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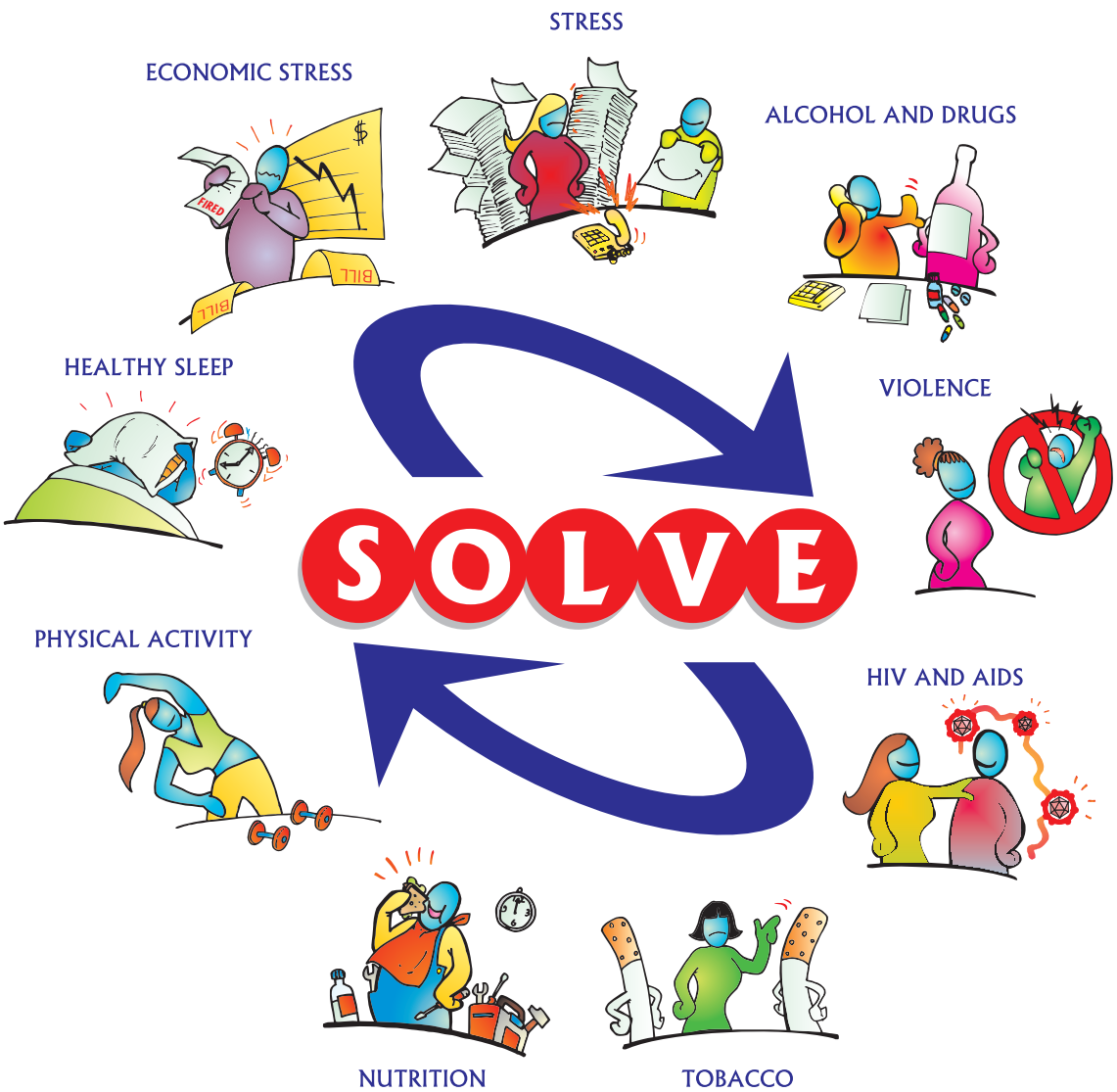
Participant's workbook

SOLVE:
Integrating Health Promotion into Workplace OSH Policies



Edited by Valentina Forastieri

International Labour Office

SOLVE:
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Participant's Workbook

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Preface

In recent years, there has been growing attention to the impact of psychosocial factors in the workplace both in developed and developing countries. Work-related stress, burnout, mobbing and other forms of violence at work are now generally acknowledged as global issues, affecting all countries, all professions and all workers. It is also accepted that they can have a significant impact on workers' health, absenteeism and performance. Rapid globalization and technological progress have transformed the world of work resulting in emerging psychosocial risks which require an approach that breaks away from traditional efforts and moves towards new effective responses.

Research and interventions are now being undertaken in many countries to devise innovative ways to deal with the consequences of psychosocial factors and, in particular, of work-related stress. These initiatives include preventive practices and incorporating health promotion measures, such as good nutrition, exercise and other healthy lifestyles to contribute to workers well-being.

The potential of workplace health promotion to enhance working life is a vital component in improving workplace productivity and performance. Integrating health promotion into Occupational Safety and Health (OSH) policies benefits both workers and employers by improving the long-term well-being of workers and their families, and reducing pressure on health, welfare and social security systems. Integrating health promotion measures into OSH management systems enhances occupational health practice and contributes to the construction of a preventive culture.

The purpose of this training package is to contribute to the design of workplace policies and preventive measures on the basis of the global knowledge gained. This second edition of the SOLVE training package builds upon the experience acquired through the implementation of SOLVE's training programme since 2002. It also takes into account the most recent trends concerning emerging psychosocial risks and integrates workers' health promotion and well-being as essential elements of workplace OSH policies and practices.

The SOLVE training package advocates that a comprehensive OSH management system should ensure that risk management also includes the assessment and control of psychosocial factors to properly manage their impact in the same way as it is done with other hazards and risks; and that health promotion measures, such as nutrition and physical activity for health are incorporated into the organization's policy.

This training package is meant for HR managers, trade unions, employers' associations, OSH professionals and practitioners as well as national institutions responsible for the health and well-being of workers.

The ILO strives for decent work, safe work and human dignity. Providing for mechanisms to address psychosocial risks at work by incorporating preventive and health promotion measures contributes to a more decent and human world of work. In the light of the recent financial crisis, this objective is more than ever everyone's concern.

Manuela Tomei
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Labour Protection Department
(PROTRAV)

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Work and the Environment (SafeWork)

Foreword

The first edition of **SOLVE**, published in 2002, was designed as a direct response to the needs of ILO's constituents to protect workers against emerging psychosocial risks and to promote their health and well-being in the workplace.

This second edition has been revised and considerably expanded to meet the new challenges of a changing world of work. The demands of constituents, course directors, and users of the original **SOLVE** training package have also been taken into account. The five original subjects have been reviewed in the light of scientific developments and good practices. The new version incorporates other health promotion aspects, such as nutrition, healthy sleep and physical activity. As any change in work organization and workplace culture requires an assessment of psychosocial factors to carefully manage and reduce stress, it also considers new challenging situations in times of change which can contribute to economic stress. The new Policy Course covers nine topics related to workplace health promotion in a highly interactive way, aiming to provide participants with the knowledge and skills necessary to integrate the topics into an occupational safety and health policy and a workplace health promotion action programme.

The ILO acknowledges that in times of global financial and social crisis and workplace change, coping successfully with psychosocial risks at the workplace is essential for protecting the health and well-being of workers while enhancing productivity. This training package intends to contribute to support ILO constituents and other social partners in protecting workers' health and promoting their well-being.

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Acknowledgements

The second edition of SOLVE is a revised and extended version of the original SOLVE Policy Course, published in 2002. SafeWork wishes to acknowledge the contributions of all those involved in the drafting, editing, reviewing, and validating of the SOLVE training package for the first and the second editions. Furthermore, we wish to express our gratitude and appreciation for the kind assistance of the course directors who were co-authors of the technical chapters from the trainers' manual in the second edition. Special thanks to Chiara Cirelli for her contribution to this edition. The following individuals have directly contributed to both editions (listed in alphabetical order):

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BAC	Blood Alcohol Concentrations
BCC	Behaviour Change Communication
CD	Compact Disk
CDC	Centers for Disease Control
CEA	California Environmental Agency
COP	Conference of Parties
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
EAP	Employer Assistance Programmes
EEA	European Economic Area
EHN	European Heart Network
ENWHP	European Network for Workplace Health Promotion
ETS	Environmental Tobacco Smoke
EU	European Union
EU-OSHA	European Agency for Safety and Health at Work
FCTC	Framework Convention on Tobacco Control
FHI	Family Health International
FVC	Forced Vital Capacity
HDL	High Density Lipoprotein (low levels of good cholesterol)
HIV	Human Immunodeficiency Virus
HSE	Health and Safety Executive
ICT	Information communication Technology
ILO	International Labour Organization
LDL	Low Density Lipoprotein (high levels of bad cholesterol)
LSD	Lysergic acid diethylamide
MSD	Management of Substance Dependence

NGO	Non-Governmental Organization
NHS	National Health Service
NIDA	National Institute on Drug Abuse
OSH	Occupational Safety and Health
PCP	Phencyclidine
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PLMD	Period Limb Movement Disorder
PPT	Power Point Presentation
PTSD	Post Traumatic Stress Disorder
PROTRAV	Labour Protection Department
RLS	Restless Legs Syndrome
RSI	Repetitive Strain Injuries
SHS	Second-hand Smoke
SIDS	Sudden Infant Death Syndrome
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counselling and Testing
WAPPA	Workplace Alcohol Prevention Programme and Activity
WHO	World Health Organization
WHO SUPRE	World Health Organization Suicide Prevention programme
WHP	Workplace Health Promotion

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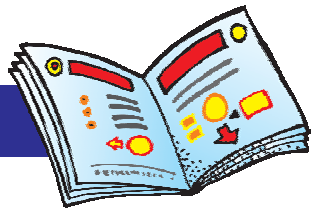
Introduction

Objective

At the end of the module the participant will understand the overall framework on which the SOLVE Policy Course is based.

Introduction to the new edition



The problem

Scientific evidence shows that in the long term, work-related stress can contribute to musculoskeletal disorders and ill-health, including hypertension and cardiovascular diseases; it may also alter immune functions which in turn can facilitate the development of cancer. Moreover, work-related stress also contributes to an inability to cope with work as well as poorer career opportunities and employment prospects. More widely, it can lead indirectly to problems in and outside of the workplace such as violence; the abuse of drugs, tobacco, and alcohol; strained family relationships; depression; and even suicide. This represents potentially huge costs, both in terms of human distress and economic burden.

Work-related stress, tobacco use and exposure to second-hand smoke, the abuse of drugs and alcohol, violence, and HIV and AIDS are major threats to an enterprise's survival. Taken together they can be responsible for a great number of occupational accidents and diseases which lead to injuries, illnesses, incapacity, and death. These problems have a considerable impact on productivity, on direct and indirect costs, and on the very existence of the enterprise. Regardless of a country's stage of development, these problems affect nearly all countries, all sectors, and all categories of workers.

In addition, many harmful effects of lifestyle behaviours, such as smoking, alcohol and drug abuse, nutritional deficiencies, and physical inactivity can also interact with workplace hazards. Their combined effects may increase the health risks of workers. However, the early detection and appropriate treatment of incipient diseases will reduce mortality and lower the frequency and extent of residual disability from many occupational and work-related diseases. There is growing evidence that the elimination or limiting of such health risks can also prevent or delay the onset of life-threatening diseases such as coronary artery diseases, and cancer.

The economic and social costs

There are considerable costs for the individual worker in terms of stigmatization, physical and mental health disorders, incapacity to work, the risk of job loss, strained or fractured relationships at home, and even death. Within the enterprise, these problems result in disturbed labour relations, increased absenteeism, high staff turnover, internal transfers and retraining, reduced motivation of staff, decreased satisfaction and creativity, together with a poor public image. The overall impact is a significant loss of productivity and decreased competitiveness of the enterprise, and what is known probably represents only the tip of the iceberg. The direct and indirect costs relating to these problems are only beginning to be quantified.

Stress: A recent study by the European Agency for Occupational Safety and Health (EU-OSHA) found that on average 22 per cent of the European workforce is stressed, with markedly higher levels in the newer member States (30 per cent) than in the older member States (20 per cent) (EU-OSHA, 2009).

Drugs and alcohol: It has been estimated that up to 54 per cent of alcohol-related incidents (such as accidents, quarrels, absenteeism, crime, etc.) are attributed to light drinkers, with 87 per cent of the total attributed to light and moderate drinkers (Becker, 2001).

Violence: Many national surveys have found that between 40 per cent and 90 per cent of the women questioned have suffered some form of sexual harassment during the course of their working lives (Hunt et al., 2007).

HIV and AIDS: In 2009, an estimated 1.8 million people died of AIDS and in that same year 2, 6 million people became infected. The most affected region is sub-Saharan Africa, which is home to 22, 5 million people living with HIV (PLHIV); that is, 68 per cent of the global total of PLHIV (UNAIDS, 2010).

Tobacco: Unless urgent action is taken, tobacco could kill one billion people during the 21st century. By 2030, more than 80 per cent of tobacco related deaths will be in developing countries (WHO, 2008).

Nutrition: It is estimated that there are more than 300 million obese people worldwide (WHO, 2006).

Physical Activity: It is associated with a 25 per cent lower risk of bowel and breast cancer in the United Kingdom (Cancer Research UK). According to the WHO, 90 per cent of people with diabetes have Type 2 diabetes which is closely related to being overweight and physical inactivity (WHO, 2009).

Healthy Sleep: Research shows that individuals suffering from sleep deprivation and sleep disorders are less productive, have an increased health care utilization, and have an increased likelihood of injury (Colten; Altevogt, 2006).

Economic Stress: in 2008 the global unemployment rate was estimated at 6.6 per cent (ILO, 2010a). The economic crisis resulted in an additional 7.8 million young workers facing unemployment, bringing the total to an estimated 81 million, or 13 per cent globally (ILO, 2010b).

The response

Health promotion programmes at the workplace are also being designed to enable workers to cope more effectively with psychosocial factors contributing to work-related, personal, or family problems that may impact on their well-being and work performance, such as stress, violence or the abuse of alcohol and drugs. Unfortunately, most of these initiatives tackle the problems only from an individual

perspective, without taking into account the contributing organizational or labour relations factors.

For the ILO, health promotion in the workplace is effective when health promotion activities complement occupational safety and health measures through their integration into OSH management practices, in order to prevent accidents and diseases, and when they protect and improve the health and well-being of men and women at work.

The fundamental principles of this approach are found in the Occupational Safety and Health Convention, 1981 (No. 155) and its accompanying Recommendation, (No. 164) as well as in the Occupational Health Services Convention, 1985 (No. 161) and its accompanying Recommendation (No. 171). Occupational health services are entrusted with preventive and advisory functions, and are responsible for assisting employers, workers, and their representatives in meeting the requirements of establishing and maintaining a safe and healthy working environment which facilitates optimal physical and mental health in relation to work. These include the adaptation of work to suit the workers' capabilities by taking into account their state of physical and mental health.

The workplace has become an ideal venue to address emerging psychosocial risks through the joint action of employers, workers, and national authorities. This implies conducting an occupational health practice which involves:

- The prevention of occupational and other work-related diseases as well as occupational injuries;
- the improvement of working conditions and work organization;
- the incorporation of psychosocial risks into risk-assessment measures; and
- the assessment of the needs of the organization itself taking into consideration organizational, individual and individual-organizational interactions when evaluating workers' health requirements.

In this context SOLVE is a tool which can contribute in addressing workplace psychosocial hazards and risks. The ILO's comparative advantage lies in its experience using the social dialogue approach, which has resulted in the implementation of successful workplace and community initiatives which address these problems with the involvement of employers, workers, OSH practitioners, governments, policy makers, public services, and NGOs.

The training material

This training package was developed by the ILO's International Programme on Safety, Health at Work and the Environment (SafeWork) in collaboration with the ILO's International Training Centre in 2002. Known as SOLVE, it provides for a six-day-long interactive training course with the goal of giving participants from

enterprises, organizations, and institutions the knowledge and skills to incorporate a health promotion strategy into a comprehensive workplace policy on OSH.

This training package was designed to complement:

- The definition of occupational health of the ILO/WHO Joint Committee on Occupational Health: "Occupational health should aim at the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations […]".
- The ILO's Occupational Safety and Health Convention, 1981 (No. 155) and its accompanying Recommendation (No. 164).
- The ILO's Occupational Health Services Convention, 1985 (No. 161) and its Recommendation (No. 171).
- The ILO code of practice on the management of alcohol- and drug-related issues in the workplace (1996).
- The ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200).
- The ILO Guidelines on Occupational Safety and Health Management Systems (2001).
- The ILO code of practice on HIV/AIDS and the world of work (2001).

SOLVE was designed to offer an integrated workplace response for dealing with stress, violence, tobacco use and exposure to second-hand smoke, drugs and alcohol abuse, and HIV and AIDS. SOLVE also introduced an innovative approach whereby workers' health, safety, and their well-being became an integral part of organizational development and economic sustainability, by contributing to productivity and competitiveness in the globalized world economy. SOLVE offers the tools for the design of such a policy and for taking immediate action to reduce or eliminate the emerging risks associated with these problems in the workplace.

To achieve these objectives SOLVE is:

People-centred: Workers are increasingly recognized as the crucial asset for the success of any business. Their well-being is essential to the development of the "new" flexible, quality-oriented, knowledge-based, healthy, and competitive enterprise.

Preventive: Prevention is a much more cost-effective and successful way to take action than waiting until a significant problem has developed. A healthy work organization and working environment are preconditions to the success of a productive enterprise.

Gender-sensitive: Consideration is paid to how psychosocial risks affect both men and women. In its training and promotional activities, SOLVE strives for gender balance and to avoid gender-specific roles.

Results-oriented: Success can only be measured by the results in the workplace. Taking action to promote changes in the workplace should be the natural follow-up to SOLVE.

Adaptable: Situations are complex and solutions are multiple. A single approach to any problem does not work in all environments and cultures. Several approaches and options are presented and discussed, so that users can develop programmes and actions that meet their unique needs and circumstances.

Self-sustainable: The programmes and means of action developed to meet the needs of the employers and workers should show positive results, be capable of being modified in order to meet changing circumstances, and be cost-effective. The training programme aims for sustainable action that can be continued easily and be cost-effective in an enterprise.

The SOLVE training package is designed with a participatory approach, as all the participants should have an active role in designing the OSH policy and the health promotion programme. Based on the training of trainers' model evolved from adult education methods and learning theories, it is conceived towards building on the knowledge of participants during the course and to support the workplace design on joint labour-management programmes. Therefore, it is not written in an academic or scholarly style, but is more practically oriented and uses concrete, everyday language.

