressions of support for the Washington Declaration on Workers' Health have been received from various heads of state and government, international agencies, nongovernmental organizations that provide cooperation, universities and research centers, religious communities, the mass media, employers associations, and labor organizations. There have also been presidential decrees and resolutions by ministries, legislators, and labor organizations.

Its plan of action will be based on the plan of action established and approved for 1992, which will be reviewed and adjusted to take into account certain factors and strategies that warrant special consideration, especially for 1994-1995.

7.1 *Some Political, Social, and Economic Considerations*

The processes of democratization foster a greater openness with regard to exchange of knowledge, experiences, and information that guarantee fundamental human rights and greater participation for representatives of society; in this context, there must necessarily be concern for workers' health as an essential condition for development. In this context of democratization, the various disciplines related to occupational health[31] will promote human development, because they enable working conditions to be adapted to the abilities and capacities of individuals and contribute to the necessary training so that not only experts but all workers and employers are involved in prevention in the workplace and in self-care.

The protection of the working environment not only seeks to reduce health impairments among the directly exposed working population but also leads to improved environmental conditions that are better for the entire population.

Workers' health programs and services and the application of their techniques can detect the most unhealthful, dangerous, and ill-adapted labor technologies and reduce occupational accidents, occupational diseases, and the disabilities associated with these occurrences. They therefore help significantly to eliminate poverty[32]. The adaptation of working conditions and techniques to the human being, even if the capacities and abilities of the workers are lacking, enables a higher percentage of the working-age population to be employed, and as a result leads to a reduction in poverty.

The greater the concentration and homogeneity of individuals in a workplace and the similarity of their exposures, the easier it is to adopt procedures for providing information and training, monitoring the environment and health, organizing work, and ensuring preventive education and medical care for the benefit of a group of people. For this reason, in modern society, in which small families and short periods of residence in one place are increasingly common, the workplace becomes, like school and the day-care

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[31] Workers' health is influenced by many factors, including prevention programs in the workplace, hygiene and occupational safety, occupational health and ergonomics, the psychopedagogy of prevention, and other sciences and technologies that are the main core disciplines of occupational health Occupational health can contribute to the training and upgrading of human resources, so that workers practice self-care and participate in occupational health programs, thereby increasing the average length of working life

[32] "Salud de los trabajadores y pobreza ambiente, derechos humanos como pilares importantes de la agenda para la paz" *in* Importancia de la salud de los trabajadores en el futuro próximo VIII Meeting of Physicians Specializing in Occupational Health Mexico City, October 1992

center, the place of choice for delivering services to promote and maintain health and to prevent risk factors that harm health and the ability to work. Moreover, the workers who benefit from such health education can become agents for the dissemination of practices of health promotion, self-care, and environmental protection.

The increase in and the improved quality of the products and services of the developing countries are related to the need to gain access to new and sometimes more demanding markets and to better serve the interests of consumers, employers, and workers.

The changes and adjustments in social and economic structures in the countries, the processes of economic and social integration in the Region, the free trade agreements between countries, as well as the new dynamics and types of labor contracts and the processes of health system reform, should not have a negative impact on health care coverage for workers[33]; on the contrary, they should impact positively on their health and well-being while at the same time enhancing productivity, and should serve as a challenge to better utilize interagency cooperation and to increase coordination between and participation by all social actors.

7.2 *Functions and Members of the Permanent Advisory Committee to the PAHO Program on Workers' Health*

The Committee will carry out political, technical, operational, and coordinating activities with the support of governments, national commissions and councils, technical working and consulting groups, occupational health institutes, the cooperation agencies concerned, and especially the WHO Collaborating Centers, the PAHO Interprogrammatic Group on Workers' Health, and the Regional Program on Workers' Health. It will have as specific functions[34]:

- To collaborate in studies, in defining strategies, and in other activities for the mobilization of resources.

- To contribute to increased cooperation and actions at the regional, subregional, and national levels and specifically to the National Plans for the Development of Workers' Health.

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[33] "Situación económica y factores que pueden favorecer el desarrollo" *in* Perfil de la Salud Ocupacional en el Siglo XXI IX Inter-American Congress on the Prevention of Work-related Risks San José, Costa Rica, July 1992

[34] From "Guidelines for the Work of the Advisory Committee," Washington, D C , 23 October (pending approval) and the report of the second meeting of the Organizing Commission for the Initiative

- To help promote the coordination and integration of the policies of the various United Nations agencies, seeking more comprehensive participation.

- To discuss technical and operational issues that are inherent in workers' health with a view to advancing the implementation of plans for workers' health.

- To promote a culture of prevention in the workplace at the levels of political, legislative, technical, commercial, labor, educational, and social decision-making.

- To foster the continuity of efforts under the 1992 Initiative.

In order to promote and facilitate an exchange of experiences and analyses from different perspectives, the Committee will be made up of prominent political figures and representatives from various regions and sectors, as well as a group of technical experts from the various occupational health disciplines.

7.3 *Some Additional Strategic Considerations*

The planning of the Initiative "Workers' Health for Development" involves incorporating and strengthening the strategies defined for the 1992 Initiative, as well as adjusting it, taking into account, for the 1994-1995 program, the following five points:

- The mobilization of human, technical, and financial resources that will further the progressive implementation of the national plans for workers' health and of the framework mandates, with an emphasis on the institutional strengthening of the operational base and on the training of personnel in the various areas of workers' health, focusing on intersectoral action and on the preparation of projects and the identification of cooperation agencies that can facilitate the mobilization of national and external resources. The mobilization of resources should also promote the creation of regional and national funds and their programmed utilization for specific actions, such as development of research, training, and information.

- The incorporation of new forces for decision-making and political commitment to promote the incorporation of workers' health in the agendas for peace, development, free trade, the battle against poverty, and other social causes, and not only in the agendas of the health, labor, and social security sectors.