The new revised version deals with the following 12 subjects: Introduction to the methodology; Managing workplace health promotion; Work-related stress; Alcohol and drugs at work; Violence at work; HIV and AIDS at work; Tobacco and workplace second-hand smoke; Nutrition at work; Physical activity for health; Healthy sleep; Economic stress, and From concept to action. **The training package includes**:

1. The participant's workbook: Each module, one per topic, includes information notes and a set of exercises, hand-outs of PowerPoint presentations, and a check-list with practical suggestions to orient the participants in the design of their health promotion policy and programme.
2. The trainer's guide: Includes 12 modules designed to provide the trainers with a structured guide to develop the key competences in training on work-place health promotion with solid technical information on all the topics addressed in SOLVE.
3. The trainer's guide is complemented by a lesson plans booklet aimed at guiding the trainer in the organization of the training sessions and delivery of the course.
4. A CD: containing the electronic version of the training package, the PowerPoints for presentation and complementary reference materials.

The target audience

This training package is intended to stimulate action; its primary audience consists of managers, supervisors, workers and their representatives, occupational physicians and safety engineers who have a concrete interest in introducing preventive programmes dealing with psychosocial hazards and health promotion within their enterprise. In a broader prospective, a secondary (but no less important) audience will consist of policy-makers, as well as officials of governments, and workers' and employers' organizations with a direct interest in this area. It has been conceived with a training of trainers' approach in order to disseminate it widely throughout institutions, organizations, and companies dealing with workplace health promotion.

The SOLVE approach

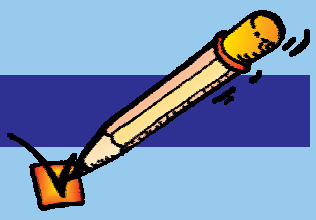
The ILO designed SOLVE with the aim of integrating workplace health promotion into OSH policies. The SOLVE training package focus on the promotion of health and well-being at work through policy design and action addressing the following areas and their interactions.

- Psychosocial health:
  - stress;
  - psychological and physical violence;
  - economic stressors.
- Potential addictions:
  - tobacco consumption;
  - alcohol and drug consumption.
- Lifestyle habits:
  - nutrition;
  - exercise or physical activity;
  - healthy sleep;
  - HIV and AIDS.

In six days, this Policy Course covers these nine topics related to workplace health promotion in a highly interactive way, aiming to provide participants with the knowledge and skills to integrate those topics into occupational safety and health policy and action. In addressing these problems, employers and workers' representatives may contribute to workers well-being, higher productivity, fewer turnovers, less absenteeism and reduced costs for enterprises. SOLVE uses the social dialogue approach to promote the implementation of successful workplace and community initiatives, with the involvement of employers, workers, governments, public services and NGOs.

Figure 1.1 The SOLVE *approach highlighting the interrelationships between areas of health promotion*

Exercise 1: Icebreaker interviews



You have 10 minutes to interview the person sitting next to you to find out the following information.

1. Their name and how he or she would like to be called during the course:

.....

.....

2. What their job is:

.....

.....

3. Why he or she is attending the SOLVE course:

.....

.....

4. Whether he or she has any experience in policy design, action, or training in the area of workplace health promotion. If yes, please give details:

.....

.....

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.....

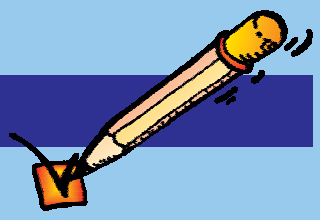
.....

5. Something personal that he or she wishes to share with the group:

.....

.....

Pre-test



You have 25 minutes to complete this exercise.

For each item below, please circle the response that you think best answers the question. Please circle only ONE response for each item.

1. The nine topics of SOLVE (stress, alcohol and drugs, violence, HIV and AIDS, tobacco, nutrition, physical activity, healthy sleep, and economic stress) can be described as:
   a. Isolated topics
   b. Dynamically interrelated topics
   c. Independent topics
   d. Each topic requiring unique action and policy statements
2. The abuse of alcohol and drugs can lead to all of the following except:
   a. Decreased productivity
   b. Higher risk of sexually transmitted diseases
   c. Lower levels of stress at work
   d. Increased levels of workplace violence
3. From the list below, identify which form of violence is not considered physical violence:
   a. Rape
   b. Sexual assault
   c. Beating
   d. Bullying
4. The main mode of transmission of HIV and AIDS globally is through:
   a. Sharing of contaminated needles
   b. Unprotected sex
   c. Transmission from an infected mother to her child
   d. Organ transplants

5. When an individual has AIDS it indicates that:
   a. The immune system is deficient
   b. The nervous system is weak
   c. Red blood cells are damaged
   d. All of the above
6. An organization's policy statement addressing emerging health-related issues at work should be:
   a. Written and implemented by the human resources department
   b. Developed, approved and implemented by the human resources department in consultation with workers and their representatives
   c. Written by the workers
   d. Developed by professional consultants external to the workplace
7. Unhealthy stress at work can result from:
   a. A defined career direction
   b. Well-defined work
   c. A fast pace of work
   d. Meaningful work
8. Which of the following are not consequences of the abuse of alcohol and drugs?
   a. Improved productivity and quality control
   b. Violence at the workplace
   c. Health disorders
   d. Increased susceptibility to HIV infection
9. From the list below, identify which form of violence is not considered psychological violence:
   a. Sexual harassment
   b. Rape
   c. Threats
   d. Bullying

10. Second-hand smoke in the workplace can best be controlled by:

    a. A ventilation system that filters and recycles the air

    b. Banning smoking in the workplace

    c. A campaign to promote smokers to ask permission of non-smokers before they smoke

    d. None of the above

11. Stress will generally decrease if:

    a. Workplace control decreases while psychological demand increases

    b. Workplace control increases while psychological demand decreases

    c. Both control and psychological demand increase

    d. Social support decreases

12. Which of the following statements is true regarding the HIV virus?

    a. All the people who get HIV develop AIDS

    b. There are no medical treatments that can slow down the rate at which HIV weakens the immune system

    c. A pregnant woman living with HIV can pass the virus to her baby in the womb or during delivery, or post-natally through breast feeding

    d. A positive HIV test result is equivalent to having AIDS

13. According to the Karasek demand and control model on psychological stress, symptoms such as fatigue, anxiety, and depression are most likely to occur in the following group:

    a. Low-strain positions

    b. Passive positions

    c. High strain positions

    d. Active positions

14. The risk of developing cancer, heart disease, chronic bronchitis, and asthma:

    a. Are the same for smokers and non-smokers

    b. Are higher for smokers

    c. Are lower for smokers

    d. Are unrelated to smoking

15. Which of the following statements is true about nicotine?
    a. It is not very addictive
    b. It is less addictive than heroin
    c. It is a substance in processed tobacco
    d. Individuals recover from the addiction easily
16. Workplace factors that can affect the risk of workplace violence include all of the following except:
    a. Physical features of the workplace
    b. Managerial style of supervisors
    c. Workplace culture
    d. All are factors that can affect the risk of workplace violence
17. The first step in alcohol prevention is:
    a. Information and education on alcohol and its effects
    b. Counselling
    c. Self-assessment
    d. Treatment
18. Which of the following foods do not contain protein?
    a. Milk
    b. Eggs
    c. Sugar
    d. Meat
19. Which of the following statements is true?
    a. Stress does not influence the way people eat
    b. Drinking alcoholic beverages decreases appetites
    c. Smoking suppresses appetite
    d. Improved diet can slow down the progression of HIV

20. A balanced diet means

    a. Not eating foods containing sugar and fats

    b. Eating carbohydrates, proteins and fats/oils in the same proportions

    c. A diet containing large amounts of meat and fish, with minimal amounts of carbohydrates, fruits, and vegetables

    d. A diet containing large quantities of carbohydrates and increasingly small quantities of fruits and vegetables, meat and fish, and sugars and fats

21. How much sleep does an adult need?

    a. The same as children and adolescents

    b. Between 5-6 hours in every 24-hour period

    c. Between 7-9 hours in every 24-hour period

    d. Between 7-9 hours in every 48-hour period

22. What are the negative consequences of insufficient sleep related to work?

    a. Slow reaction time

    b. Poor work performance

    c. Commuting accidents

    d. All of the above

23. Lack of quality sleep cannot lead to:

    a. Better performance

    b. Mental errors

    c. Difficulty in paying attention

    d. The worsening of health problems

24. Football, exercise, and aerobics can be defined as different types of:

    a. Physical inactivity

    b. Occupational physical activity

    c. Physical activity

    d. None of the above

25. Which of the following is not a consequence of a lack of physical activity?
    a. Lower back pain and neck pain
    b. Malnutrition
    c. Obesity
    d. Arthritis
26. Which of the following statements is not true?
    a. Physical inactivity is a serious hazard to health, working capacity, and productivity
    b. Physical inactivity is an issue concerning the individual with no direct consequences in the workplace
    c. A healthy diet loses effectiveness if it is not complemented by physical activity
    d. Regular participation in aerobics over a period of several years decreases the risk of many chronic diseases and some cancers
27. Economic stress can be defined as:
    a. Any emotional, physical, social, or economic factor that requires a response or change from an individual
    b. Refers specifically to stress that is associated with risk or uncertainty regarding one's financial situation
    c. Refers specifically to stress that is associated with risk or uncertainty regarding one's health
    d. Negative stress caused by pressure to improve productivity at work
28. Which of the following is not a cause of economic stress?
    a. Perceiving your job as insecure
    b. Having strong job security
    c. Being underemployed
    d. Being laid off
29. Economic stressors have a strong impact on:
    a. The individual and their family
    b. The individual and their work
    c. The individual, their work, their family and society
    d. The work itself

Introduction presentation

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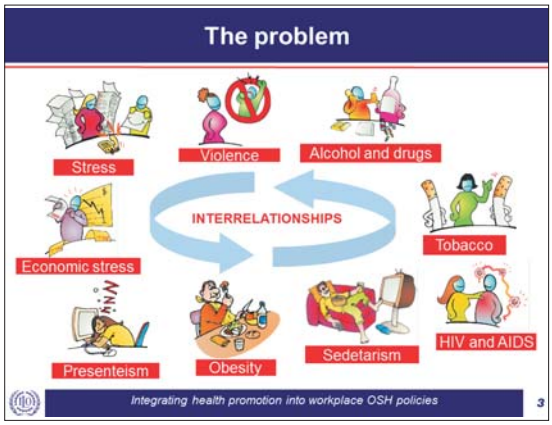

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Examples of the scope of the problem

- A recent study by EU-OSHA found that on average 22 % of the European workforce is stressed
- Many national surveys have found that between 40 % and 90 % of the women questioned have suffered some form of sexual harassment during their working lives (Hunt et al., 2007)
- In 2009, an estimated 1.8 million people died of AIDS and in that same year 2.6 million people became infected (UNAIDS, 2010)

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Examples of the scope of the problem

- Unless urgent action is taken, tobacco could kill one billion people during the 21st century
- It is estimated that there are more than 300 million obese people worldwide (WHO, 2006)
- Individuals suffering from sleep deprivation and related disorders are less productive, have an increased use of health care services and likelihood of injury (Colten; Altevogt, 2006)

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Psychosocial risks at work

The levels of stress experienced by different groups of workers in EU Member States:

- Stress by age: highest levels observed among middle-aged workers
- Stress by gender: prevalence of stress among men and women is similar
- Stress by sector and occupation: especially prevalent in education and health, agriculture, hunting, forestry and fishing sectors
- Stress by employment status: well-being for self-employed workers is lower than for employed workers

European Risk Observatory Report 2009, OSH in figures: stress at work - facts and figures

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The impact of psychosocial risks to the individual

For the worker:

- Higher risk of accidents
- Increased family or social problems
- Stigmatization and discrimination
- Health deterioration
- Physical or psychological illness
- Pain, distress, disability and death

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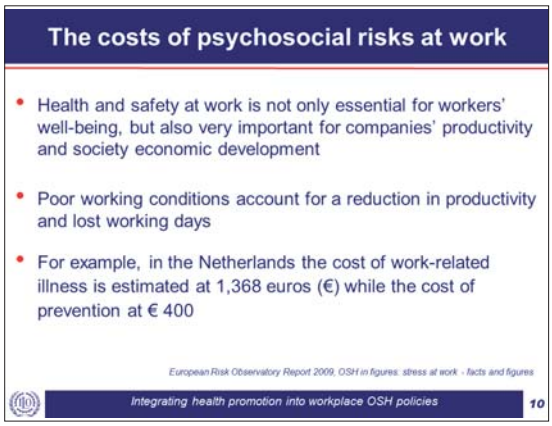

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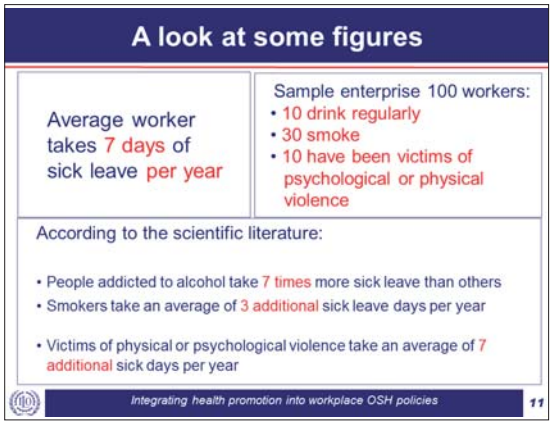

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The costs of psychosocial risks at work

A database with 2 million subjects was created to study the costs of health risk factors. The following were included:

- Australian Health Management Group
- Bank One
- Detroit Diesel
- Genesis Health System
- Honeywell General Electric
- The Progressive Corporation
- Steelcase
- Xerox
- United Autoworkers General Motors (UAW-GM)

Health Management Research Center of the University of Michigan (Edington. D.W., (2001) American Journal of Health Promotion)

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The costs of psychosocial risks at work

There was a clear relationship between health risk factors and health care costs

- Reduction of one worker health risk factor = $150 reduction in health care costs per worker
- Increase of one worker health risk factor = $350 increase in health care costs per worker
- Therefore, the cost associated with an increase in health risk factors is more than twice the amount saved by the reduction of a health risk factors

Health Management Research Center of the University of Michigan (Edington. D.W., (2001) American Journal of Health Promotion)

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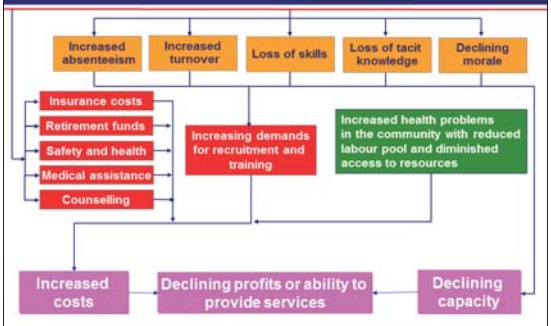
The impact of psychosocial risks at work



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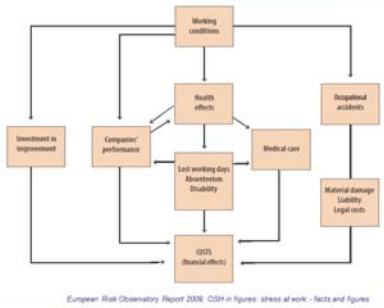
The impact of psychosocial risks at work



European Risk Observatory Report 2009, OSH in figures: stress at work - facts and figures

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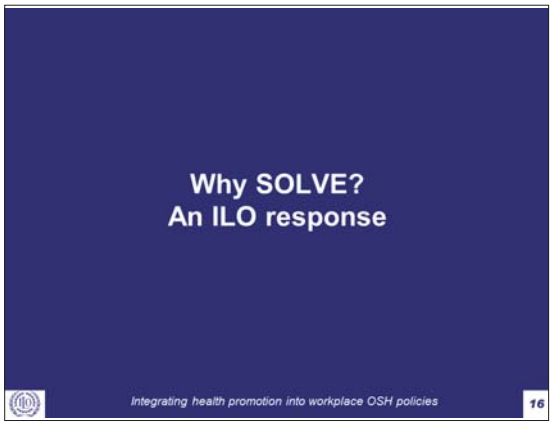

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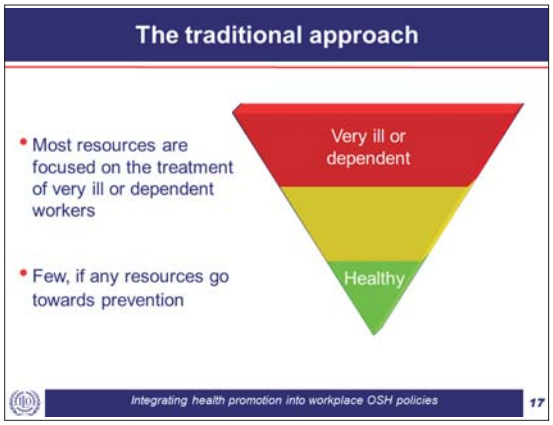

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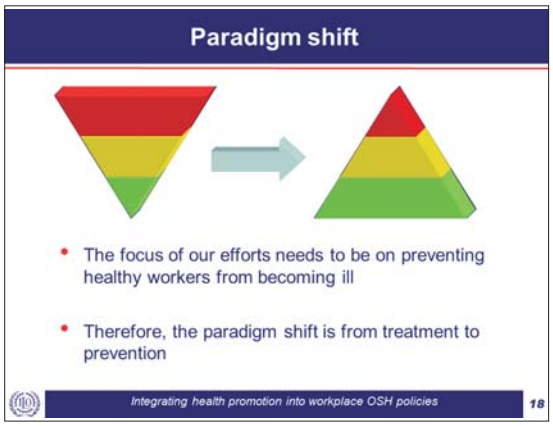

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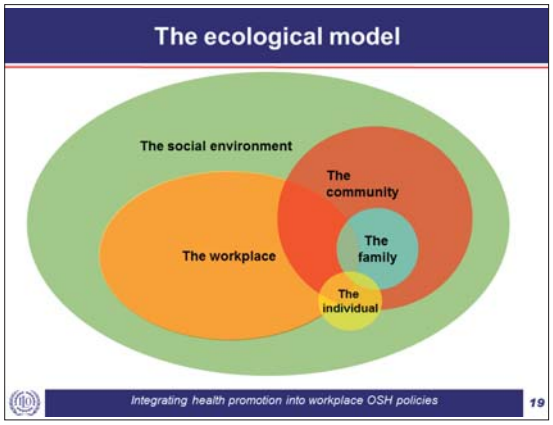

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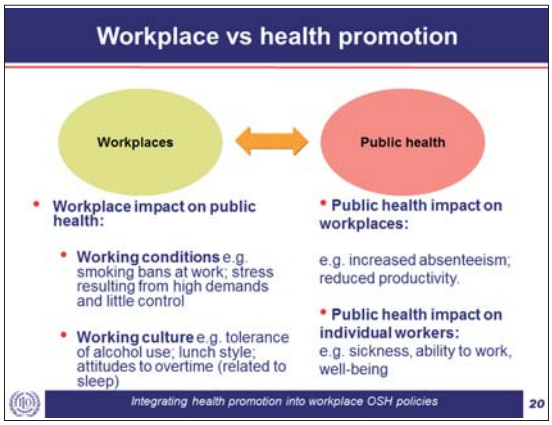

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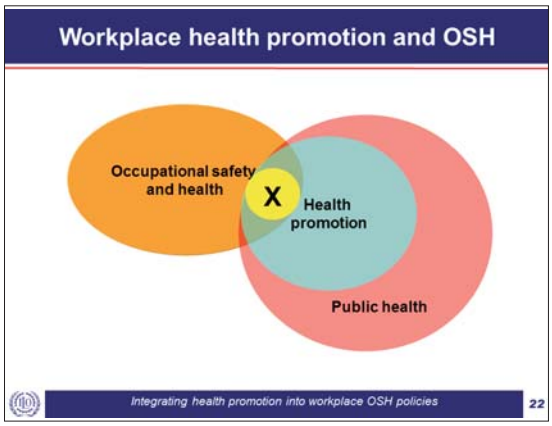

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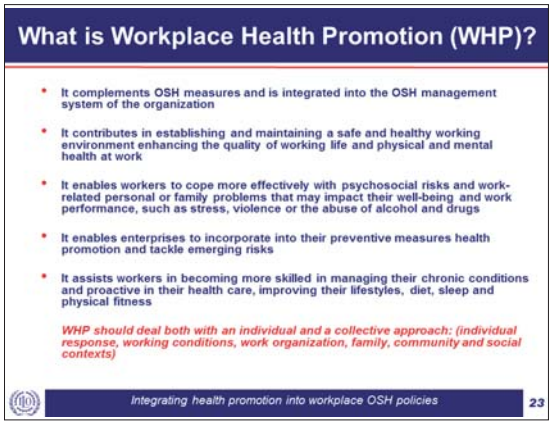

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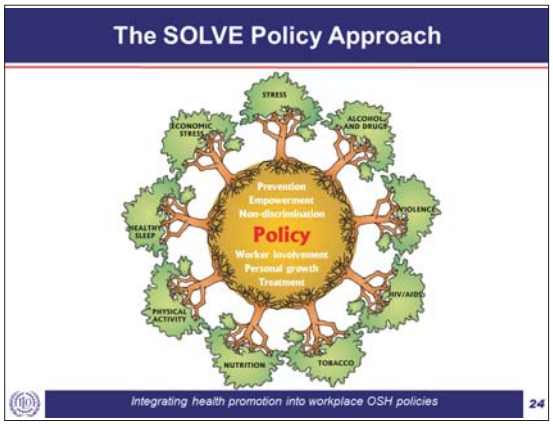

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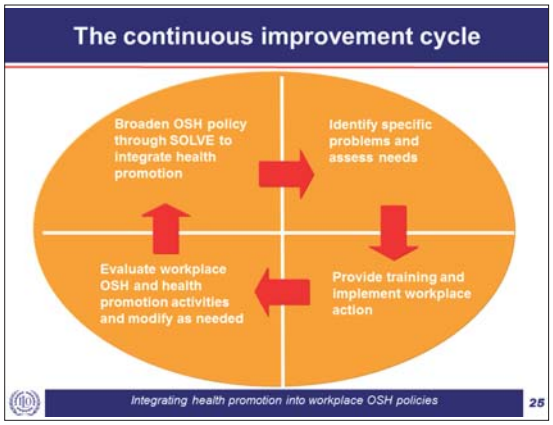

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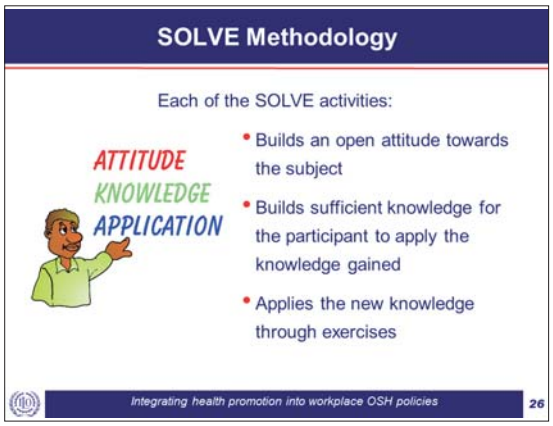

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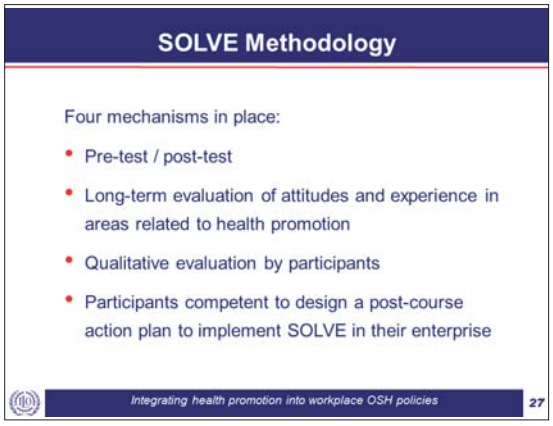

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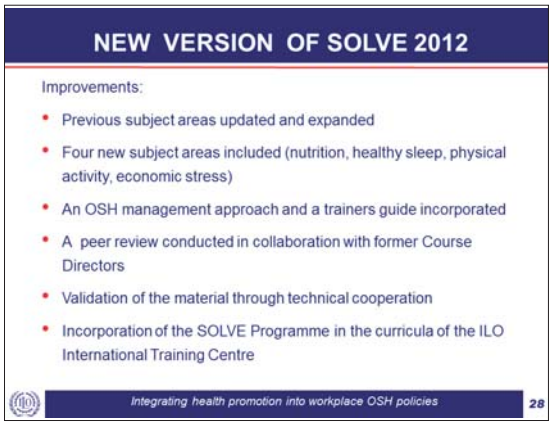

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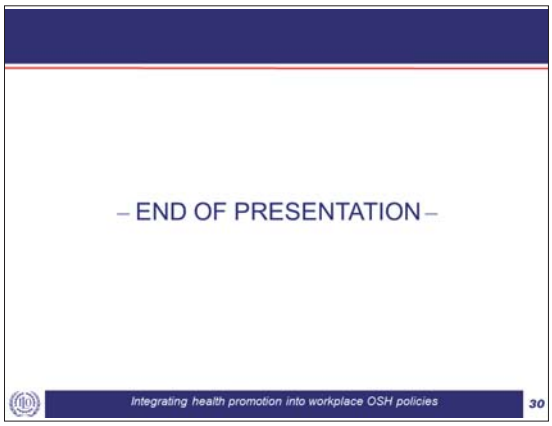

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International
Labour
Office
Geneva

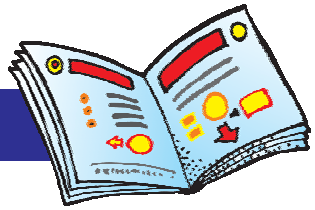
Managing workplace health promotion

Objectives

The participant will be able to:

- Identify the interrelationships among the nine areas related to health promotion presented in the SOLVE manual.
- Apply a management model to address these issues through a coherent Occupational Safety and Health (OSH) policy.

Introduction



Rapid globalization and technological progress have transformed the way we work across the world. In some cases many of the more traditional hazards and risks have been reduced or eliminated, in other cases new risks have emerged, while in a further set of cases existing risks have increased. As a result, enterprises have placed greater emphasis on preventing occupational accidents and ill-health through OSH management systems. More than ten years of global implementation of such systems have shown that ensuring good safety and health standards is good for business productivity as well as for quality employment.

Among the most important emerging risks in the workplace are psychosocial risks and their outcomes. Work-related stress, burnout, mobbing and other forms of violence, the abuse of alcohol and drugs, have now been generally acknowledged as global issues affecting all countries, all professions, and all workers. Moreover, they have a significant impact on workers' health, absenteeism, and performance.

Consequently, the workplace has become an ideal venue to address emerging psychosocial risks in order to protect the health and well-being of all workers. This will also contribute towards improving workplace productivity and performance, improving the long-term well-being of workers and their families, and reducing pressure on the enterprise, as well as on the health- care, welfare, and social security systems.

What is an occupational safety and health policy?

A policy is a declaration of values, principles and commitment by management to implement OSH measures at the workplace.

The first step to design an OSH policy is recognizing that the management of health and safety at work is integral to the productivity, success, and prosperity of the company.

An OSH policy should:

- be specific to the enterprise size and nature of activity;
- be concise, clearly written, dated and made effective by the signature of endorsement of the employer or the most senior manager in the enterprise;
- be communicated and readily accessible to all persons at their place of work;
- be updated as necessary;
- reflect the commitment to conduct activities in a transparent, honest and open environment in consultation with workers and their representatives respecting human rights.

The policy should include the following key principles and objectives:

- protect the safety and health of all members of the enterprise by preventing work-related injuries, diseases and incidents;
- comply with all relevant laws, regulations, codes of practice, directives, collective agreements, and other requirements to which the enterprise subscribes;
- ensure that workers and their representatives are consulted and participate actively in the implementation of the OSH measures;
- continually improve the performance of the OSH management system (when there is one).

Senior management should support this policy unequivocally and undertake resource allocation accordingly.

What is workplace health promotion (WHP)?

The term "workplace health promotion" (WHP) is interpreted in different ways by different stakeholders. Many enterprises/organizations may be undertaking health promotion activities in the workplace without realizing they are doing so. Others may be giving priority to health promotion measures, such as promoting healthy habits, rather than to occupational safety and health practice.

In recent years, health promotion programmes at the workplace have been mainly designed to assist workers in becoming more skilled in managing their chronic conditions and in becoming proactive in their health care. These programs will continue to develop and expand as the workforce ages and chronic health problems place increased burdens on health systems and national economies.

For the ILO, an effective workplace health promotion (WHP) programme:

1) Complements occupational safety and health measures and is integrated into the OSH management system of the organization. This way, it contributes in establishing and maintaining a safe and healthy working environment enhancing the quality of working life and adding to optimal physical and mental health at work.

2) It also contributes to enable workers to cope more effectively with psychosocial risks and work-related, personal or family problems that may impact their well-being and work performance, such as stress, violence, or the abuse of alcohol and drugs.

3) It assists workers in becoming more skilled in managing their chronic conditions and becoming proactive in their health-care improving their lifestyles, the quality of their diet and sleep, and their physical fitness.

4) This implies that the measures taken should not only address these issues from an individual point of view but also from a collective one, which is closely related, to the improvement of working conditions , the working environment and work

organization, as well as family, community and social contexts. Workplace health promotion (WHP) is the combined effort of employers, workers, their communities, and society to improve the health and well-being of women and men at work.

The ecological model

The ecological model acknowledges the many factors which influence health outcomes; for example, whether and how much an individual smokes, or how they organize their diet, or how apparently similar stressful events lead to radically different consequences for different people. Human behaviour is determined by a "reciprocal causation" between many areas of life, for example, what the individual does has an impact on the environment, but also how the environment impacts on the individual in a series of complex interactions.

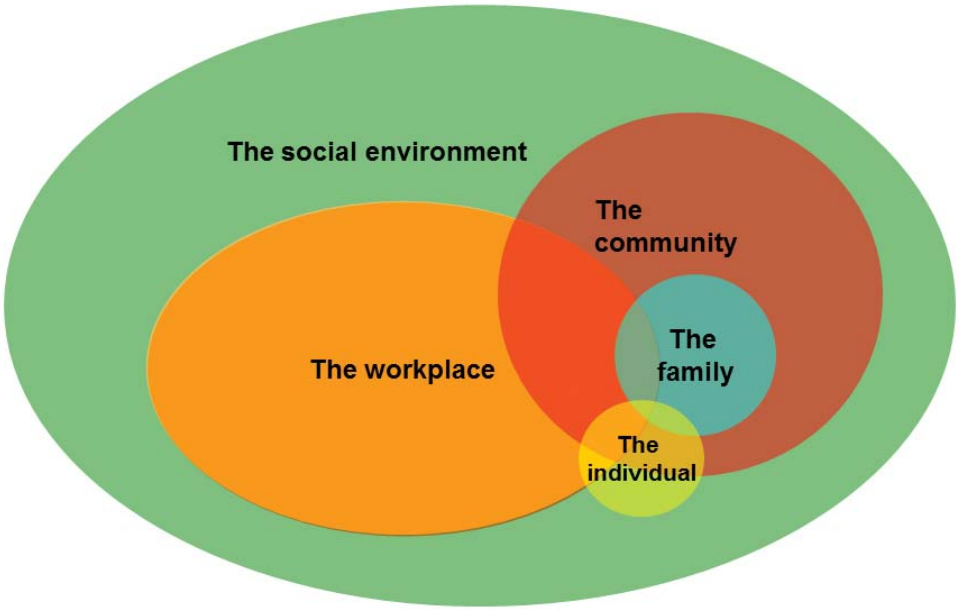


Figure 2.1: The ecological model (Adaptation from McLeroy et al., 1988)

The following factors make up these complex interactions:

Intrapersonal Factors: Individual characteristics which are modifiable, such as knowledge, attitudes, skills, or actions which may or may not correspond to social expectations.

Interpersonal Relationships: Relationships with family, friends, neighbours, co-workers and acquaintances, which can greatly influence how people behave with regards to their health. These relationships link the person with their family, their social environment, their work, and the community they live in.

Organizational Factors: Workplaces, professional or neighbourhood groups, school, or religious groups may have positive or negative effects on health. They can act as a source of unhelpful role models and false information about health, but they can also function as resources that support health promotion and help individuals make healthy choices. For long-term changes in the behaviour of individuals, the support of the workplace is essential.

Community Factors: Play a key role in defining and prioritizing health problems which need to be addressed, and in identifying the resources available to do so. This happens between more informal actors, such as family and informal social networks, as well as between formal organizations working in the area. In order to achieve the most effective interventions for health promotion, it is vital that these community actors coordinate their actions and build on each other's strengths, rather than working in conflict with each other.

Public Policy: Regulatory policies, procedures, and laws (whether at national, state, or local level) which protect the health of communities. Such policies increasingly address the areas of health promotion and the long-term chronic diseases associated with them. Creating public awareness of health risks and how to avoid them must also be part of a public policy.

The basis of a successful enterprise is the people who work in it and its organizational culture. Healthy workers in a supportive environment feel better and healthier, which in turn leads to reduced absenteeism, enhanced motivation, improved productivity, improved recruitment, reduced turnover, a positive image, and consistent corporate social responsibility.

Studies in Europe on workplace health promotion show that every euro invested yields a return on investment of € 2.5 to € 4.8 in reduced absenteeism costs (BKK BV and HVBG, 1996).

Workplace health promotion programmes are an effective business investment as they can enhance and extend existing occupational safety and health programmes by contributing to keep workers fit and healthy, maintaining their ability to work and allowing them to remain active and productive members of society, while at the same time contributing to the well-being both of workers and their enterprises with more efficient and profitable working practices.

The OSH management Model

A risk management framework provides a useful tool that enables enterprises to identify workplace hazards, assess the risks associated with each of them, and develop appropriate preventive measures and customized solutions that fit within a continuous improvement cycle to implement the health and safety policy of an enterprise.

Five core stages of the risk assessment and management process are identified:

- identification of the hazards;
- assessment of the risks;
- establishment of measures for risk reduction and control;
- monitoring the effectiveness of the measures undertaken;
- appropriate adjustment of those measures through continuous improvement.

After designing an OSH policy, certain organizational measures need to be put in place:

- defining responsibilities and mechanisms for accountability;
- organizing appropriate training;
- setting up documentation and communication infrastructures to make the policy effective;
- enterprises/organizations can then move to the planning and implementation of the policy and related strategies; and
- evaluating them and taking action to make improvements based on the evaluation results.

A good guidance for implementing an OSH management system is in the ILO's "Guidelines on occupational safety and health management systems" (ILO-OSH, 2001).

When applying the continuous improvement cycle to workplace health promotion, some additional steps are advisable. It is essential to define the health promotion needs adequately in order to find the appropriate solutions, for example concerning physical activity and exercise, improved diet, and an adequate rest to keep workers healthy and productive.

Management and workers will be more open to accept a health promotion programme when it meets their needs and expectations. Managers will also need good arguments to commit resources.

Given the important overlap between OSH and health promotion, it makes sense to use and expand the structures already in place for occupational safety and health in order to incorporate health promotion.

At the same time, care must be taken not to overload the system, as it may still be necessary to allocate some resources for the new health promotion tasks. This will help to avoid a further pitfall: health promotion should not be seen merely as a fashionable "add-on" which is not taken seriously; while making good use of existing structures, it should have weight of its own and be recognized as making a valuable contribution to the health, safety, and well-being of workers, as well as to the productivity of the company. This can be achieved by emphasizing the existing complementarities between occupational safety and health, and workplace health promotion.

Participation

Joint health and safety committees involving workers' representatives and management are a standard practice and are even required by law in many countries. Such committees already have procedures, personnel and practices in place to deal with safety and health issues. It is more efficient to integrate the related area of health promotion into these existing structures than to create something entirely new.

Essential to the successful management of health promotion measures is the participation of all those concerned in the process: workers, supervisors, managers and from time to time, external people such as government inspectors, suppliers, clients and external specialists.

Action-oriented

The management of workplace health promotion needs to be dynamic. It needs to be based on equity, transparency, local practice and initiatives that are easy to implement. Its results should be visible to all parties involved. Once decisions are made, they should be rapidly communicated to all those concerned.

Sustainability and continuous improvement

Policy-oriented action should be measurable on a long-term basis through commonly agreed criteria. From time to time the actions should be evaluated and adjusted, if, and where necessary. Mechanisms should be designed to ensure that all those involved have the knowledge and skills necessary to implement the actions proposed by the policy.

The five phases of Workplace health promotion (WHP) management

Workplace health promotion (WHP) is the combined effort of employers, workers, and society to improve the health and well-being of people at work.

One of the most important elements in the successful implementation of WHP is continuous commitment from all sides. Management commitment is essential for avoiding a conflict between WHP and OSH management practices. It is also of major importance to integrate staff wherever possible, and to encourage a maximum participation during all stages of the WHP implementation.

Furthermore, most well-planned WHP programmes combine the needs of the organization with those of the workers. As a consequence, each organization needs to tailor the core principles of WHP to fit its own characteristics and circumstances.

The five phases of WHP management include:

1. Preparation

Establish a task force responsible for planning and implementing the WHP programme. It should include representatives from senior management, the human resources department, the occupational health and safety unit, and the bipartite OSH committee.

Inform everyone about the WHP programme using different communication channels, such as posters, notice boards, intranet, and meetings.

Make sure legal requirements on health and safety at work are followed. WHP is only effective when occupational hazards and risks are managed successfully.