- The promotion and strengthening of national mechanisms of cooperation between governmental institutions, and collaboration, dialogue, participation, and consensus between the government, employers, and workers.

- The development and coordination of interagency work for delivering cooperation at the level of the Region of the Americas in the field of workers' health.

- The creation of a greater awareness about self-care, health promotion, and other preventive activities in the workplace through and with the support of all the mass media, in order to achieve the highest visibility for the humanitarian, economic, and social importance of workers' health, and to enhance the applicability of appropriate legislation and practices.

REFERENCE DOCUMENTS:

- Plan of Action for the Initiative "1992: Year of Workers' Health"
- Reports of the Meetings of the Organizing Commission for "1992: Year of Workers' Health"
- Guidelines for the Work of the Advisory Committee
- International mandates relative to workers' health
- Resolutions, legal instruments, and declarations of political commitment in the countries
- Information on Bernardino Ramazzini (Resolution XXII of the XXXVI Meeting of the Directing Council, operative paragraph 5)

ABBREVIATIONS USED IN THIS DOCUMENT:

CIESS	Inter-American Center for Social Security Studies
CSP	Pan American Sanitary Conference
IDB	Inter-American Development Bank
ILO	International Labor Organization
OAS	Organization of American States
PAHO	Pan American Health Organization
PHC	Primary Health Care
PLANSAT	National Plan for the Development of Workers' Health
SILOS	Local Health Systems
WHA	World Health Assembly
WHO	World Health Organization

NATIONAL PLANS FOR WORKERS' HEALTH IN THE COUNTRIES OF LATIN AMERICA AND THE CARIBBEAN. SITUATION AT THE END OF 1992

The countries of Latin America and the Caribbean are undergoing major changes in their economic structure and within their work forces. The increase in informal activities in inner cities and in subsistence economies in rural areas, the proliferation of temporary work, the incorporation of women and minors into the labor market, and the failure to enforce legislation applicable to these situations, among other things, mean that efforts must be intensified to facilitate intersectoral work in developing joint programs for workers' health, in which governmental action is complemented by the private-sector involvement of workers, employers, intellectuals, educators, the church, and the mass media.

Given economic trends and the composition of the labor market, the need to implement National Plans becomes evident, with new options for organizing workers' health programs and services that fulfill primarily preventive functions and develop a form of social management that allows for the participation of employers, workers themselves, their organizations, and all governmental sectors that have responsibilities in this area.

The National Plans for the Development of Worker's Health will have as their objective to establish the general framework and to define the responsibilities of all social actors in order to achieve rapid progress. Thus, they should take into account the repercussions that workers' health and improved working conditions have on the quality of life of the population, social well-being, increased productivity, and national economic development.

NATIONAL PLANS - SITUATION AT THE END OF 1992

CENTRAL AMERICA			**SOUTHERN CONE**		
Costa Rica	⊜⊜⊜		**Argentina**	*	(Unarticulated activities)
El Salvador	⌂⌂		**Brazil**	⊜⊜⊜	(Unarticulated sectoral plans)
Guatemala	⌂⌂		**Chile**	⊜⊜⊜	(Sectoral plan, Ministry of Health)
Honduras	⌂⌂		**Paraguay**	⌂⌂	
Nicaragua	⌂⌂		**Uruguay**	⌂⌂	
Panama	⊜⊜⊜				
Dominican Rep.	*		**CARIBBEAN**		
			Barbados	⌂⌂	
ANDEAN			**Guyana**	⌂⌂	
Bolivia	⊜⊜⊜		**Jamaica**	⌂⌂	
Colombia	⊜⊜⊜		**Trinidad/Tobago**	*	
Ecuador	*				
Peru	⌂⌂ (PLANSAT and Plan for INSO)		**OTHER COUNTRIES**		
			Cuba	⊜⊜⊜	(Needs adjustments)
Venezuela	⌂⌂ (Needs articulation)		**Mexico**	⊜⊜⊜	(Unarticulated sectoral plans)

⊜⊜⊜ National Plan in progress, with funds allocated
⌂⌂ National Plan prepared
* No National Plan

One of the purposes of the national plans is to develop new alternatives that will facilitate the extension of coverage in the context of the new economic and labor-market realities. They seek to coordinate all agencies and institutions, both governmental and nongovernmental, that can contribute effectively to the promotion and protection of workers' health, attaching priority to the prevention of work-related risk factors, with the collaboration of the organizations that represent companies and workers.

The national plans, which aim at improving workers' health, should include lines of action to extend health coverage to the most exposed, most vulnerable, or least covered workers, such as children, women, the indigenous population, and the handicapped, as well as those in the informal sector, taking into account that only a small percentage--less than 10% of the working population--currently benefits from comprehensive care in accordance with ILO standards. These lines of action will have to be innovative, embracing strategies such as primary health care and local health services, in addition to considering the new modalities in social security, including preventive, not just curative action. The plans should incorporate various basic components such as: specific policies; legislation, regulation, and standardization; promotion of workers' health; information, generation of knowledge, and epidemiological surveillance; human resources development; institutional strengthening and the development of services and programs; and surveillance and control.

The preparation and development of a national plan for workers' health is based on various principles: comprehensive health care for workers; a primarily preventive approach; the epidemiological and risk approach; multisectoral, multidisciplinary contributions, plus teamwork; the responsibility of the state, employers, and workers; active, informed participation; the adoption of the workplace as the hub from which preventive action emanates and at which it converges; and the ergonomic approach, so that simultaneous consideration is given to the working environment and technique, machinery and tools, organization of work, and health education and prevention in the workplace.

The national plans for the development of workers' health will have the following objectives, among others:

- Improvement of the health of workers:

- Reduction of the number of fatal accidents;
- Reduction of the cases of disability and disease;
- Reduction of work-related illnesses;
- Promotion of factors that contribute positively to health;

- Promotion of health education and healthy practices in the workplace and healthy lifestyles;
- Implementation of measures to increase the average length of economically active life.

▸ Improvement and adaptation of working conditions to the characteristics and abilities of workers:

- Reduction of risk factors (based on priorities);
- Creation of better safety and hygiene conditions in the workplace;
- Guarantee of basic sanitary conditions in all workplaces;
- Control of workers' exposure to unhealthful, toxic, and dangerous substances.

▸ Formulation of a national plan of action:
- Generalized participation and interinstitutional cooperation;
- Programs, services, protection, and prevention;
- Special care for underserved and higher-risk groups;
- Utilization of innovative strategies;
- Collaboration in the areas of hygiene, safety, occupational medicine, ergonomics, and other disciplines of occupational health that are concerned with the issue, making use of existing structures.

TABLES

TABLE 1
Total Population and Economically Active Population in the America's during the Period 1960 to 1990

Country or Territory	1960 Total Population	1960 E.A.P.	%	1970 Total Population	1970 E.A.P.	%	1980 Total Population	1980 E.A.P.	%	1990 Total Population	1990 E.A.P.	%
Antigua and Barb.	54,060	18,212	33.7%	64,794	23,067	35.6%	--	--	--	--	--	--
Argentina	20,010,539 [1]	7,524,469 [1]	37.6%	23,390,050	9,011,450	38.5%	27,947,446	10,033,798	35.9%	31,928,519 [19]	12,141,440 [19]	38.0%
Bahamas	130,220	51,948	39.9%	168,802	69,791	41.3%	209,505	87,052	41.6%	255,500	137,000	53.6%
Barbados	232,327	92,200	39.7%	235,229	91,069	38.7%	249,000	103,033	41.4%	261,000	137,000	52.5%
Belize	90,505	27,006	29.8%	119,934	33,121	27.6%	145,353	47,327	32.6%	--	--	--
Bermuda	42,640	19,444	45.6%	52,330	27,319	52.2%	54,050	31,436	58.2%	--	--	--
Bolivia	2,704,165 [2]	1,361,227 [2]	50.3%	4,613,486 [3]	1,501,391 [3]	32.5%	4,613,486 [11]	1,501,391 [11]	32.5%	7,314,000	2,284,000 [19]	31.2%
Brazil	70,119,071	22,651,263	32.3%	93,139,037	29,557,224	31.7%	119,011,052	43,235,712	36.3%	150,368,000	61,047,954 [19]	40.6%
Brit. Virg. Isl.	7,921	2,164	27.3%	9,672	4,042	41.8%	10,985	5,272	48.0%	--	--	--
Canada	18,238,247 [4]	6,510,356 [4]	35.7%	21,568,310 [5]	8,813,340 [5]	40.9%	24,359,000 [6]	12,054,155 [6]	49.5%	26,525,000	13,360,000	50.4%
Cayman Island	8,511	3,159	37.1%	10,068	3,492	34.7%	16,677 [7]	8,119 [7]	48.7%	--	--	--
Chile	7,374,115	2,388,667	32.4%	--	2,695,566	--	11,478,000 [13]	3,680,277 [13]	32.1%	13,173,000	4,753,000	36.1%
Colombia	17,484,508 [8]	5,134,125 [8]	29.4%	19,735,286 [9]	5,974,992 [9]	30.3%	27,837,932 [10]	9,557,868 [10]	34.3%	31,819,000	10,394,000	32.7%
Costa Rica	1,336,274 [1]	395,273 [1]	29.6%	1,871,780 [9]	585,313 [9]	31.3%	2,416,809 [11]	804,193 [11]	33.3%	3,015,000	1,024,000	34.0%
Cuba	5,829,029 [12]	2,059,659 [12]	35.3%	8,569,121	2,633,309	30.7%	9,723,605 [6]	3,540,692 [6]	36.4%	10,324,000	4,461,000	43.2%
Dominica	59,916	23,409	39.1%	69,548	21,171	30.4%	73,795 [6]	25,333 [6]	34.3%	--	--	--
Dominican Rep.	3,047,070	820,710	26.9%	4,009,458	1,241,000	31.0%	5,647,977 [6]	1,915,388 [6]	33.9%	7,170,000	2,187,000 [19]	30.5%
Ecuador	4,476,007 [14]	1,442,591 [14]	32.2%	6,521,710 [15]	1,940,628 [15]	29.8%	8,060,712 [13]	2,346,063 [13]	29.1%	10,490,251	3,551,017 [19]	33.9%
El Salvador	2,510,984 [4]	807,092 [4]	32.1%	3,554,648 [5]	1,166,479 [5]	32.8%	4,497,257 [11]	1,593,353 [11]	35.4%	5,252,000	2,156,000	41.1%
French Guyana	33,535	11,981	35.7%	55,125	20,903	37.9%	73,012	32,375	44.3%	--	--	--
Grenada	88,677	27,314	30.8%	92,775	28,682	30.9%	--	--	--	--	--	--
Greenland	33,140	11,800	35.6%	46,531	18,741	40.3%	--	--	--	--	--	--
Guadaloupe	283,355 [4]	114,267 [4]	40.3%	324,530 [15]	107,959 [15]	33.3%	327,002 [13]	123,888 [13]	37.9%	340,000	158,000	46.5%
Guatemala	4,287,997 [8]	1,363,669 [8]	31.8%	5,160,221 [9]	1,545,658 [9]	30.0%	6,054,225 [6]	1,696,464 [6]	28.0%	9,197,000 [20]	2,628,000 [20]	28.6%
Guyana	560,330	171,730	30.6%	699,823 [5]	177,164 [5]	25.3%	758,619 [13]	239,331 [13]	31.5%	756,072	270,074	35.7%
Haiti	--	--	--	4,329,991 [15]	2,326,201 [15]	53.7%	5,053,190 [11]	2,129,661 [11]	42.1%	6,504,000	3,132,000	48.2%
Honduras	1,884,765 [4]	567,988 [4]	30.1%	2,656,948	762,795 [15]	28.7%	4,092,175 [11]	1,210,510 [11]	29.6%	5,138,000	1,576,000	30.7%