2. Planning

Assess the needs. You can maximise the effectiveness of a WHP programme by assessing workers' needs and expectations. Options to do this include:

- focus groups;
- surveys conducted by online questionnaires;
- tying-in the assessment with existing similar actions.(e.g. including questions on health promotion and well-being into a risk assessment survey);
- reviewing the existing data and company statistics, such as work force demographics, absenteeism and turnover rates, and other health data from occupational health surveillance; or
- through voluntary health screening might indicate areas where action is needed.

Decide on priorities. Identify the specific goals of the WHP programme and set priorities accordingly. These goals may include:

- enhancing work-life balance;

- reducing musculoskeletal disorders;
- promoting a healthy lifestyle in general.

Link to risk prevention activities. Wherever possible, WHP planning and interventions should be integrated into risk prevention activities.

Integrate existing successful health promotion activities, such as running groups, into the WHP programme.

Implement a coordinated programme rather than running several disconnected interventions.

Involve intermediary organizations, if necessary, and take advantage of any offers, materials, or initiatives available. These could include:

- statutory accident insurance companies offering, for example, reduced premiums to organizations implementing WHP programmes;
- health insurance plans offering members a refund if they enrol in a sports club or course;
- taking advantage of insurance coverage to treat workers for tobacco dependence.

Give opportunities to all workers. Avoid creating inequalities by, for example, not taking into account the timetables of all workers. It might also be worth considering how to communicate with those without email accounts.

Think about evaluating the outcome before starting the process. Monitoring the signs of success or failure will help to evaluate and improve the programme, if necessary.

3. Implementation

Get active and visible support from senior, middle, and ground management. This is one of the most important factors in creating a healthy workplace culture and a key foundation for the development of a WHP programme.

Engage workers as much as possible. The better you match the WHP programme with workers' needs, the less you will need to promote it. Incentives tailored to your organization can be useful for introducing a healthy culture within your organization. These may include:

- Financial incentives and donations for external social or sporting activities;
- time off for participation in leisure and sport activities;
- competitions and prizes to honour and reward participation in WHP programmes.

Adapt information and training materials to the target audience. The degree of complexity, detail, and reading level should be appropriate to your audience. Ask for feedback.

4. Evaluation

Analyse the impact of the WHP programme:

- On staff satisfaction by, for example, conducting a survey;
- On relevant economic factors, such as staff turnover, productivity, and rates of absenteeism.

Evaluate the financial benefits of the WHP programme.

Communicate the results of your evaluation: Inform people about your success and the changes that you plan to make in the future.

5. Review and update: ongoing implementation (principle of continuous improvement).

Do not stop planning and improving, good WHP is a continuous process.

Understand the detailed results of the evaluation when planning for the future.

Some examples of Workplace Health Promotion measures:

Organizational measures:

- offering flexible working hours and workplaces;
- enabling workers to participate in the improvement of their work organization and their work environment;
- giving workers opportunities for lifelong learning.

Environmental measures:

- providing social rooms;
- providing a comprehensive smoking ban;
- providing a supportive psychosocial work environment.

Individual measures:

- offering and funding sports courses and events;
- encouraging healthy eating;
- offering smoking cessation programmes; and
- supporting mental well-being by, for example, offering external anonymous psychosocial advice, counselling, and anti-stress training.

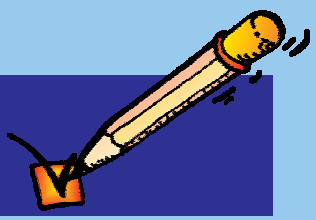
The importance of the gender dimension

General measures directed to all workers do not necessarily achieve the same desired benefits for women workers. The concentration of women workers in particular occupations leads to a specific pattern of injury and disease; more women than men suffer from occupational repetitive strain injuries (RSI) and from sexual harassment at work. Women are more likely to be victims of physical violence but equally likely to be perpetrators of psychological violence; they are more affected by occupational illness

than men by serious accidents; women and men have different eating and physical activity habits.

Health promotion policies incorporating the needs of working women have to take into account all their three roles: as housewives, as mothers, and as workers. The effects on health of each of their roles have to be looked at and the potential conflicts and contradictions between them need to be considered.

Exercise 1:
Modelling interrelationships



You have 10 minutes to complete this exercise individually.

Problems related to stress, alcohol and drugs, violence, HIV and AIDS, tobacco, nutrition, insufficient physical activity, lack of quality sleep and economic stress are different but interrelated. Many factors link these areas of concern in a number of ways. Describe the interrelationships. Feel free to use a model if you like.

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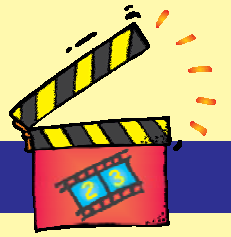
Managing WHP presentation



Slide 1

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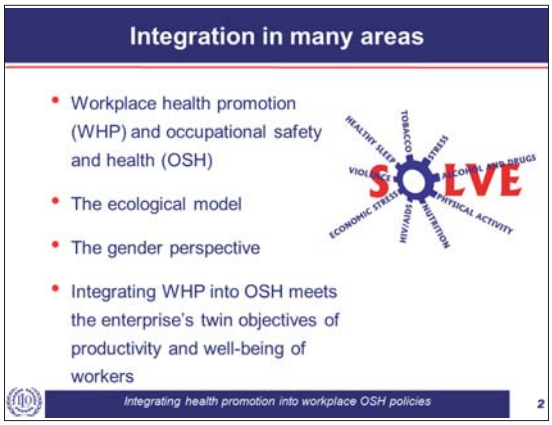

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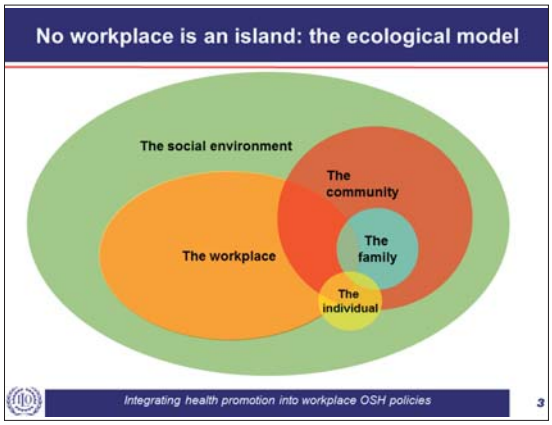

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Slide 4

Elements of the ecological perspective

Health behaviour can be affected by or can affect:

- Individual factors (intrapersonal)
- Interpersonal factors (social)
- Organizational factors (institutional)
- Community/cultural factors
- Public policy factors

Slide 5

The gender perspective

- Occupational hazards and risks affect men and women differently
- General measures addressing all workers may not be enough
- Workplace health promotion measures should take into account the different impact of occupational hazards in men and women's health, in the light of both their biological characteristics and the social aspects related to their gender roles

Slide 6

Workplace health promotion

- Large proportion of time spent at work
- Workplace support and peer pressure

→ Very promising setting for an integral approach to worker's health

Slide 7

Workplace health promotion

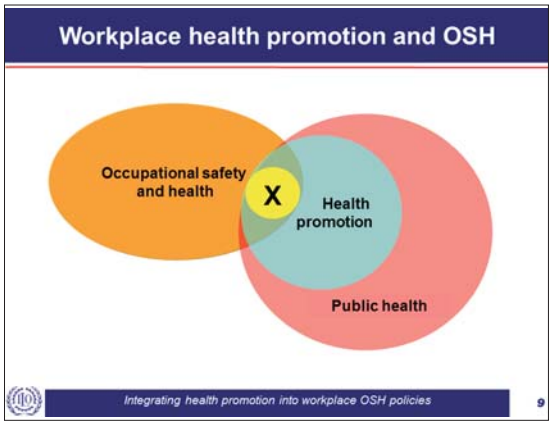
- Public health impact on workplaces

  E.g. obesity in 2007 in the USA resulted in increased **absenteeism** ($2.6 billion); reduced **productivity** while at work ($20 billion)
- Public health impact on individual workers

  (sickness, ability to work, well-being)

Slide 8

Slide 9

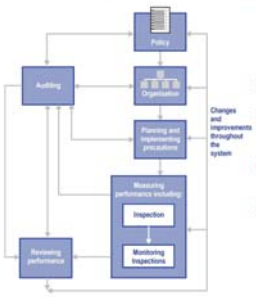


Slide 10

Slide 11

Slide 12

The ILO Safety and Health management system



1. Policy
2. Organization
3. Planning and implementation
4. Monitoring performance
5. Auditing and reviewing performance

Integrating health promotion into workplace OSH policies 12

Slide 13

Health promotion and workplace OSH policy

- Use of synergies:
  - The preventive measures and the OSH management systems are tools already available in the workplace
  - Efficient use of human and financial resources
  - Health promotion activities should complement preventive and protective measures in the workplace
  - Workplace health promotion contributes to the well-being of workers and to productivity

Integrating health promotion into workplace OSH policies 13

Slide 14

OSH management systems and the 5 phases of Workplace Health Promotion:

Workplace Health Promotion	OSH management systems
1. Preparation	(Policy/strategy)
2. Planning	Planning and implementation
3. Implementation	
4. Evaluation	(Monitoring performance)
5. Review and update	(Auditing and reviewing performance)

Integrating health promotion into workplace OSH policies 14

Slide 15

WHP 1st Phase: Preparation

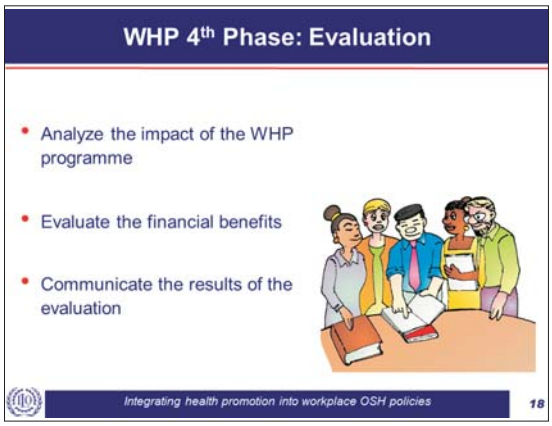
- Establish a task force responsible for planning and implementing the WHP programme
- Inform everyone about the WHP programme using different communication channels
- Make sure legal requirements on health and safety at work are followed

Integrating health promotion into workplace OSH policies 15

Slide 16

Slide 17

Slide 18



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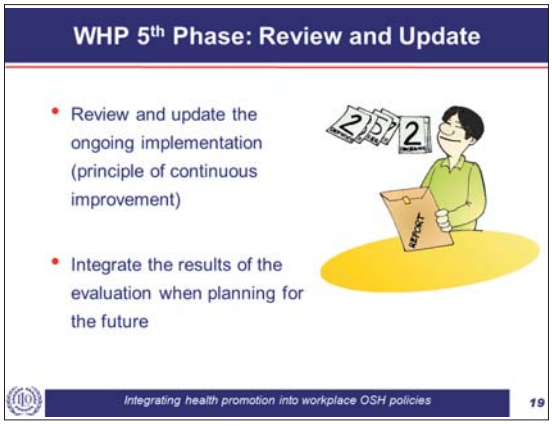

Slide 20

Good policy process

Setting the direction of the organization by:

- The commitment of senior management
- Working in context with other business objectives
- Commitment to continuous improvement of all

Integrating health promotion into workplace OSH policies 20

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Slide 21

Good policy process

Implementation through:

- Clear responsibilities for management and staff
- Involvement of workers and workers' representatives
- Leadership commitment, i.e. document signed and dated by the Chief Executive Officer
- Effective communication

Integrating health promotion into workplace OSH policies 21

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Slide 22

Good policy process

Implementation through:

- Allocation of resources
- Ensure all staff are competent to carry out the policy requirements
- Get necessary advice from specialists

Integrating health promotion into workplace OSH policies 22

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Slide 23

Examples of Workplace Health Promotion measures

Organizational measures:

- Offering flexible working hours and workplaces
- Enabling workers to participate in the improvement of their work organization and their work environment
- Giving workers opportunities for life-long learning

Environmental measures:

- Providing social rooms, a comprehensive smoking ban and a supportive psychosocial working environment

Individual measures:

- Offering and funding sports courses & events and encouraging a healthy diet
- Offering smoking cessation programmes and supporting mental well-being

Integrating health promotion into workplace OSH policies 23

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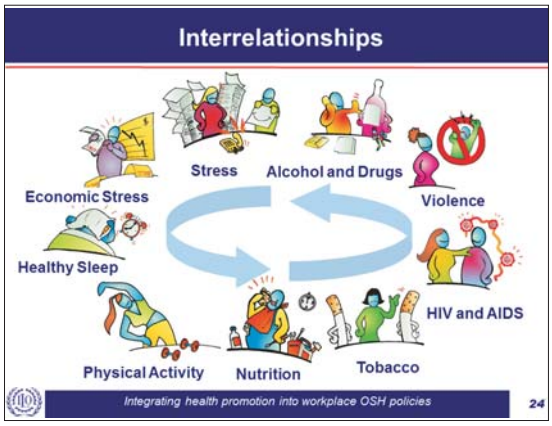
Slide 24



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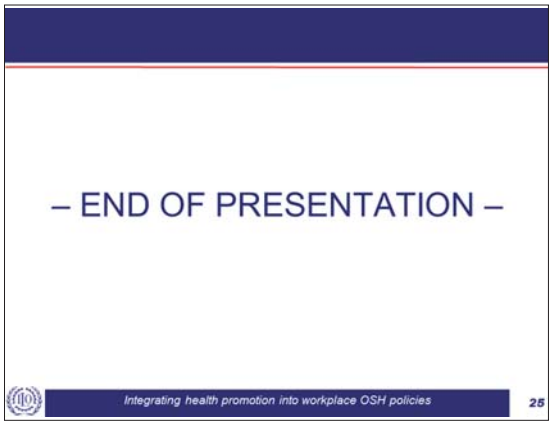

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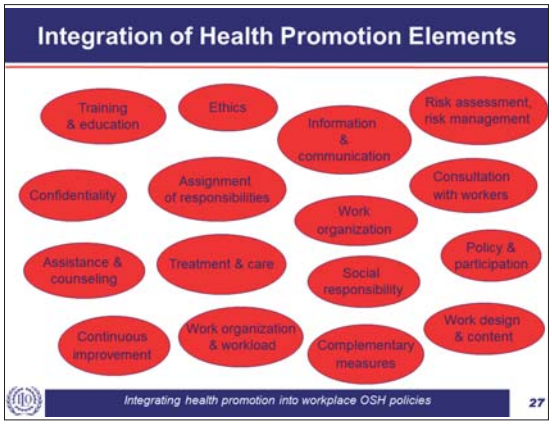
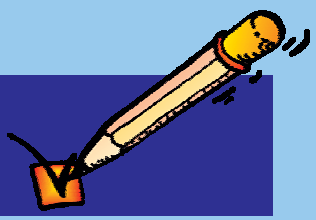


Exercise 2:
Building your management team



You have 5 minutes to complete this exercise.

From now on you will be divided into groups. In the simulation exercise at the end of each module, the groups will act as management teams to make operational decisions concerning each topic on running a "virtual" enterprise. Each group will complete the same tasks.

The decisions taken during the exercise will help your group in identifying the health promotion measures that will allow you to build your occupational safety and health workplace strategy and, at the end in the *Action* module, design your workplace health promotion (WHP) programme and action plan.

Please discuss a suitable name for your enterprise:

Name of enterprise

.....

The simulation exercise runs from one module to the next. Once your group is assigned, please select and fill the following positions for the week-long simulation exercise:

The executive director .....

The sales manager .....

The director of human resources .....

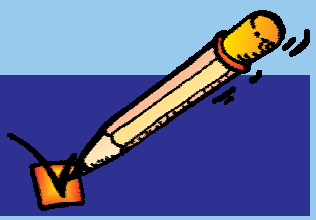
The director of safety, health and environment.....

The production manager.....

The workers' representative .....

The medical doctor.....

Exercise 3: Policy Statement on Health and Safety at Work



You have 10 minutes to complete this exercise.

Below you will find an example of an Occupational Safety and Health (OSH) Policy that a company should endorse in order to ensure that at every level of management the safety, health and well-being of workers, clients, and visitors is ensured.

Designing the elements of a health promotion policy is the first step to start a process that aims towards integrating health promotion measures into an occupational safety and health workplace policy.

This means defining principles, objectives and methods of action that will guide the team towards the development of a WHP programme and its implementation through an action plan.

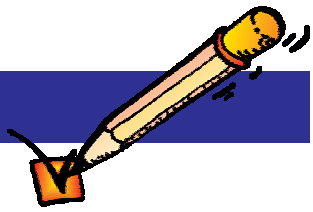
In this exercise you will improve the following draft policy by incorporating a general statement on health promotion taking into account the checklist in this module.

Policy statement on Health and Safety at work:

- Workers are this company's most important resource. We will foster a safe and healthy environment for all employees, contract workers, clients, and visitors.
- We will commit to make all premises and equipment as safe as reasonably practicable, in order to ensure a healthy, injury-free working environment.
- Health and safety considerations will be incorporated into all phases of business, including product design and development, facility design, operation, maintenance and product delivery.
- Emergency procedures including emergency evacuation measures will be developed, reviewed with local competent authorities, and implemented.
- We will regularly assess, implement and verify compliance with health and safety measures.
- This policy will be reviewed at regular intervals.

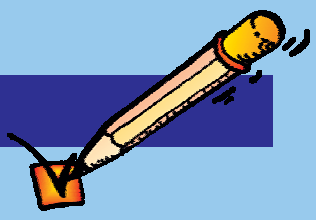
Please use the following space to revise and expand the draft policy statement incorporating a statement concerning the health promotion elements you want to include.

Checklist



Action–oriented checklist for managing health promotion at work			
1.	**Is the direction for the organization established?**		
1.1	Senior management demonstrates a commitment.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	The management of psychosocial hazards at work and health promotion are set in the context of the safety and health policy and other objectives of the organization.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	A commitment is made to the continuous improvement in the measures addressing psychosocial hazards and for the promotion of the health and well-being of workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.	**Details of a policy framework**		
2.1	Managers are designated with the key responsibilities for formulating and implementing the policy.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	The responsibilities of all managers and all workers are explained.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	The involvement of workers and workers' representatives in policy and programme design and development is recognized and encouraged.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	The basis for effective communication is outlined.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.5	Adequate resources are allocated to implement the OSH policy and health promotion programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.6	Managers are committed to review, implement, and adjust the policy elements on health promotion, as necessary.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.7	Necessary advice is obtained from specialists.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.8	The policy document is signed and dated by the high level management.	Is action needed?	☐ Yes ☐ No ☐ Comment

Exercises on Simulation



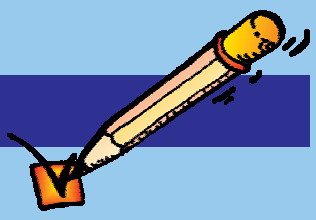
Now that your management team has drafted a health promotion statement and has incorporated it in your health and safety policy, you will have to work through-out the modules, from *Work-related stress* (3) to *Economic stress* (11) making decisions to deal with existing problems related to health promotion in your "virtual" enterprise.