(continues)

TABLE 1 (continuation)
Total Population and Active Economic Population in the America's during the Period 1960 to 1990

Country or Territory	1960 Total Population	1960 E.A.P.	1960 %	1970 Total Population	1970 E.A.P.	1970 %	1980 Total Population	1980 E.A.P.	1980 %	1990 Total Population	1990 E.A.P.	1990 %
Jamaica	1,609,814 [14]	654,582 [14]	40.7%	1,813,594 [16]	566,445 [16]	31.2%	2,190,357 [13]	708,442 [13]	32.3%	2,521,000	1,246,000	49.4%
Malvinas	2,172 [4]	1,163 [4]	53.5%	1,957 [15]	916 [15]	46.8%	1,813 [13]	951 [13]	52.5%	--	--	--
Martinica	290,679	92,344	31.8%	324,862	104,484	32.2%	326,717	130,500	39.9%	331,000 [18]	156,000 [18]	47.1%
Mexico	34,923,129	11,332,016	32.4%	48,225,238	12,955,057	26.9%	66,846,833	22,066,084	33.0%	82,721,200 [18]	31,806,000 [18]	38.4%
Montserrat	12,167	4,332	35.6%	11,458	3,988	34.8%	11,597 [6]	5,107 [6]	44.0%	--	--	--
Netherlands Antil.	192,538 [1]	60,199 [1]	31.3%	218,390 [16]	73,270 [16]	33.6%	231,932 [6]	96,193 [6]	41.5%	188,444 [18]	71,327 [18]	37.9%
Nicaragua	1,535,588	474,960	30.9%	1,877,952 [5]	505,445 [5]	26.9%	--	--	--	3,807,900 [19]	1,276,900 [19]	33.5%
Panama	1,013,354	336,969	33.3%	1,428,082	488,335	34.2%	1,701,921 [13]	546,852 [13]	32.1%	2,418,000	872,000	36.1%
Paraguay	1,819,103 [14]	586,415 [4]	32.2%	2,357,955 [16]	752,456 [16]	31.9%	3,029,830 [13]	1,039,258 [13]	34.3%	4,277,000	1,411,000	33.0%
Peru	9,906,746 [4]	3,124,579 [4]	31.5%	13,538,208 [16]	3,871,613 [16]	28.6%	17,005,210 [6]	5,363,891 [6]	31.5%	22,332,000	7,138,000	32.0%
Puerto Rico	2,349,540	594,100	25.3%	2,712,033	683,790	25.2%	--	939,834	--	3,709,000	1,245,000	33.6%
St.Kitts & Nevis	56,693	19,616	34.6%	44,884	13,053	29.1%	43,309	17,125	39.5%	--	--	--
Saint Lucia	86,108 [14]	31,372 [14]	36.4%	99,806 [15]	28,988 [15]	29.0%	120,300 [13]	49,451 [13]	41.1%	--	--	--
St.Pier. y Mig.	4,990 [14]	1,773 [14]	35.5%	5,840 [15]	2,153 [15]	36.9%	6,037 [13]	2,380 [13]	39.4%	--	--	--
St.Vinc. y Gren.	79,948 [8]	24,856 [8]	31.1%	86,314	23,731	27.5%	--	--	--	--	--	--
Suriname	324,211	80,199	24.7%	--	--	--	355,240	80,821	22.8%	403,000	135,000	33.5%
Trinidad & Tobago	827,957	278,147	33.6%	931,071	287,976	30.9%	1,079,791	374,713	34.7%	1,283,000	501,000	39.0%
Turks & Caicos	5,668	2,108	37.2%	5,558	1,582	28.5%	7,413	2,909	39.2%	--	--	--
United States	179,323,175 [1]	69,877,476 [1]	39.0%	203,212,877 [17]	82,897,433 [17]	40.8%	227,255,000 [10]	106,084,668 [10]	46.7%	246,649,000	125,557,000	50.9%
Uruguay	2,595,510	1,022,267	39.4%	2,788,429	1,094,599	39.3%	2,955,241	1,176,808	39.8%	3,128,000	1,217,000	38.9%
USA Virg.Isl.	32,099 [4]	11,334 [4]	35.3%	62,468 [5]	25,899 [5]	41.5%	96,569 [6]	38,167 [6]	39.5%	--	--	--
Venezuela	7,523,999	2,351,291	31.3%	10,721,522	3,014,674	28.1%	14,516,735 [6]	4,693,768 [6]	32.3%	19,245,522 [19]	6,900,588 [19]	35.9%
Total	405,443,096	144,563,821	35.7%	491,537,705	177,777,754	36.2%	600,492,709	239,420,613	39.9%	712,844,408	304,930,300	42.8%

-- Data not available

Sources: ILO Yearbook of Labour Statistics, 1945-1989, Idem 1989-1990, Idem 1992. Geneva
PAHO Health Conditions in the Americas. 1990 Edition, Washington D.C.