For this purpose a simulation exercise has been created for each module. During this exercise, each management team will have to take decisions and propose corrective actions.

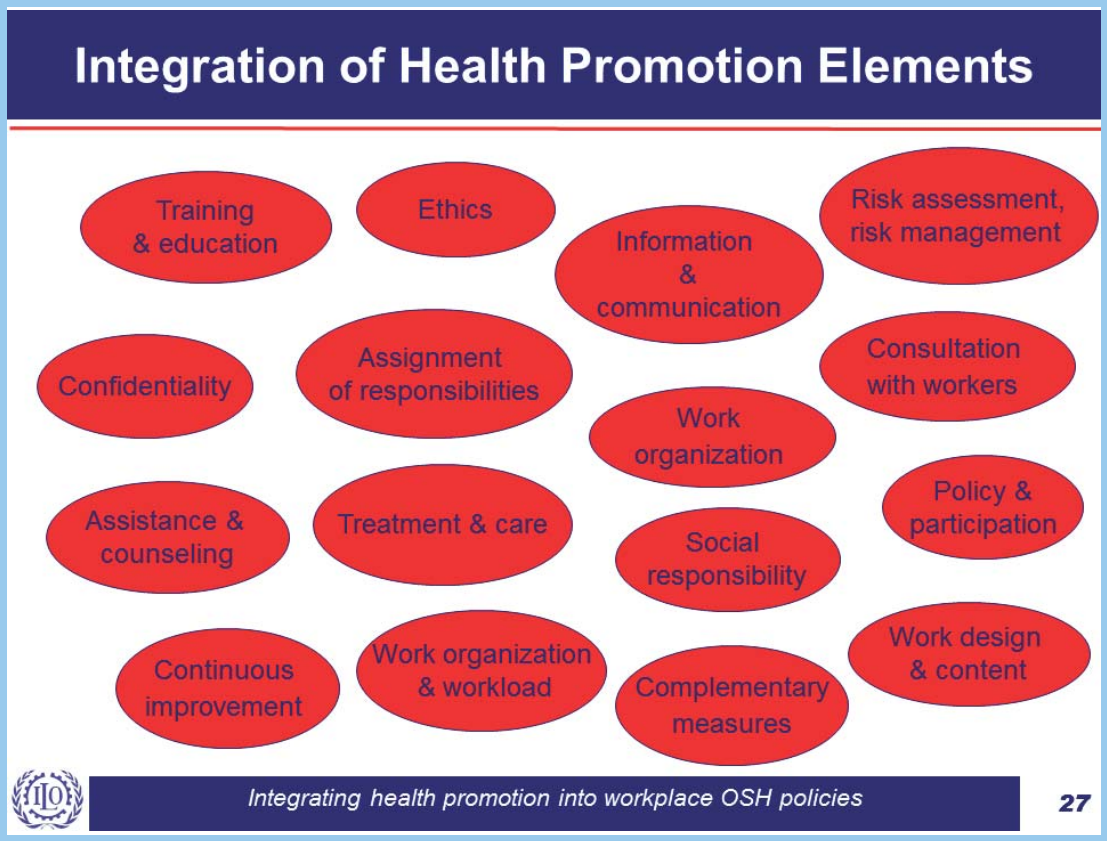
Based on the outcomes of the simulation exercise, your group will focus on the policy integration exercise and design a workplace health promotion (WHP) programme with a preventive approach to avoid such a problem from happening again. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

Exercises on Policy Integration



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan



The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the most relevant policy elements from the PowerPoint slide shown. You can already note down the elements chosen in your workbook. Use the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of each module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to the topic. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with each topic in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each team will finalize the WHP programme and develop an action plan for its implementation.

Each management team will present their work to the whole group during the Action module of the SOLVE Policy Course.

Your course instructor will give you more details about this at the appropriate time.

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Work-related stress

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for a response to stress at work.

Introduction

The effects of stress on health

The human being, in a very primitive way, responds physiologically to threats or pressures by preparing for intense physical activity (either by fighting or fleeing). These responses include increased heart and breathing rates and the movement of blood to the muscles. Although these reactions are important for survival, they can also create problems. Unhealthy levels of stress at work and in the family may lead to a number of disorders and illnesses including chronic fatigue, migraines, headaches, insomnia, anxiety, depression, allergies, and the abuse of tobacco, alcohol, and drugs. Stress can contribute to hypertension, heart diseases and cerebrovascular disease, as well as to peptic ulcers, inflammatory bowel diseases and musculoskeletal disorders. It may also alter certain immune functions, which in turn can facilitate the development of cancer.

In seeking relief from stress, people may turn to psychologically or physically violent behaviour, an excessive use of tobacco or alcohol, or engage in risky behaviours such as unprotected sexual activities, thereby running the risk of contracting sexually transmitted diseases such as HIV and AIDS.

Altogether, the above mentioned disorders may be responsible for a large number of cases of disability and deaths. Stress has a considerable impact on the use and costs of medical care.

Who is affected by stress?

Everyone is affected at one time or another by stress. Although work-related stress is by no means a new phenomenon, it is becoming increasingly globalized and affects all categories of workers, as well as their families, and has an impact on society as a whole. Although work-related stress has traditionally been considered a problem of industrialized countries, workers in developing countries are undoubtedly also affected.

Other factors which may affect vulnerability to stress include:

- age, as adolescents and older workers often cope with stressful situations with more difficulty;
- gender, as the impact of stress in women and men is different;
- low socio-economic status or unemployment without social support.

Work-related stress and other stress-inducing factors outside the workplace are often responsible for bringing workers closer to the point where they can no longer cope efficiently with stress.

Does everyone react in the same way to stress?[1]

Everyone does not react to stress in the same way and some people are more sensitive to stress than others. Different ways of coping with stress include:

1. the person assesses the stressful situation;
2. the person deals directly with the stressful situation; or
3. the person avoids confronting the problem.

Coping is the effort to reduce the negative impacts of stress on individual well-being. Coping, like the experience of work stress itself, is a complex, dynamic process. Coping efforts are triggered by the perception of situations as threatening, harmful or as a source of anxiety.

Coping styles include combinations of thoughts, beliefs and behaviours that result from the experience of stress and may be expressed independently of the type of stressor.

Individual differences in personality, age, experience, gender, intellectual ability and cognitive style affect the way an individual copes with stress. Coping styles are the result of both prior experience and previous learning.

For coping to be effective, the person must be motivated to cope, have clarified the nature and dimensions of the problem and the reality in which it exists, and then selected the most appropriate resources to deal with it.

The most common typology of coping style includes:

- problem-focused coping (which includes information seeking and problem solving);
- emotion-focused coping (which involves expressing emotion and regulating emotions);.
- appraisal-focused coping (whose components include denial, acceptance, social comparison, redefinition and logical analysis).

A social coping style integrates social and interpersonal factors with cognitive factors. Research showed significant relationships between various kinds of social support and the above coping forms (e.g., problem-focused and emotion-focused). Women, generally possessing relatively greater interpersonal competence, were found to make greater use of social coping.

[1] Adapted from Encyclopaedia of Occupational Health and Safety, ILO, Volume II, pages 34.46 & 34.47.

Family responsibilities as a source of stress

One combination of factors that may raise the level of stress is the interaction between work and family life. This is true of families in which both parents work, as well as in single-parent families.

A number of factors make it difficult to achieve a harmonious balance between work and family life, including abrupt changes in work schedules, time-pressured work, unsympathetic treatment by management and co-workers, and a lack of control over the content and organization of work. Shift work and irregular working hours are particularly difficult to reconcile with family routine and needs. Homeworkers and teleworkers often find it difficult to adapt their work to the requirements of family life. Fast paced and intensive work increases the conflict between working and family roles.

Balancing work and family life has been addressed in the ILO's Workers with Family Responsibilities Convention, 1981 (No. 156) and its accompanying Recommendation (No. 165), as well as in the Maternity Protection Convention, 2000 (No. 183) and its accompanying Recommendation (No. 191). Both Conventions call for governments, employers and workers organizations to take into account the needs of workers with family responsibilities regarding the terms and conditions of their employment, and social security. Recommendation No. 165 also covers measures to facilitate their lives, thereby reducing the level of stress encountered by workers with family responsibilities.

Such measures include:

- the provision of child care facilities;
- the reduction of hours of work, the reduction of overtime and the introduction of more flexible working hours;
- arrangements in relation to work schedules, rest periods, and holidays;
- adequate regulation and supervision of the terms and conditions of part-time workers, temporary workers and home workers, many with family responsibilities;
- granting to either parent the possibility of taking parental leave, immediately following maternity leave, without the loss of their job or employment rights; and
- the possibility of a leave of absence to care for a sick child or family member.

Gender, work and stress

The relationship between gender, work and stress is a complex one. Several factors appear to magnify the impact of stress on women. It is well established that the total workload for women who are employed full-time is higher than that of full-time male workers, particularly in regards to family responsibilities due to the main role that women still play in the provision of family care.

In addition to their family responsibilities, other factors also tend to make women more vulnerable to work-related stress. These include:

- lower levels of control in their jobs, since the great majority of women still tend to occupy less senior positions than men;
- a higher proportion of women who work in precarious forms of employment;
- large numbers of women in stressful occupations, such as nursing, teaching, helpdesk services and in temporary and outsourced employment; and
- the prejudice and discrimination suffered by many women who are in senior positions, such as managerial posts, both as a result of organizational and corporate actions, and because of the reaction of their male colleagues at work.

The costs of stress

Because stress is so widespread, it has a very high cost for individuals, enterprises and organizations, and for society as well.

For the individual, in addition to the devastating impact of the serious health impairments referred to earlier, the inability to cope with work and social situations can lead to lower levels of success at work, including the loss of career opportunities and even employment. It can give rise to greater strain in family relationships or with friends. It may even ultimately result in depression or suicide.

For the enterprise or organization, the costs of stress take many forms. These include absenteeism, an increase in the incidence of violence in the workplace, high medical costs and, higher staff turnover associated with recruiting and training new workers. In recent years it has been shown that stress takes a heavy toll on productivity and efficiency.

Since it is now widely acknowledged that workplace stress is a very common problem and has a very high cost on workers' health, well-being, and overall performance, it is in the interests of all parties concerned to take action to minimize its impact.

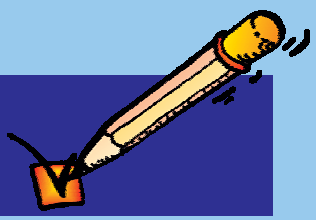
It has been proven time and again that effective solutions exist for the prevention of stress at work. These offer a very good return in terms of reduced absenteeism, better health, improved efficiency and productivity, as well as lower medical costs and other benefits.

EU-OSHA estimates of the cost of work-related stress in EU countries:

- In 2002, the European Commission reported that the yearly cost of work-related stress in the EU15 was EUR 20,000 million each year.
- In the United Kingdom, it has been suggested that over 70 million days are lost every year through poor mental health. In 2005/06 work related stress depression and anxiety cost Great Britain in excess of £530 million.

Source: EU-OSHA, 2009.

Exercise 1:
Causes and Effects of Stress



You have 10 minutes to complete this exercise individually.

After watching the video "Modern Times" answer the following questions.

1. How does this situation affect the individual?

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2. How does this situation affect the worker's health?

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3. How does this situation affect the worker's self-esteem?

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4. How can the situation showed in the film have an impact on family and social life?

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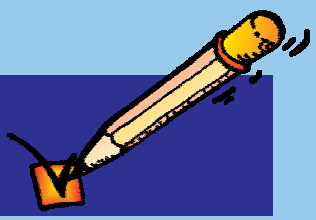
Exercise 2:
Social readjustment rating scale



This is a list of events that may lead to increased stress.

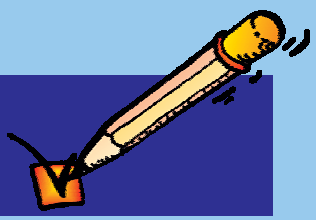
You have 5 minutes to complete this exercise individually. It will not be collected, but it will be used for the next exercise.

Mark the life events that have happened to you in the past 18 months

- ☐ Death of a spouse .....
- ☐ Divorce .....
- ☐ Marital separation .....
- ☐ Jail term .....
- ☐ Death of close family member(s) .....
- ☐ Personal injury or illness .....
- ☐ Marriage .....
- ☐ Loss of job .....
- ☐ Marital reconciliation .....
- ☐ Retirement .....
- ☐ Change in health of family member(s) .....
- ☐ Pregnancy .....
- ☐ Sexual difficulties .....
- ☐ Arrival of new family member(s) .....
- ☐ Death of a close friend .....
- ☐ Change to a different line of work .....
- ☐ Change in the number of arguments with spouse .....
- ☐ Change in responsibilities at work .....
- ☐ Son or daughter leaving work .....
- ☐ Trouble with in-laws .....
- ☐ Outstanding personal achievement .....
- ☐ Spouse beginning or stopping work .....
- ☐ Beginning or ending school .....

- ☐ Spouse beginning or stopping work
- ☐ Beginning or ending school .....
- ☐ Change in living conditions .....
- ☐ Revision of personal habits .....
- ☐ Trouble with boss .....
- ☐ Change in working hours or conditions .....
- ☐ Change in residence .....
- ☐ Change in schools .....
- ☐ Change in recreation .....
- ☐ Change in religious activities .....
- ☐ Change in social activities .....
- ☐ Change in sleeping habits .....
- ☐ Change in the number of family get-togethers.....
- ☐ Change in eating habits .....
- ☐ Vacations.....
- ☐ Minor violation of the law .....

Exercise 3:
Defining work-related stress



You have 5 minutes to complete this exercise individually.

Stress can be defined in many ways. How would you define it?

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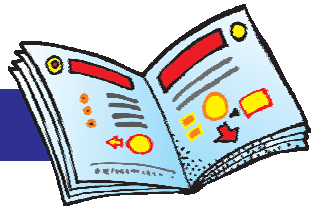
Handout 3.1



What is stress?

Stress is a natural phenomenon. It can be defined as a defence mechanism that has any emotional or physical response and that in many ways assured the survival of the human species. However, today, prolonged stress is destructive and debilitating.

ILO definition of stress:

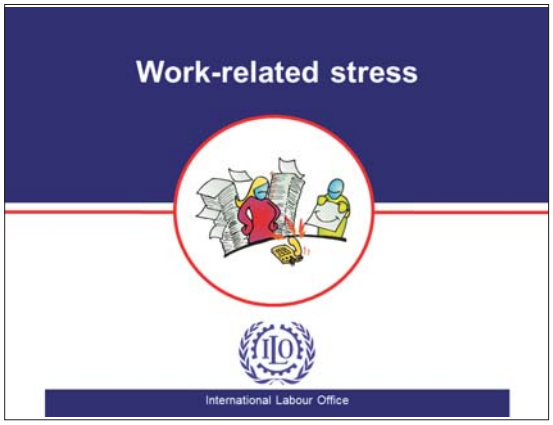
Stress is caused by an imbalance between the perceived demands and the perceived resources and abilities of a person to cope with those demands. Work-related stress is the harmful physical and emotional response that occurs when the demands of the job do not match or exceed the capabilities, resources, or needs of the worker. It becomes a risk to safety and health when work exceeding the person's capacity and ability to cope is prolonged.

Work-related stress is determined by work organization, work design and labour relations. It emerges when the knowledge and abilities to cope, of an individual worker or of a group, are not matched with the expectations of the organizational culture of an enterprise. Therefore, measures undertaken at the workplace level need to be managed with a multi-pronged approach by:

- implementing collective risk assessment and management measures, as it will be dealt with other workplace hazards;
- increasing the coping ability of workers by increasing their control over their tasks; and
- building up social support systems for workers within the workplace.

Work-related stress presentation

Slide 1



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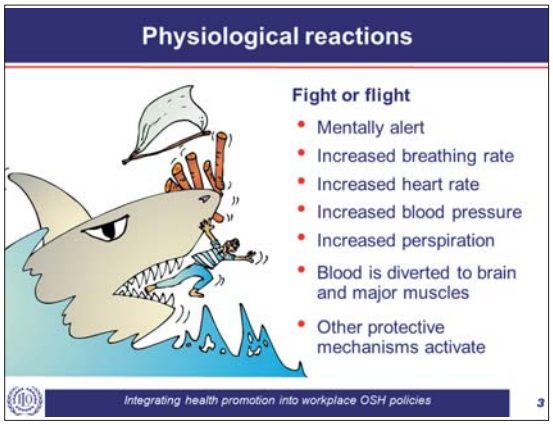

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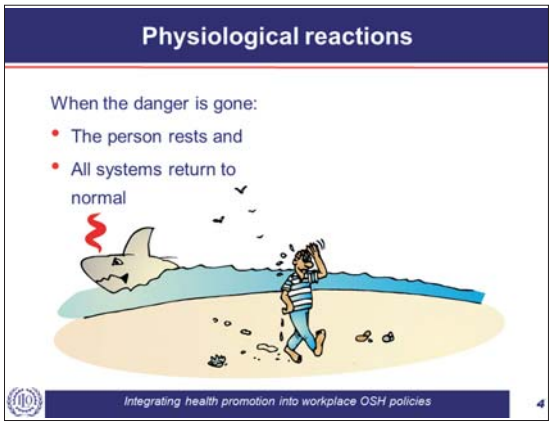

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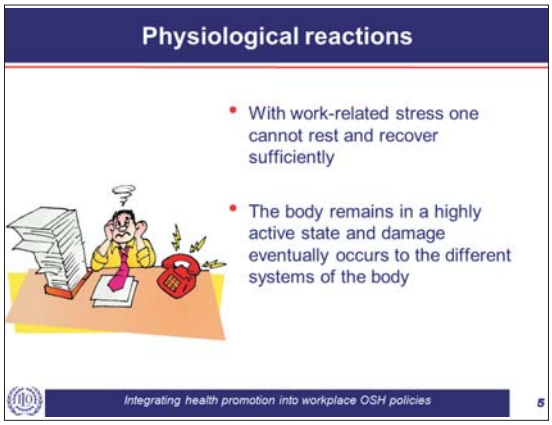

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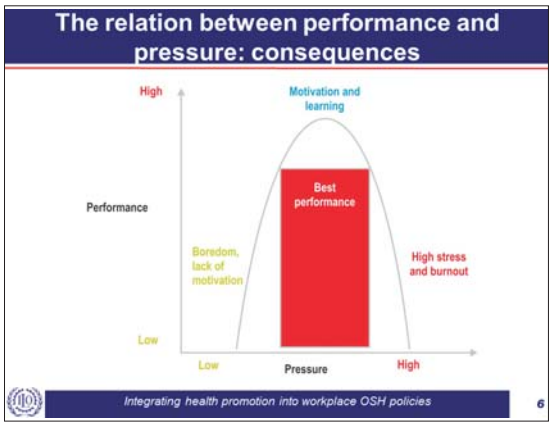