Notes:
1) 1963
2) 1950
3) 1976
4) 1961
5) 1971
6) 1981
7) 1979
8) 1964
9) 1973
10) 1985
11) 1984
12) 1953
13) 1982
14) 1962
15) 1974
16) 1972
17) 1975
18) 1988
19) 1989
20) 1987

Table 2
CHILD LABOR IN SEVERAL COUNTRIES OF LATIN AMERICA AND THE CARIBBEAN, CIRCA 1990

COUNTRY	YEAR	WORKING POPULATION OF MINORS (10 - 14) YEARS	% OF THE E.A.P. **
ARGENTINA	1990	214,238	1.7
BOLIVIA	1990	74,835	3.3
BRAZIL	1988	2,962,648	4.8
COLOMBIA *	1980	1,097,334	11.4
COSTA RICA	1991	20,947	1.9
EQUATOR	1990	139,908	4.2
EL SALVADOR	1991	23,722	2.5
GUATEMALA	1989	210,634	7.3
HAITI	1990	182,855	6.8
HONDURAS	1991	60,890	3.8
MEXICO	1990	459,445	1.9
NICARAGUA	1991	85,951	6.2
PANAMA	1980	9,572	4.2
PARAGUAY	1990	10,962	2.1
PERU	1988	1,100,000	15.0
TOTAL		**6,653,941**	

SOURCE: Based on figures from the ILO Yearbook of Labor Statistics, Geneva, 1983, 1984, 1987, 1970, 1992

* 6 to 17 years. Study of the National Institute of Health. Colombia.
** Economically active population

NOTE: Information is not available on children under 10 years of age who are working in the countries (except in Colombia)

Table 3

PARTICIPATION OF WOMEN IN THE WORK FORCE IN THIRTY-ONE COUNTRIES OF LATIN AMERICA, 1950-2000 *

YEAR	ECONOMICALLY ACTIVE FEMALE POPULATION	
	NUMBER IN THOUSANDS	% OF THE TOTAL WORK FORCE
1950	10,334	18.0
1960	12,976	19.2(a)
1970	18,846	21.7(a)
1975	22,753	22.3
1980	27,108	23.2
1985	32,639	24.2
1989	47,627	32 2(b)
2000	52,875	27.5(a)

SOURCES: ILO Task Force Estimate and Projections. 1950-2000, 2nd. ed Vol. V, World Summary (Geneva, 1978).
(a) Inter-American Development Bank, 1987
(b) ILO Yearbook of Labor Statistics. 1989-1990. Geneva

* Does not include Canada or the United States

Table 3-A
Labor Force Distribution, by gender, in 31 Countries
in the Americas, 1950-2000 (in thousands)

Country or Territory		1950	1960	1970	1980	1990	2000
Argentina	Men	5,704	6,404	7,012	7,532	8,304	9,589
	Women	1,402	1,706	2,326	2,771	3,244	3,940
	% women	19.7%	21.0%	24.9%	26.9%	28.1%	29.1%
Barbados	Men	58	53	54	62	72	83
	Women	43	38	36	56	65	74
	% women	42.6%	41.8%	40.0%	47.5%	47.4%	47.1%
Bolivia	Men	815	942	1,110	1,348	1,695	2,198
	Women	197	242	303	392	588	755
	% women	19.5%	20.4%	21.4%	22.5%	25.8%	25.6%
Brazil	Men	15,145	19,262	24,686	32,326	39,932	48,301
	Women	2,730	4,077	6,858	11,913	15,094	19,561
	% women	15.3%	17.5%	21.7%	26.9%	27.4%	28.8%
Canada	Men	--	--	--	--	7,525 [1]	--
	Women	--	--	--	--	5,978 [1]	--
	% women	--	--	--	--	44.3% [1]	--
Colombia	Men	3,233	3,842	4,904	6,198	8,117	10,097
	Women	733	927	1,324	1,794	2,276	2,892
	% women	18.5%	19.4%	21.3%	22.4%	21.9%	22.3%
Costa Rica	Men	250	320	435	612	801	1,004
	Women	44	60	96	165	223	293
	% women	15.0%	15.8%	18.1%	21.2%	21.8%	22.6%
Cuba	Men	--	--	--	--	2,920 [2]	--
	Women	--	--	--	--	1,649 [2]	--
	% women	--	--	--	--	36.1% [2]	--
Chile	Men	1,728	1,963	2,295	2,739	3,399	3,934
	Women	431	544	661	1,026	1,354	1,601
	% women	20.0%	21.7%	22.4%	27.3%	28.5%	28.9%
Dominican Republic	Men	716	840	1,030	1,037	1,860	2,359
	Women	71	93	126	194	328	514
	% women	9.0%	10.0%	10.9%	15.8%	15.0%	17.9%
Ecuador	Men	958	1,209	1,571	1,969	2,653	3,489
	Women	193	236	305	470	634	857
	% women	16.8%	16.3%	16.3%	19.3%	19.3%	19.7%
El Salvador	Men	573	700	942	1,192	1,614	2,215
	Women	112	141	241	395	541	749
	% women	16.4%	16.8%	20.4%	24.9%	25.1%	25.3%
Guadaloupe	Men	--	--	--	2,484 [4]	--	--
	Women	--	--	--	600 [4]	--	--
	% women	--	--	--	19.5% [4]	--	--
Guatemala	Men	868	1,090	1,379	1,695	2,198	2,949
	Women	128	153	208	272	430	716
	% women	12.9%	12.3%	13.1%	13.8%	16.4%	19.5%
Guyana	Men	114	130	159	220	287	361
	Women	25	31	41	71	96	126
	% women	18.0%	19.3%	20.5%	24.4%	25.1%	25.9%
Haiti	Men	943	1,072	1,251	1,433	1,827	2,379
	Women	900	984	1,091	1,125	1,304	1,535
	% women	48.8%	47.9%	46.6%	44.0%	41.6%	39.2%
Honduras	Men	413	542	678	909	1,279	1,779
	Women	54	76	112	169	297	521
	% women	11.6%	12.3%	14.2%	15.7%	18.8%	22.7%

(continues)

Table 3-A (continuation)
Labor Force Distribution, by gender, in 31 Countries in the Americas, 1950-2000 (in thousands)