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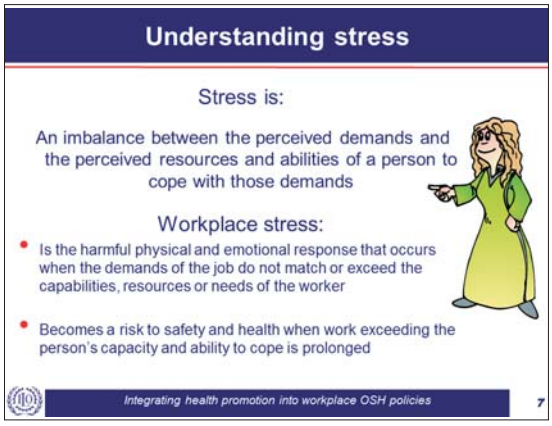

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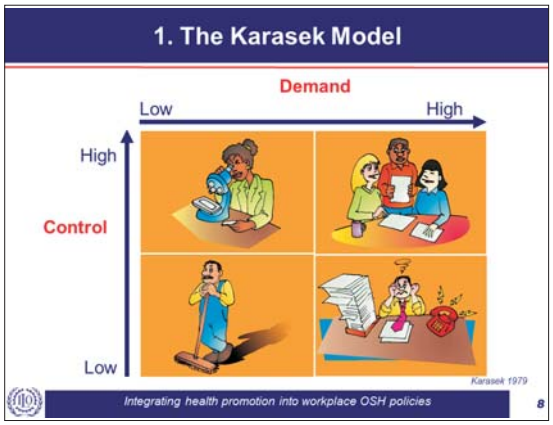

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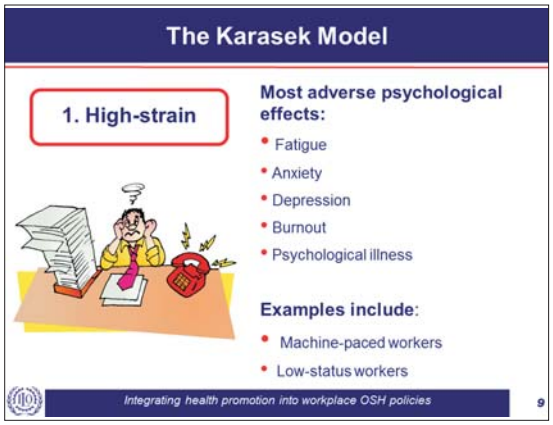

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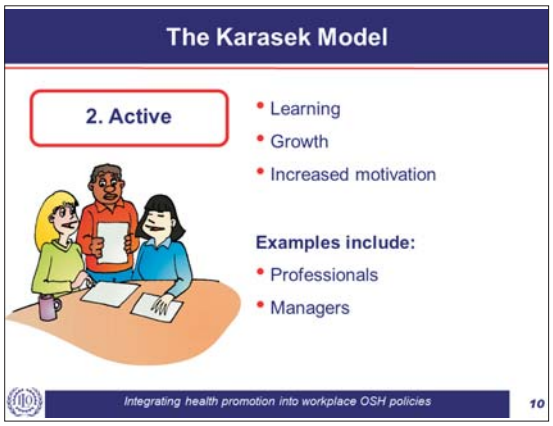

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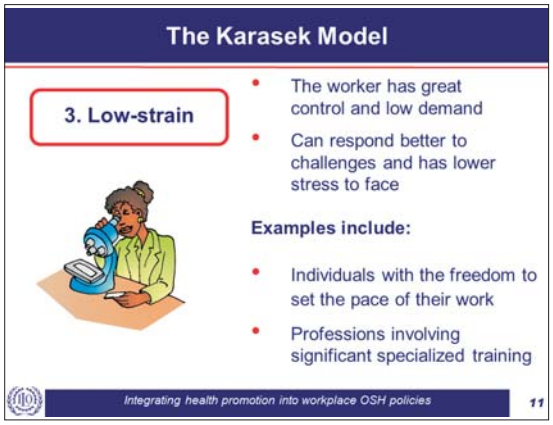

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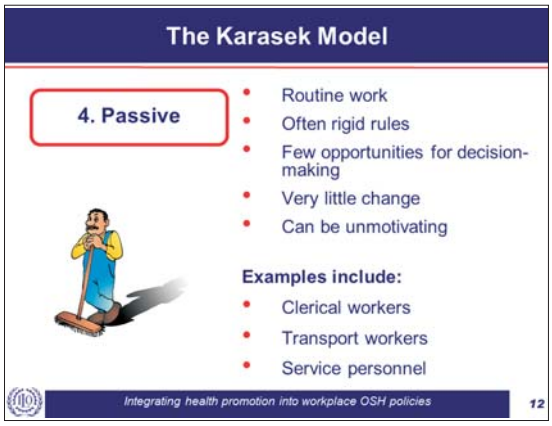

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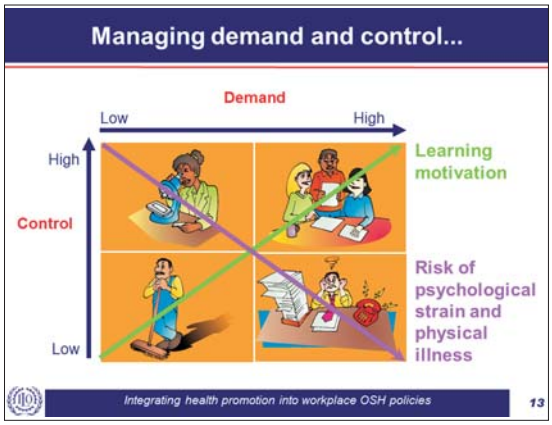

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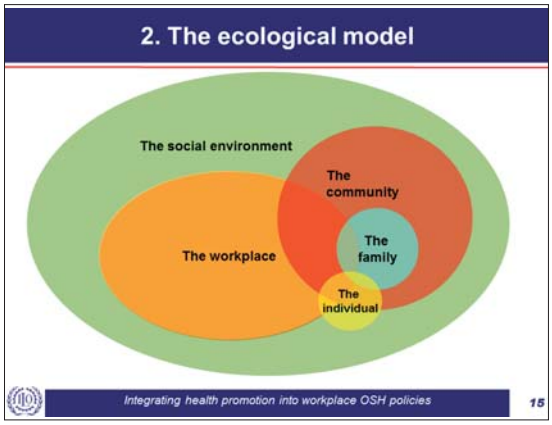

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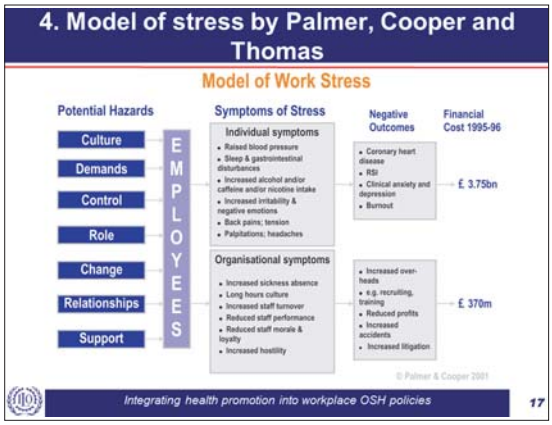

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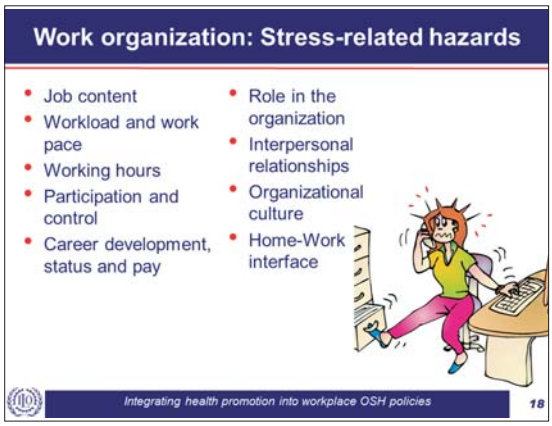

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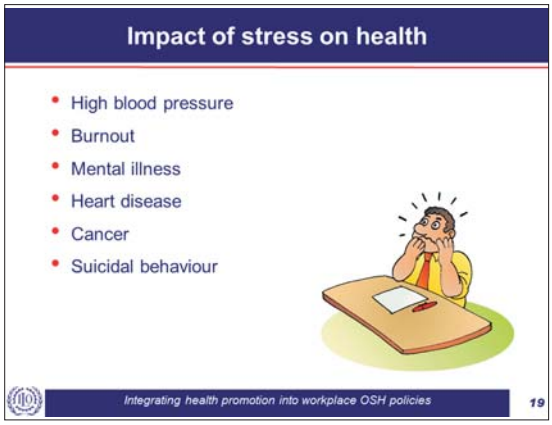

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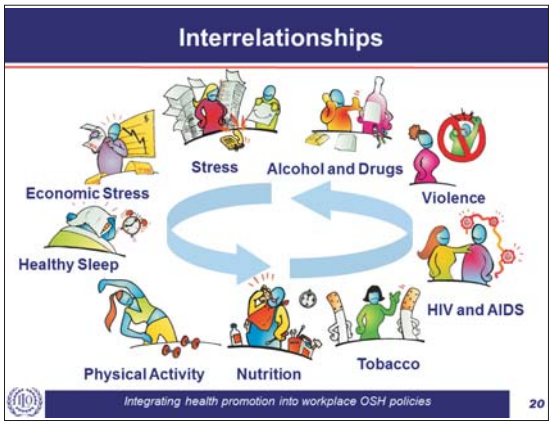

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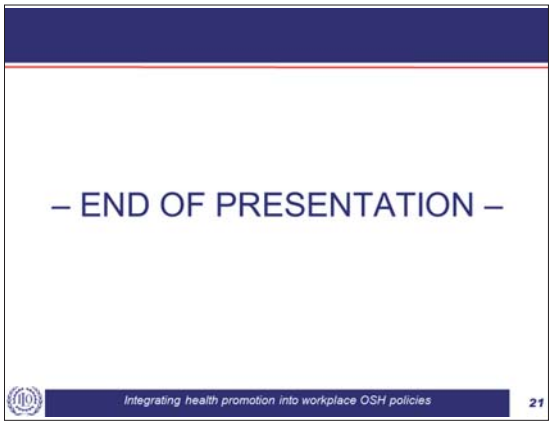

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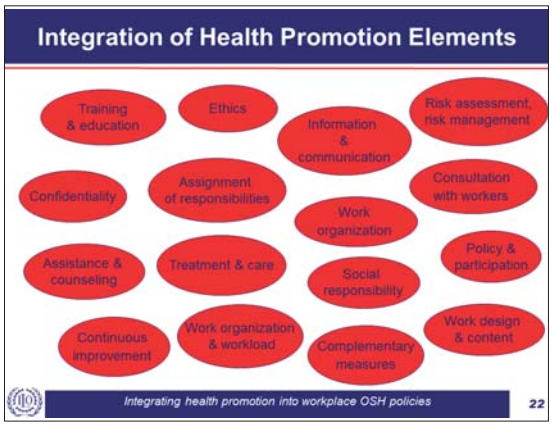

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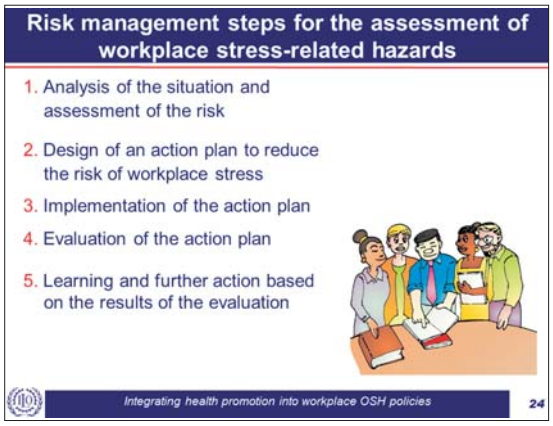

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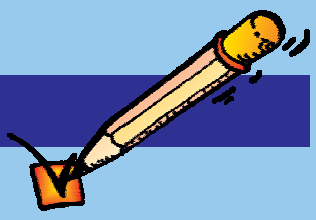
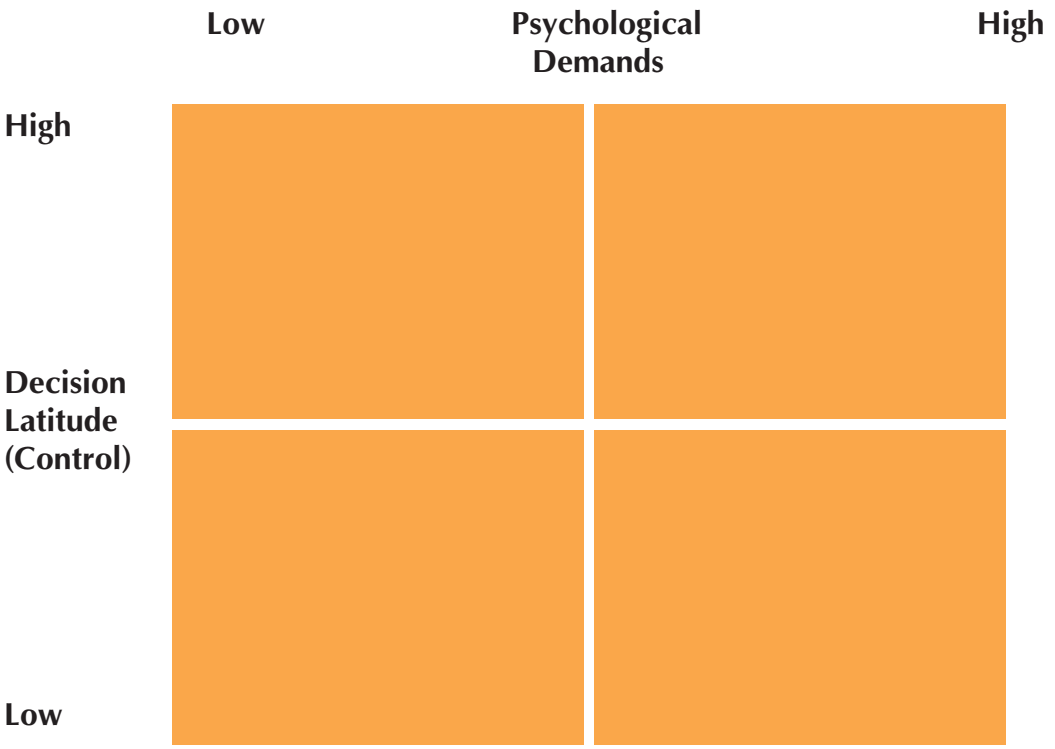
Exercise 4: Activating the model



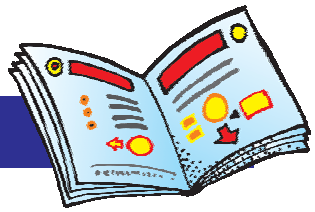
You have 10 minutes to complete this exercise.

1. Place yourself in the model.



2. In pairs discuss your placement and your partner's placement in the model.

Handout 3.2



The Karasek model[2] describes the characteristics of workers' tasks that are associated with psychological stress. According to this model, not only the psychological demands of work lead to stress and related illnesses, but also a situation of high perceived demand, combined with low perceived control over the work process. Stress occurs when workers are prevented from responding to a stressor according to their own optimal psychological and physiological response pattern because of external factors over which they have no control.

Karasek's model

The model for stress is based on three variables:

I. Job decision latitude or control

II. Psychological demands

III. Social support

Four situations (control – demand) can be identified:

1. **Low control - low demand:** A passive situation where the worker has enough control and the demand is not too high. This leads to little stress.

2. **Low control - high demand:** A high strain situation where the worker has little control but demand is high. This leads to stress.

3. **High control - low demand:** Low, relaxed or low-strain situation where the worker has a lot of control and demand is low. This leads to little stress.

4. **High control - high demand**: An active situation where the worker has a high demand for his/her services and high control. This leads to situations where most people feel they can manage.

   - Stress will increase if control declines in combination with an increase of psychological demand or stressors.
   - Stress will decrease if control increases in combination with a decrease of psychological demand or stressors.
   - Stress will decrease if social support increases.

2 Karasek, 1979.

Social support and social interaction at work contribute to stress reduction. The following aspects of social support are important:

- **Quality of relations:** The extent to which someone has satisfying relationships or works in a workplace with a satisfying social climate, e.g. the mere fact that it is possible to communicate with colleagues about futile matters, or make jokes, can reduce stress.
- The extent to which someone thinks he/she can rely on others for **social support**.
- **Actual social support**: The extent to which social support can be provided and was actually provided in other situations.

The use of Karasek's model, by locating the category of workers under consideration in the quadrant, can facilitate understanding of the factors involved in the generation of stress and the identification of the most appropriate measures to combat stress.

In contrast, motivation can be achieved when the demands of the task are met according to a response pattern that is determined by the workers. The model seems to capture some important stressful job circumstances: The low-control, high-demand tasks, particularly in combination with low social support. In Figure 1, the vertical dimension of decision latitude (increasing towards the top) and the horizontal dimension of psychological job demands (increasing to the right) create four quadrants. If the model is considered in terms of the health consequences of work, the following is found: Stress is strongest in the lower right quadrant (high demands, low decision latitude); the upper right quadrant (high demands, high decision latitude) is called active work; the diagonally opposite situation is called passive work (low demands and low decision latitude); while low strain work is in the upper left quadrant.