Country or Territory		1950	1960	1970	1980	1990	2000
Jamaica	Men	403	406	409	511	676	840
	Women	231	260	302	435	570	715
	% women	36.4%	39.0%	42.5%	46.0%	45.7%	46.0%
Mexico	Men	1,672	9,367	11,915	16,246	22,226	29,223
	Women	1,138	1,689	2,574	6,002	8,261	11,218
	% women	40.5%	15.3%	17.8%	27.0%	27.1%	27.7%
Netherlands Antill.	Men	--	--	--	44 [4]	--	--
	Women	--	--	--	32 [4]	--	--
	% women	--	--	--	42.1% [4]	--	--
Nicaragua	Men	317	384	497	647	901	1,257
	Women	50	84	122	178	303	517
	% women	13.6%	17.9%	19.7%	21.6%	25.2%	29.1%
Panama	Men	254	302	385	485	635	792
	Women	60	80	130	172	237	319
	% women	19.1%	20.9%	25.2%	26.2%	27.2%	28.7%
Paraguay	Men	384	460	584	831	1,118	1,467
	Women	104	125	158	218	292	386
	% women	21.3%	21.4%	21.3%	20.8%	20.7%	20.8%
Peru	Men	2,044	2,514	3,082	4,073	5,416	7,079
	Women	540	663	783	1,301	1,722	2,284
	% women	20.9%	20.9%	20.3%	24.2%	24.1%	24.4%
Puerto Rico	Men	--	--	--	--	--	665 [3]
	Women	--	--	--	--	--	393 [3]
	% women	--	--	--	--	--	37.1% [3]
Suriname	Men	57	63	74	75	95	121
	Women	15	18	25	29	40	53
	% women	20.8%	22.2%	25.3%	27.9%	29.6%	30.5%
Trinidad and Tobago	Men	171	205	223	282	350	427
	Women	60	76	94	115	150	184
	% women	26.0%	27.0%	29.7%	29.0%	30.0%	30.1%
United States	Men	--	--	--	--	69,360 [1]	--
	Women	--	--	--	--	56,198 [1]	--
	% women	--	--	--	--	44.8% [1]	--
Uruguay	Men	720	782	818	798	838	906
	Women	210	248	292	336	379	436
	% women	22.6%	24.1%	26.3%	29.6%	31.1%	32.5%
Venezuela	Men	1,372	1,899	2,437	3,673	4,964	6,492
	Women	300	425	638	1,275	1,896	2,629
	% women	17.9%	18.3%	20.7%	25.8%	27.6%	28.8%
Virgin Islands	Men	--	--	--	20 [3]	--	--
	Women	--	--	--	17 [3]	--	--
	% women	--	--	--	45.9% [3]	--	--
Latin America	Men	44,912	54,751	67,930	89,780	191,727	139,341
	Women	9,771	12,976	18,846	30,983	64,218	52,875
	% women	17.9%	19.2%	21.7%	25.7%	25.1%	27.5%

-- Data not available

SOURCES: IDB. 1987.
ILO. Yearbook of Labour Statistics. 1989-1990. Geneva.

ILO. Yearbooks of Labour Statistics. 1989-1990. Geneva.
Those marked: (1) 1989 (2) 1988 (3) 1987 (4) 1986

Table 4
Job Related Accidents in several Latin American Countries and The Caribbean, 1981-1991
(fatal accidents reported and accidents implying loss of work-days)

Country	Years									
	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Argentina	61,525	70,658	98,051	--	--	--	--	--	--	--
Barbados	869	1,351	778	611	395	882	744	1,120	959	862
Belize	--	660	720	565	506	672	778	1,030	--	--
Bermuda	--	--	--	--	--	47	38	30	--	--
Bolivia	2,238	2,312	2,013	2,200	1,416	397	493	967	507	--
Brazil	1,078,800	926,343	878,337	938,500	1,154,480	1,143,360	997,353	892,897	646,092	592,283
Colombia [1]	102,784	91,854	89,895	87,322	96,709	100,249	103,906	105,468	106,655	100,481
Costa Rica	49,620	55,337	--	72,600	77,856	105,658	108,831	113,301	124,290	129,571
Cuba	--	64,559	65,835	62,556 [3]	63,467	71,244	64,206	--	--	--
Chile	72,539	77,193	99,884	122,543	-- [5]	--	--	--	--	--
Dominican Rep.	--	--	--	--	2,495	4,178	--	--	--	--
Ecuador	--	1,472	1,569	1,750 [5]	1,500	1,717 [5]	3,797 [7]	4,611 [7]	4,931	--
El Salvador	8,320	8,555	8,376	9,553	--	10,193	12,301	10,922 [6]	11,850	--
Guatemala	83,060	81,984	85,268	81,495	84,981	--	--	110,982	--	--
Guyana	7,964	9,922	8,938	9,396	6,608	4,906	--	--	--	--
Haiti	1,736*	1,979*	1,845*	1,883*	1,839	1,818	1,488	1,650	--	--
Honduras [5]	4,470**	2,753**	3,143**	3,736**	3,657**	4,721	5,104	6,446	6,785	6,748
Jamaica	2,189	1,962	--	162	162	167	129	100	115	--
Mexico	524,000	505,981	524,684	500,516	546,182	529,188	507,807	496,597	509,970	--
Nicaragua [5]	6,990	7,933	8,048	5,813	5,176	6,657	5,098	5,147	4,935	2,645
Panama	26,632	25,114	26,393	23,573	19,474	20,792	12,421	12,310	15,176	15,335
Paraguay [4]	--	--	--	--	2,088	2,320	--	--	--	--
Peru	830	688	753	6,748	6,061 [2]	8,320 [2]	7,025	6,699	6,672	--
Suriname	6,894	4,395	2,273	3,419	2,803	2,217	2,067	1,859	1,561	--
Trinidad y Tabago	2,207	1,880	1,633	1,241	967	923	827	700	726	--
Uruguay	33,656	30,487	30,094	31,865	34,432	34,640	30,636	--	--	--
Venezuela	13,930	11,350	9,660	9,708	10,128	5,309	--	--	--	--
TOTAL	2,091,253	1,986,722	1,948,190	1,977,755	2,123,382	2,060,575	1,865,049	1,772,836	1,441,224	847,925

* Includes job-related deseases. Quoted year end in September.
** Includes job related accidents.
*** Data related to the first three months.
-- Data not available

Sources:
OIT- Annual of Labor Statistics. 1987, 1988, 1991, 1992.
1 Instituto de los Seguros Sociales, Colombia
2 Instituto Peruano de Seguridad Social
3 Accidentes de Trabajo y Enfermedades Profesionales y Accidentes Escolares, Ministerio de Salud, Chile 1985
4 2do. Encuentro Iberoamericano sobre Seguridad y Salud de los Trabajadores, 31 de octubre a 4 de noveiembre. 1988
5 PAHO. Workers health situation in Central America, Panama, and Dominican Republic.
6 PLANSAT - Guatemala. Febrero 1991
7 PAHO. Reunión Técnica sobre Salud de Trabajadores. Informe de País. Guatemala, 1991

In the five years period (1984-1988) = 10,036,534 injured workers.