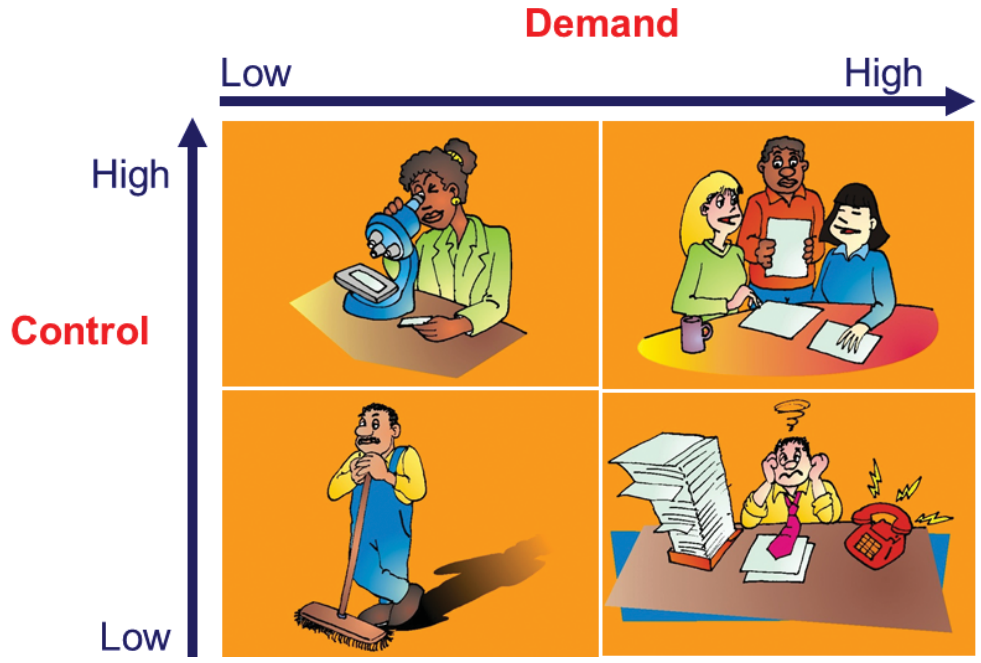
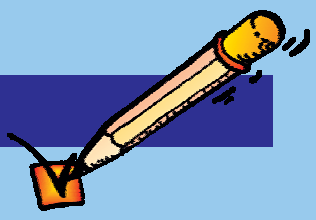


Figure 3.1: The Karasek Model

Exercise 5: Simulation - Stress



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* module, in this simulation exercise, you and your management team will begin to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

Today is 12 December. The executive director has called an urgent meeting for it is clear that the plant cannot meet the current orders.

The sales manager reports that the customers are unhappy and that unless something is done, they will take their business elsewhere.

The production manager reports that in order to meet the demands of the customers, the supervisors have increased the demands on the workers but are not able to provide incentives or paid overtime due to the adverse financial situation.

Action

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There is also more pressure on the supervisors to ensure output, while at the same time maintaining a calm and effective workforce. Last week, after a rather difficult day with his shift, one of the supervisors was hospitalized with chest pains. He was diagnosed as having suffered a mild heart attack and will be incapacitated for at least 15 weeks.

This reduces the number of crew supervisors from six to five.

The other supervisors are expressing concern both for their colleague and for themselves due to the extra workload.

Action

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The executive director has decided that due to the financial situation, there will be a recruitment freeze until further notice.

The director of human resources complains that even if there is no such employment freeze, there are insufficient skilled workers in the employment catchment area.

The workers' representative is calling for a meeting between the staff union and management to help resolve the situation.

On the shop floor the forklift truck has broken down.

The replacement has been ordered but it will not be available for at least 10 more weeks as the importer says the orders are backlogged.

The workers are using hand trucks and dollies to move the finished machinery from the assembly line to the shipping area.

The medical doctor reports that he is seeing an increased number of workers complaining about back pain. Workers are also complaining about being more tired at the end of the day. There is also an increase in minor injuries and there has been an 11 per cent increase in sick leave over the past quarter.

Action

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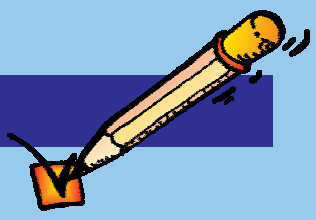
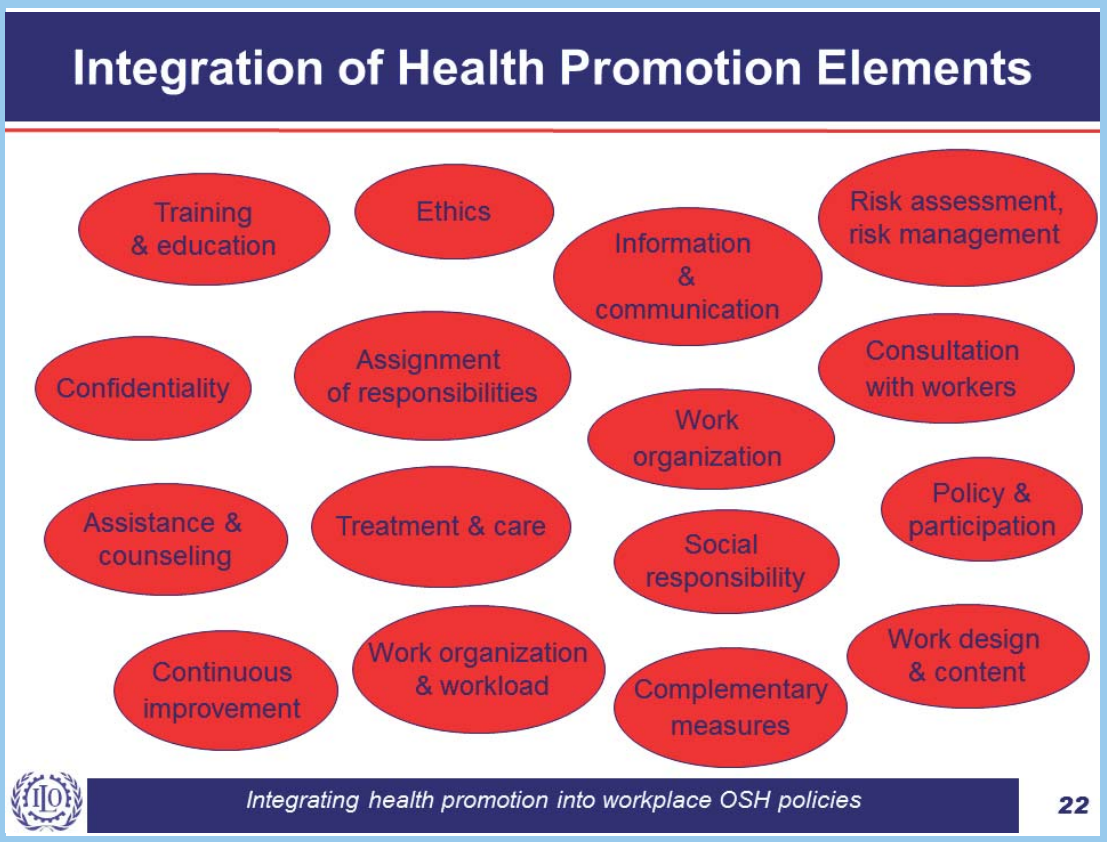
Exercise 6: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme, and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Work-related stress*.

After that, use the checklist at the end of this module to choose the measures relevant to *Work-related stress* to be incorporated in your workplace health promotion (WHP) programme. You can also use handout 3.3 of your workbook.

The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *Work-related stress* from the PowerPoint slide shown to you. Note down the elements chosen in your workbook. Begin filling in the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Work-related stress* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *Work-related stress*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with each topic in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their Occupational Health and Safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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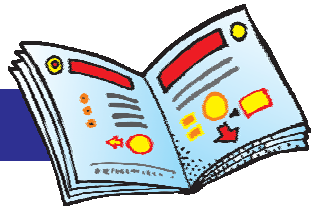
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Handout 3.3



Anti-stress intervention

Once the existence of stress has been recognized and the stressors identified, action to deal with stress should be taken. Assuming that stress is a mismatch between the demands of the environment and the individual's abilities, the imbalance may be corrected either by adjusting external demands to fit the individual, or by strengthening the individual's ability to cope, or both. At this point, it should be kept in mind that since stress is a multifaceted phenomenon, no simple solution is available. Furthermore, differences in the particular circumstances of each case make it impossible to provide a unique or universal solution for the individual management of stress. As this cannot always be achieved in the short term, it is generally agreed that improving the ability of the individual to cope with stress is one valuable strategy in the process of combating stress. The ideal solution to combat stress is to prevent its occurrence. This may be achieved by tackling the core of the problem: the cause itself. However, there is no single cause of stress, and the elimination of all stressors is not feasible. Therefore, in the workplace, action should be aimed at eliminating as many causes as possible, so that the action taken reduces stress and prevents future stress. The causes should be identified and dealt with through risk assessment and management measures.

Stress assessment and management

Given that the goal of any stress prevention programme is to manage specific causes of stress and their effects, related to both the work situation and the personal characteristics of the individual, an effective preventive programme requires proper identification of the stressors (psychosocial hazards) causing the stressful situations and an assessment of the working conditions, work organization, work performance, and labour relation problems resulting from stress.

Work-related psychosocial hazards can be assessed, and their effects controlled, through risk-assessment and management measures, in the same way as other occupational hazards. As the causes of stress are hazards related to the design and management of work and working conditions, it will be necessary to identify work practices or work organization measures that cause significant imbalances between demand and resources; for example, in terms of mismatch between demands and pressures, on the one side - and workers' knowledge and abilities on the other.

Involving workers in identifying those stressors which they feel cause unnecessary stress in their jobs, and in rating them to establish priorities for intervention, should be part of the assessment. Moreover, workers should also be asked to express their concerns about any other situation that may be causing additional stress at work, and should be involved in the implementation of the measures of prevention and control. This would allow setting priorities and managing the risk reduction in a more effective way.

Risk management steps:

1. analysis of the situation and assessment of the risk;
2. design of an action plan to reduce the risk of workplace stress;
3. implementation of the action plan;
4. evaluation of the action plan; and
5. learning and further action based on the results of that evaluation.

Wide-ranging types of interventions may be considered.

The most effective combination will depend on the specific enterprise or workplace, according to the specific features of the particular work situation.

The following is a list of possible types of intervention, ranging from interventions targeted at the working environment, to those targeted at the individual.

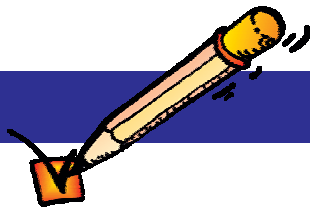
1. intervention of the external socio-economic environment through legislation, international and national directives;
2. intervention on technology and work organization;
3. improving job planning and reliability of the work systems;
4. reduction of working hours and arrangement of working teams and rest periods in relation to the workload;
5. arrangement of shift schedules according to psychological, physiological, and social criteria;
6. participation of workers in decision-making and effective two-way communication;
7. interventions in work organization and tasks structure;
8. improving the working environment (improved lighting, noise reduction; improvement in micro-climatic conditions and indoor air quality);
9. arranging workplaces according to ergonomic criteria (better workstation design, improving workstations of those working with visual display units, correct sitting postures);
10. better recruitment and selection and improved training;
11. specific interventions for health protection and health promotion;
12. social support;
13. counselling or advice on individual ways of coping with stress;
14. counselling and other supportive measures at the enterprise level;
15. appropriate medical surveillance.

Practically all of the above-mentioned measures can, in principle, be beneficial for all occupations affected by stress, so particular attention needs to be paid to avoid the risk of generalization. Therefore, each preventive programme should deal with the specific measures relevant to the particular workplace or category of workers under consideration (e.g., if improved organization of working hours is a measure for the prevention of stress for nursing personnel performing shift work, practical changes in shift arrangements should be proposed).

Preventive approaches to stress are thus becoming increasingly relevant in terms of research, risk management and policy orientation, and are opening new paths for intervention in the fight against work-related stress.

The following checklist also provides guidance on the measures to incorporate in a workplace policy that can be useful.

Checklist



Action–oriented checklist for addressing stress at work			
1. Policy and participation			
1.1	Adopt a comprehensive approach to stress at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of preventing stress at work for workers' health well-being and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and the prevention of stress in the health promotion programme, with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly, in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

1.11	Ensure that the policy of the organization enables workers to recognize the value of their work and to see the connection between their good performance and the positive outcomes of the organization.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.12	that organizational changes are clearly and timely communicated to the workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.13	Set clear objectives and ensure that all workers are aware of their role in achieving them.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.14	Provide for an environment conducive to problem-solving.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.	**Training, Education, Information and Communication**		
2.1	Ensure that information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and work-related stress and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and plan of action through all means possible such as notice boards, mail, payslip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on the management of work-related stress, including information on where support is available in-house and outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.5	Ensure an efficient communication level between the management and employees in order to avoid rumours and misleading information.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.6	Implement measures (periodical questionnaire, interviews, etc.) to assess and monitor the workers' perception of their working conditions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.7	Provide adequate training and updating opportunities for knowledge and skills.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.8	Provide adequate training to fill the gap between current job requirements and workers' skills.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.	Work organization, Workload, Design and Content		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Ensure that tasks are clearly defined.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Assign tasks according to experience and competence.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Ensure career development opportunities for all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	Ensure that there are supportive relationships between supervisors and managers and all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.6	Allow for social contact among workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.7	Reinforce motivation by emphasizing the positive and useful aspects of the work.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.8	Provide adequate pay for the work performed.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.9	Allow workers' opinions to be heard on how their work is to be carried out.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.10	Assign clear roles, avoiding role conflict and ambiguity.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.11	Ensure the proper utilization of skills.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.12	Ensure that targets and appraisal schemes are clear and fair.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.13	Provide adequate recognition and feedback about work.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.14	Incorporate a specific risk assessment of psychosocial hazards and management of stress in the broader workplace's risk management procedures.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.15	Encourage workers to discuss any conflicting demands between work and home and find solutions collectively with management.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.16	Match jobs to physical and psychological skills and abilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.17	Regularly assess time requirements and assign reasonable deadlines.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.18	Ensure that working hours are predictable and reasonable.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.19	Maintain a workplace that is free of physical and psychological violence.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.20	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Provide adequate support, counselling and referral for treatment , as appropriate, for people showing either physical or psychological symptoms of stress.	Is action needed?	☐ Yes ☐ No ☐ Comment

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4

Alcohol and drugs at work

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for a response to alcohol and drugs at work.

Introduction

The problem

In the public's mind substance abuse is associated with drug overdoses or drunkenness, and is thus seen as a social problem. However, in reality, this is the very tip of a long and complex process of health deterioration. It contains the two distinct and related components of addiction and intoxication.

Addiction is a chronic, often relapsing brain disease that causes compulsive drug seeking and use despite harmful consequences to the individual who is addicted and to those around them. Drug addiction is a brain disease because the abuse of drugs leads to changes in the structure and function of the brain.[1]

Intoxication is a condition that follows the administration of a psychoactive substance and results in disturbances in the level of consciousness, cognition, perception, judgment, or behaviour, or other psychophysiological functions and responses.[2]

While addiction causes many health problems for individuals, intoxication can pose safety risks.

Problems related to alcohol and drugs may arise as a consequence of personal, family or social factors, from certain work situations or from a combination of these elements. Such problems not only have an adverse effect on the health and well-being of workers, but may also cause many work-related problems, including deterioration in job performance. In the workplace, it results in increased absenteeism and higher accident rates leading to lower productivity. The problem is also felt beyond the enterprise through dissension and distress in the family and financial difficulties, as well as increased social costs.

Impact on the individual

The effects of alcohol and drugs on the user depend on the amount consumed at any given time, how it is used, and the individual's previous history and experience. Each class of drugs affects the mind and the body in a different way.

The abuse of all kinds of drugs, however, has negative consequences for the workplace environment, safety and work performance. Such substances can affect reaction time, learning and memory, intellectual performance, motor performance, vision, behaviour, emotion and mood, and therefore, relations with co-workers. The first signs of alcohol or drug abuse are sickness, hangovers, hand tremors, late arrivals, long lunch breaks, and early departures. This will soon lead to stress, nervousness, irritability, resentment

1 NIDA: *Understanding Drug Abuse and Addiction*; http://www.nida.nih.gov/Infofacts/understand.html

2 WHO: *Acute Intoxicatio*n; http://www.who.int/substance_abuse/terminology/acute_intox/en/index.html

and reduced morale, friction, and quarrels with co-workers. These are accompanied by poor quality workmanship, lower output, unsound decisions that may cause or contribute to workplace accidents, decreased productivity, missed deadlines, and losses for business.

Implications for co-workers

The effect of substance abuse in the relationships with other co-workers will result in increased workloads, higher safety risks and reduced overall output. This will obviously lead to disputes, grievances, lost time and decreased productivity. The situation is likely to be aggravated by the increased possibility of accidents and injuries due to intoxication, negligence and impaired judgment.

Notes from around the world

Australia: In a survey carried out by the Australian Government in 2007, nine out of every ten Australians aged 14 years and over had tried alcohol at some time in their lives, and 82.9 per cent had consumed alcohol in the 12 months preceding the survey. Almost two in every five Australians had used an illicit drug at some time in their lives and almost one in seven had used illicit drugs in the previous 12 months.

Canada: The Canadian Addiction Survey in 2009 found that 76.5 per cent of Canadian adults were current drinkers, and of these, 36.4 per cent drank weekly and 5.1 per cent were described as heavy drinkers. The number of marijuana (cannabis) users had doubled in 10 years. One in six Canadians reported using an illicit drug other than cannabis in their lifetime.

European Union: The European Monitoring Centre for Drugs and Drug Addiction (2009) examined drug use throughout the EU and estimated that for 13 European countries where data was collected, 4 million people used cannabis on a daily basis. It also reports other findings, such as the use of new psychoactive substances.

India: Bengal (2005) reported drinking in only 21 per cent of men; the problem was regional, from an average of 7 per cent in the Western state of Gujarat (officially under prohibition) to 75 per cent in the North Eastern state of Arunachal Pradesh. It is also estimated that illicitly distilled spirits accounted for 95 per cent of the alcoholic beverages drunk by men and women.

Japan: Two major factors accelerate access to illicit drugs among young people: one is the presence of illicit drug-dealing groups, which indiscriminately offer them, the other is new technology, such as the Internet and mobile phones (Yamamoto, 2004).

Philippines: A study by the International Labour Organization on drug use by children working in the drug trade in a Philippine city found that over 90 per cent of children used drugs such as methamphetamine, glue and cannabis, and the majority of children in that sector began working in the drug trade at age 14–16.

Costs to employers

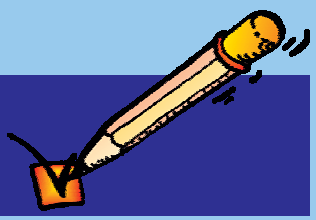
Sickness increases medical costs, while absenteeism lowers the availability of manpower and decreases output. Deteriorating working relations due to grievances in turn causes a decrease in productivity. Poor work performance, unsound decisions, and impaired judgment lead to accidents, missed deadlines and increased costs in business. Injuries due to accidents requiring compensation, damage to property and equipment, and lost production time due to breakdowns, increase the employer's expenses. Substance abuse can also result in additional costs to the employer due to lower quality in products or services, recruitment, retraining and loss of experienced workers; it can also become a serious threat to public safety as well.

The response

While the elimination of substance abuse is a highly desirable goal, experience has shown the difficulties in achieving it at the workplace level. Given the size of the problem and its implications for both workers and the enterprise, no employer, big or small, can afford to ignore the issue. The traditional approach, however, has been to respond to the needs of a small number of individuals who are regarded as 'alcoholics' or 'drug addicts'. This passive approach, in fact, does not deal with the causes of the problem and implies that enterprises are willing to absorb costs over a long period of time and workers may or may not recover.