Table 5
Fatal Job-Related Accident Rate
For 1,000,000 People in the Economically Active Population
(E.A.P), in 1990

Country or Territory	Year	E.A.P.	Fatal Accidents	Mortality Rate
Barbados	1991	137,000	3	21.8
Bolivia	1989	1,996,459	38	19.1
Brasil	1990	61,947,954	5,012	82.1
Canada	1989	13,360,000	830	62.1
Colombia	1990	10,394,000	352	33.9
Costa Rica	1990	1,024,000	116	113.3
Cuba	1988	4,342,280	346	79.7
Chile	1982	3,660,800	36	9.8
Ecuador	1989	3,551,017	143	40.3
Guatemala	1990	2,628,000	194	73.8
Haiti	1989	3,132,000	1	0.3
Honduras	1990	1,576,000	4	2.5
Jamaica	1990	1,246,000	2	1.6
Mexico	1988	31,806,000	1,253	39.3
Nicaragua	1990	1,276,900	85	66.5
Panama	1990	872,000	28	32.1
Peru	1990	7,138,000	78	10.9
Puerto Rico	1990	1,245,000	31	24.8
Suriname	1990	135,000	6	44.4
Trinidad and Tobago	1990	501,000	1	1.9
United States	1989	119,540,000	3,600	30.1
Uruguay	1988	1,217,000	72	59.1
Venezuela	1985	5,567,057	45	8.1
Region Total	c1990	278,293,467	12,276	--
Sweden	1991	4,552,000	117 (90)	25.7
Spain	1991	15,073,100	1,446 (90)	95.9

SOURCE: ILO. Yearbook of Labour Statistics. Geneva, 1984, 1987, 1988, 1991, 1992.

Table 6
Fatal Job-Related Accident Rate
According to different Economic Activity Sectors from Selected Countries, 1980-1991

A. AGRICULTURE, SILVICULTURE, HUNTING AND FISHING (*)

Country	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Barbados	0.210	0.100	0.120	--	0.120	--	0.380	0.120	--	--	--	0.170
Belize	--	--	--	0.080	0.070	0.240	0.160	0.100	--	--	--	--
El Salvador	1.458	1.040	0.510	0.450	0.850	--	--	--	--	--	--	--
Guatemala	--	--	1.130	0.950	0.790	0.720	0.750	0.750	0.470	0.270	0.230	--
Peru	--	--	0.080	0.040	0.010	0.010	0.010	0.010	--	--	--	--
Spain	--	--	--	0.089	0.110	0.108	0.122	0.115	0.102	0.112	0.130	0.136

B. MINES AND QUARRYS (*)

Country	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Bolivia	--	0.650	0.385	0.385	0.206	0.278	--	--	--	--	--	--
El Salvador	1.701	1.870	1.420	--	--	--	--	--	--	--	--	--
Guatemala	--	--	0.970	1.480	0.930	1.440	2.380	2.270	0.530	0.350	0.310	--
Peru	0.180	0.070	0.210	0.710	0.440	0.160	0.490	0.580	--	--	--	--
Belgium	--	--	0.410	0.190	0.630	0.380	0.130	--	--	--	--	--

C. CONSTRUCTION (**)

Country	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Argentina	0.720	0.700	0.520	0.430	0.750	0.290	0.210	--	--	--	--	--
Canada	0.400	0.370	0.340	0.310	0.410	0.350	0.280	--	--	--	--	--
Cuba	--	--	--	0.187	0.186	0.194	0.187	0.248	0.159	--	--	--
Panama	0.430	0.320	0.260	0.060	0.130	0.150	0.120	0.110	0.860	0.060	0.110	0.130
Suriname	--	0.220	--	--	--	--	--	--	--	--	--	--
Trinidad and Tobago (***)	--	--	0.040	0.050	0.020	0.010	--	--	--	--	--	--
Finland	--	--	0.127	0.092	0.123	0.094	0.116	0.094	0.075	0.085	0.111	--
Germany	0.100	0.090	0.070	0.070	0.070	0.070	0.060	0.060	0.070	0.070	--	--

(*) Rates for one thousand workers under risk.
(**) Rates for one thousand workers employed.
(***) Includes electricity, gas and water.
(****) Includes quarrys.
-- Data not available.

Source: ILO. Yearbook of Labour Statistics, 1988, 1991, 1992. Geneva.

Table 7
Number of Work-days Missed due to Job-Related Accidents in Selected Latin American Countries and the Caribbean, 1982-1991

Country or Territory	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Argentina	991,800	1,224,940	1,572,550	--	--	--	--	--	--	--
Bolivia	--	--	--	5,704	5,559	--	--	9,724	--	--
Colombia [1]	1,006,136	--	--	--	--	--	--	--	--	--
Costa Rica	--	--	--	--	--	--	--	1,096,000	1,214,140	1,293,540
Cuba	--	1,358,470	1,472,600	1,545,050	1,533,300	1,687,960	1,615,000	--	--	--
Chile	1,056,870	1,129,870	1,338,540	774,280	--	--	--	--	--	--
Guyana	12,029	365,612	--	400,299	191,205	74,229	--	--	--	--
Haiti	107,027	165,794	111,838	147,727	107,502	77,245	89,442	96,142	--	--
Mexico	9,497,000	6,889,000	7,489,000	--	9,856,670	9,906,640	10,137,900	11,336,100	11,336,100	4,776,090 [3]
Nicaragua [2]	--	--	--	--	33,769	81,625	59,996	825,551	51,556	53,886
Paraguay	--	--	--	--	67,920	77,799	--	--	--	--
Peru	1,020,030	635,371	753,859	--	96,147	192,236	252,162	278,329	191,006	--
Suriname	55,026	57,121	22,787	3,415	15,234	27,631	9,750	67,958	51,646	--
Virgin Islands	--	--	--	--	--	7,101	9,078	6,476	9,491	--
Total	13,745,918	11,826,178	12,761,174	2,876,475	11,907,306	12,132,466	12,173,328	13,716,280	12,853,939	6,123,516

-- Data not available

Sources: ILO. Yearbook of Labour Statistics. Geneva, 1987, 1988, 1991, 1992.

1 Instituto de los Seguros Sociales, Colombia 1980
2 2do. Encuentro Iberoamericano sobre Seguridad y Salud de los Trabajadores, 31 de octubre a 4 de noviembre de 1988, Colombia.
3 January-April

Each year in nine Latin American Countries and the Caribbean, almost 12 million work-days or lost (taking in consideration the information for 1986 and the 630,464, accidents occurred; each accident implied the loss of 19 work-days), this would mean that each year in Latin America, for 2 million accidents, 38 million work-days are missed, which equals to stopping all the industries of these countries for one day.

Table 8
Percentage of Economically Active Population Covered by Social Security in Latin American Countries and the Caribbean

Country	1960	1970	1980	1985 - 1988
Argentina	55.2	68.0	69.1	79.1
Bahamas	--	--	85.3	85.9
Barbados	--	75.3	79.8	96.9
Bolivia	8.8	9.0	18.5	16.9
Brazil	23.1	27.0	87.0	96.0
Colombia	8.0	22.2	30.4	30.2
Costa Rica	25.3	38.4	68.3	68.7
Cuba	--	--	--	93.6
Chile	70.8	75.6	61.2	79.2
Dominican Rep.	--	8.9	11.6	10.2
Ecuador	11.0	14.8	21.3	25.8
El Salvador	4.4	8.4	11.6	--
Guatemala	20.6	27.0	33.1	27.0
Honduras	3.7	4.2	14.4	12.8
Jamaica	--	58.8	80.9	93.2
Mexico	15.6	28.1	42.0	40.2
Nicaragua	5.9	14.8	18.9	31.5
Panama	20.6	33.4	52.3	59.8
Paraguay	8.0	10.7	14.0	32.0
Peru	24.8	35.6	37.4	--
Uruguay	--	95.4	81.2	73.0
Venezuela	11.9	24.4	49.8	54.3

-- Data not available

Sources: OPS. AARP. Mid-Life and Older Women in Latin America and The Caribbean, 1989. Carmelo Mesa-Lago. Aspectos Económico-Financieros de la Seguridad Social en America Latina y El Caribe: Tendencias, Problemas y Alternativas para el Año 2000, Washington,D.C. Banco Mundial, 1989b.

DATA TO BE COLLECTED FROM SOCIAL SECURITY

These data need to be included in the first draft of the report to be prepared before 23 March and subsequently presented to the Governing Bodies of PAHO in June/93. These data from social security institutions will make it possible to calculate the values for the entire working population.

NOTE: Please submit the requested information as succinctly and clearly as possible (no more than 2 pages)

DATA	USE	OBSERVATIONS
1. **Number of affiliated workers**	- To ascertain the total number of affiliates (if possible, the affiliates every social security Institution) in order to determine what percentage of the working-age population and of the formal work force they account for	- If possible, by age groups and by branch of activity
2. Number of pensioners 2.1 disability pension owing to an occupational accident or occupational disease (including those who received worker's compensation) 2.2 retirement pension (old age and/or common illness)	- To determine the extent and number of cases of disability - to calculate the ratio of the contributor population to the population receiving pensions for occupational accidents and occupational diseases - to calculate the ratio of the contributor population to the population receiving pensions	- If possible, indicate the numbers by type/degree of disability (we suggest disability groupings: 10-25%; 26-40%; 41-60%; 61-100% of IPP) - If possible, separate occupational accidents from occupational diseases - If possible, they should be related to age at the time of retirement - If possible, by type of activity
3. Fatal occupational accidents	- Makes it possible to evaluate the severity of the situation	- If possible, by age groups and branch of activity
4. **Total mortality of member workers**	- To determine the cause of death and the age at which the member workers die	- If possible, classify by age groups and branches of activity.

DATA	USE	OBSERVATIONS

5. Number of years that the workers currently receiving pensions have contributed	- To ascertain how many years they contributed and how many will probably receive benefits
	- To calculate the average length of working life
		- Classify the situations of pensioners by:
		  - occupational accidents and occupational diseases
		  - common diseases
		  - old age

6. Average duration of treatment of those injured at work (in days)	- To have data to study the severity of accidents	- If possible, classify by branch of activity and type of accident
7. Average duration of temporary disability among those injured at work	- To have data to study the severity of accidents	- If possible, classify by branch of activity and type of accident
8. Accidents en route to and from work	- To find out about commuting accidents (if in that country they are considered occupational accidents)	- If possible, indicate separately the statistical values of occupational accidents in the workplace and commuting accidents
9. Composition of the Units (or departments) of Occupational Health	- To be able to relate the dimension of specialized services in Occupational Health, especially their prevention-oriented capacities, to the remaining curative medical services	- If possible, indicate the number of professionals in this unit (and the number of professionals in every institution) - Describe the principal functions of the unit