Programmes to address the problem of substance abuse by workers have traditionally focused on the identification and rehabilitation of individual workers with severe alcohol and, more recently, drug abuse problems. However, as understanding of the multiple causes of alcohol and drug related problems, and the resulting multiple approaches to prevention, assistance, treatment, and rehabilitation have increased, more progressive enterprises, workers' organizations and local authorities have placed a much greater emphasis on the development of partnerships designed to achieve a real improvement in the situation both at the workplace, and at national level, from a collective perspective. It is for this reason that a change of strategy is taking place and the emphasis is shifting from assistance to **prevention**, addressing all workers, not just a handful of them. While help and care are available to those who need them, the main focus is on prevention, by creating awareness through educational programmes with the aim of bringing about changes in attitudes and behaviours.

Exercise 1:
Self-assessment questionnaire



You have 10 minutes to compile this exercise individually. It will not be collected.

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?
   - Never
   - Monthly or less
   - 2-4 times a month
   - 2-3 times a week
   - 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7 to 9
   - 10 or more
3. How often do you have six or more drinks on one occasion?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily
4. During the past year, how often have you found that you were not able to stop drinking once you had started?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

8. During the past year, have you ever been unable to remember what happened the night before because you had been drinking?

   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   - No
   - Yes, but not in the past year
   - Yes, during the past year

10. Has a relative or friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?

   - No
   - Yes, but not in the past year
   - Yes, during the past year

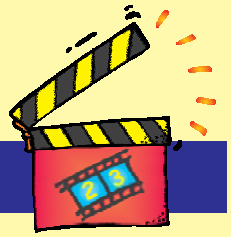
Scoring the questionnaire

Scores for each question range from 0 to 4, with the first response for each question (e.g. "never") scoring 0; the second (e.g. "less than monthly") scoring 1; the third (e.g. "monthly") scoring 2; the fourth (e.g. "weekly") scoring 3; and the last response (e.g. "daily or almost daily") scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2, and 4 (from top to bottom).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate **alcohol** dependence.

Questionnaire adapted from: J. B. Saunders, O. G. Aasland, T.F. Babor et al. 1993. "Development of the **alcohol** use disorders identification test (**AUDIT**): WHO collaborative project on early detection of persons with harmful **alcohol** consumption" in *Addiction*, Vol.88: pp.791–803.

Alcohol and Drugs presentation



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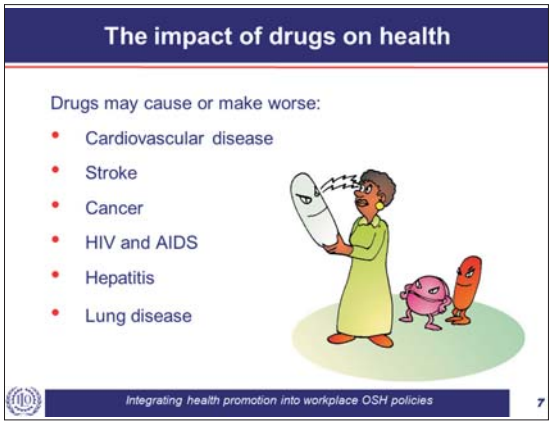

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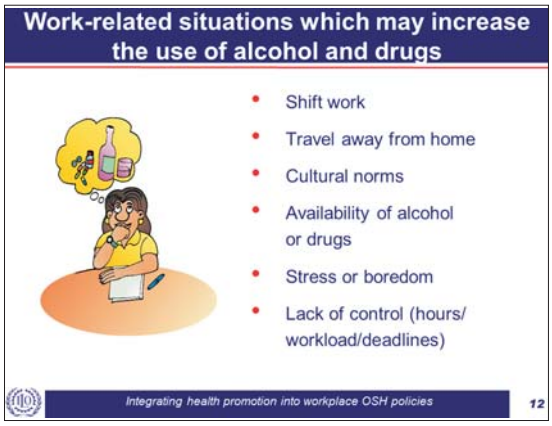

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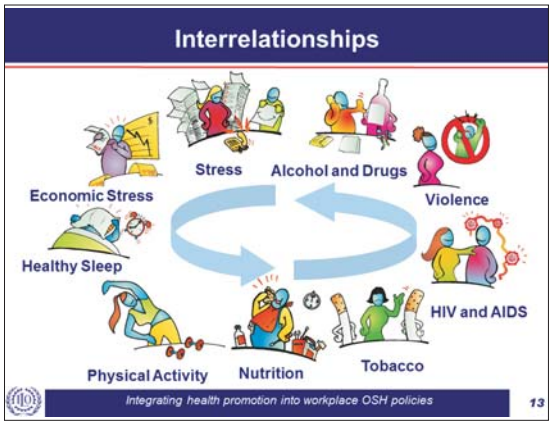

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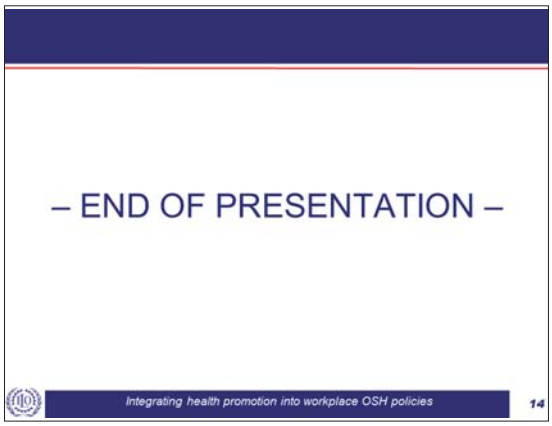

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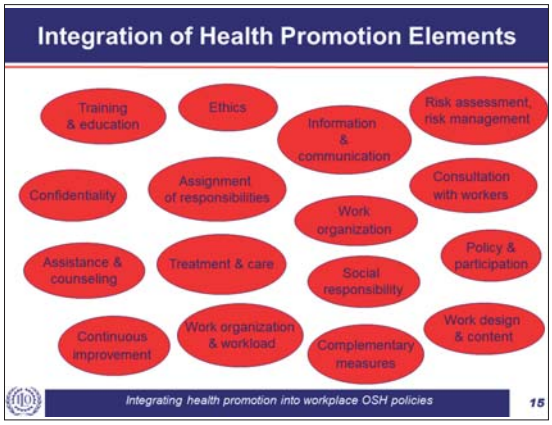

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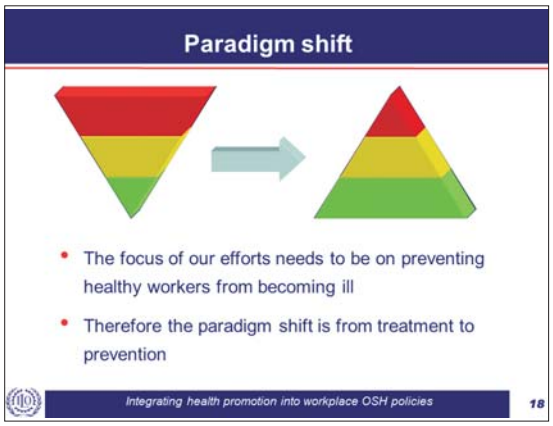

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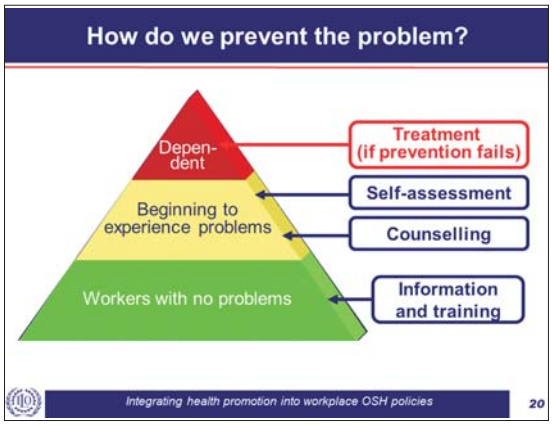

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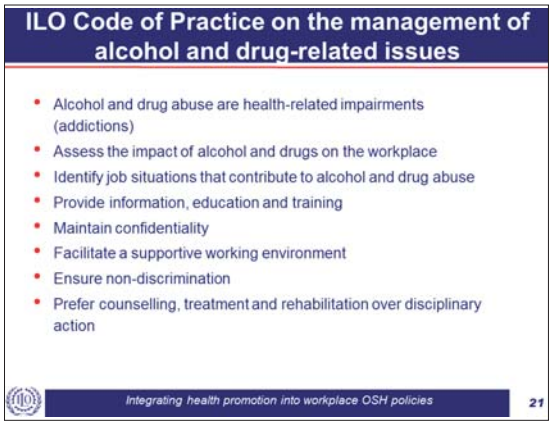
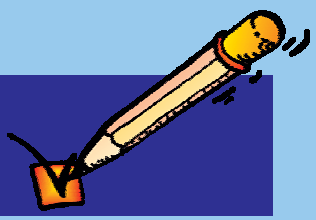


Exercise 2:
Problems on the production line



You have 10 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary using the overhead projector.

Introduction

For this exercise, you are a consultant to a number of medium-sized enterprises. In one of the factories the production line has changed, giving people additional work together with extra hours. Although the human resources department is recruiting new staff, its director does not see a possibility of having additional trained staff on the production line for at least six months. During the past several weeks the supervisors have noticed the following behaviours among production line workers:

1. An increase in short-term absenteeism.
2. Instability and eruptions of violence.
3. Deteriorating inter-personal relations.
4. Sudden and sharp changes in behavioural patterns.

You have also learnt that there is increasing use of drugs and alcohol in the areas just outside the factory gates. As a consultant you have been asked to analyse the possible impact on the enterprise of drug and alcohol use by workers, and the root causes for the current problems. Prepare a brief presentation to management explaining why the company needs to address alcohol and drugs at this time. You may like to mention the role of OSH policy and some possible areas for action.

Causes and impact

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Presentation notes

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Handout 4.1 Identifying drug- or alcohol-related problems in the workplace

Two main circumstances in the workplace may provide indications of drug or alcohol use:

1. When a worker is under scrutiny because of poor performance, frequent absences, frequent accidents and injuries or antisocial behaviour.
2. When a worker reports to the occupational health or medical service with a condition that appears to be related to drug or alcohol use.

Straight facts….About alcohol and drugs

It should be stressed that very few of the following pointers taken on their own are specific to drug and alcohol abuse. It is when two or more conditions occur in the same person (though not necessarily at the same time) that harmful drug or alcohol use may be suspected:

Physical evidence of alcohol intoxication:

- Smell of alcohol on the breath.
- Slurred speech.
- Uninhibited behaviour.
- Smelling of alcohol in the morning.
- Signs of intoxication (slurred speech, unsteady on feet. confused.).
- Bleary-eyed.

Physical evidence of alcohol withdrawal:

- Sweating.
- Vomiting.
- Increased pulse and blood pressure.
- Agitation.
- Tremor and sweating of hands.
- Multiple bruises, especially if some are more recent than others.
- Loss of weight and gaunt appearance.

Physical evidence of drugs intoxication:

- Dilated pupils.
- Excited, racing thoughts, disordered thinking, paranoia.
- Raised pulse and blood pressure.
- Aggressive, erratic, or violent behaviour.
- Injection signs on arms (drugs used intravenously). The person may not visibly show where they have injected drugs; old injection marks appear as skin pigmentation, or thinning of the skin. New injection sites are small and usually slightly red and inflamed. In cases of dependence of injecting drugs (such as heroin), both new and old injection sites should be visible.
- Other common health conditions associated with drug use can be poor dentition, parasitic skin infections (lice, scabies) and loss of weight.

Signs of drug abuse withdrawal:

- Anxiety, dilated pupils, abdominal cramps, yawning, runny nose, and "gooseflesh" (signs of opioid withdrawal).
- Fatigue, increased appetite, irritability, emotional depression, and anxiety (signs of stimulant withdrawal).
- Mood swings, anxiety and muscle cramps (signs of cannabis withdrawal).
- Tremor and sweating of hands.
- Multiple bruises, especially if some are more recent than others.
- Loss of weight and gaunt appearance.

Other signs and symptoms:

Habits and mood

- Wearing long sleeves in all weather, especially in the morning to cover up injection marks.
- Becoming less neat in dress or appearance or sometimes excessive care about dress.
- Fluctuations in mood in a single day or shift (alternation between drug-induced euphoria and delayed depression).
- Increased irritability, nervousness and argumentativeness.
- Poor relations with fellow workers and with management.
- Avoidance of supervisor.
- Tendency to blame others.

Absence from work

- Frequent absenteeism especially after the weekend or pay days.
- Frequent sick absences especially after the weekend.
- Bad time-keeping.
- Late arrivals and early leaving.
- Unexplained absences during the working day.

Accident Record

- Accidents at work, at home, or on the road.
- Trauma from accidents or fights.

Work Performance

- Deterioration of standards of work.
- Reduced quality and quantity of work. Increasing number of mistakes and errors of judgment.
- Loss of interest in work.
- Failure to meet deadlines.

Managing the Problem

Major issues essential for managing the problem of alcohol and drugs at work:

- Joint assessment of the problem by management workers and their trade unions and cooperation in developing a written policy.
- A shift towards prevention and early intervention rather than a passive approach towards treatment of a few.
- Consideration of alcohol- and drug-related problems as health problems.
- Stability, normal job security and same opportunities as other workers for those seeking assistance.
- Employers can take disciplinary action if the treatment option is refused.

Psychosocial interventions for workers with drug- or alcohol-related problems

- Engage the person in a discussion about their substance use in a way that he / she is able to talk about both the perceived benefits of it and the actual and / or potential harmful effects.

- Inform them about and help them access support groups (e.g. self-help groups or families and carers) and other social resources.
- Work with local agencies and community resources to find supported housing or assisted living facilities, as well as independent living facilities, if these are needed.

BUT REMEMBER: The focus of your strategy needs to be on preventing healthy workers from becoming ill rather than providing treatment of a few. While help and care should still be made available to those who need it, the main focus of your efforts should be on implementing preventive measures, such as creating awareness through educational programmes targeting all the workers, with the aim of bringing about changes in attitude and behaviour.

The ILO Code of Practice on the Management of alcohol- and drug-related issues in the workplace (Geneva, 1996)

It focuses on the design of workplace policies and programmes to assist individuals with alcohol and drug related problems and support both employers and workers and their organizations in dealing with the problem in a constructive way.

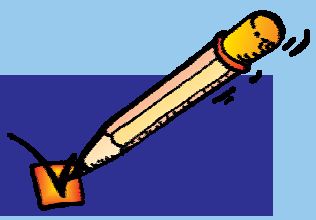
The practical recommendations of this code of practice are intended to provide guidance to all those who have responsibility for addressing alcohol and drug-related problems at the workplace. The strategies outlined in this code should apply to all staff. Managers and employees should not discriminate on grounds of their ethnic group, sex, religion, political opinion, national extraction or social origin. The key points in this code of practice are described below:

- Alcohol and drug related policies and programmes should promote the prevention, reduction and management of alcohol- and drug-related problems in the workplace. This code applies to all types of public and private employment including the informal sector. Legislation and national policy in this field should be determined after consultation with the most representative employers' and workers' organizations.
- Alcohol and drug-related problems should be considered as health- related problems, and therefore should be dealt with, without any discrimination, like any other health disorder at work and covered by the health-care systems (public or private), as appropriate.
- Employers and workers and their representatives should jointly assess the effects of alcohol and drug use in the workplace and should cooperate in developing and implementing a written policy for the enterprise.

- Employers, in cooperation with workers and their representatives, should identify job situations that contribute to alcohol and drug-related problems and take appropriate preventive or remedial action.
- The same restrictions or prohibitions with respect to alcohol should apply to both management and workers, so that there is a clear and unambiguous policy.
- Information, education and training programmes concerning alcohol and drugs should be undertaken to promote safety and health in the workplace and should be integrated into broad-based health programmes when appropriate.
- Employers should establish a system to ensure the confidentiality of all information communicated to them concerning alcohol and drug-related problems. Workers should be informed of exceptions to confidentiality which arise from legal, professional or ethical principles.
- Testing of bodily samples for alcohol and drugs in the context of employment involves fundamental moral, ethical, and legal issues requiring a determination of when it is fair and appropriate to conduct such testing.
- The stability which results from keeping a job is frequently an important factor in facilitating recovery from alcohol and drug-related problems. Therefore, employers and workers should acknowledge the special role the workplace may play in assisting individuals with such problems.
- Workers who seek treatment and rehabilitation for alcohol and drug-related problems should not be discriminated by the employer and should enjoy normal job security and the same opportunities for transfer and advancement as their colleagues.
- It should be recognized that the employer has authority to discipline workers for employment-related misconduct associated with alcohol and drugs. However, counselling, treatment, and rehabilitation should be preferred to disciplinary action. Should a worker fail to cooperate fully with the treatment programme, the employer may take appropriate disciplinary action.
- The employer should adopt the principle of non-discrimination in employment based on previous or current use of alcohol or drugs, in accordance with national law and regulations.

Source: ILO Code of Practice on the Management of Alcohol- and Drug-related Issues in the Workplace, Geneva, 1996.

Exercise 3:
Simulation - Alcohol and Drugs



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* **module, in this simulation exercise, you and your management team will continue to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.**

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

Today is 26 February. The executive director has called an urgent meeting.

The production manager reports that the new forklift truck has arrived and is in use. He also informs the management team that within two months all orders could be met if the current pace of production (with the new forklift truck) can be maintained.

The sales manager reports that the customers have agreed to maintain their orders for the time being.

In early January, the director of human resources found two workers drunk on the production line in the early afternoon. He immediately suspended the two workers for two months without pay.

In mid-January, the spouse of one of the two workers asked for an appointment with the executive director, the director of human resources and a member of the staff union. At the meeting she asked why her husband was singled out for disciplinary action when it was widely known that many workers consume both alcohol and drugs at lunch. She mentioned that this habit had grown since the increased demands on the production line. After the meeting, the director of human resources and the director of safety, health and environment started to informally ask around about alcohol, illicit drugs and prescription drugs; they found that:

- It was habitual for workers to go to a local bar for lunch and consume alcohol with their lunch;
- several younger male workers were using drugs during lunch and after working hours. It was suspected that certain drugs are also being used during working hours;
- several truck drivers were taking drugs to stay awake while driving;
- an increasing number of white-collar workers have asked the plant medical doctor for prescription drugs to deal with stress.

The executive director is concerned that the use of alcohol and drugs is not only unhealthy and illegal, but may also cause an accident and have an impact on the quality of the product. She calls for urgent action and is willing to allocate some money towards solutions to the problem.

Action

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The executive director asks for the management group's opinion on the following question: Did the stress cause the use of alcohol and drugs, or did the use of alcohol and drugs cause the stress?

Response

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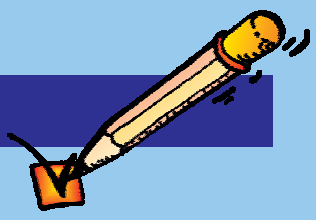
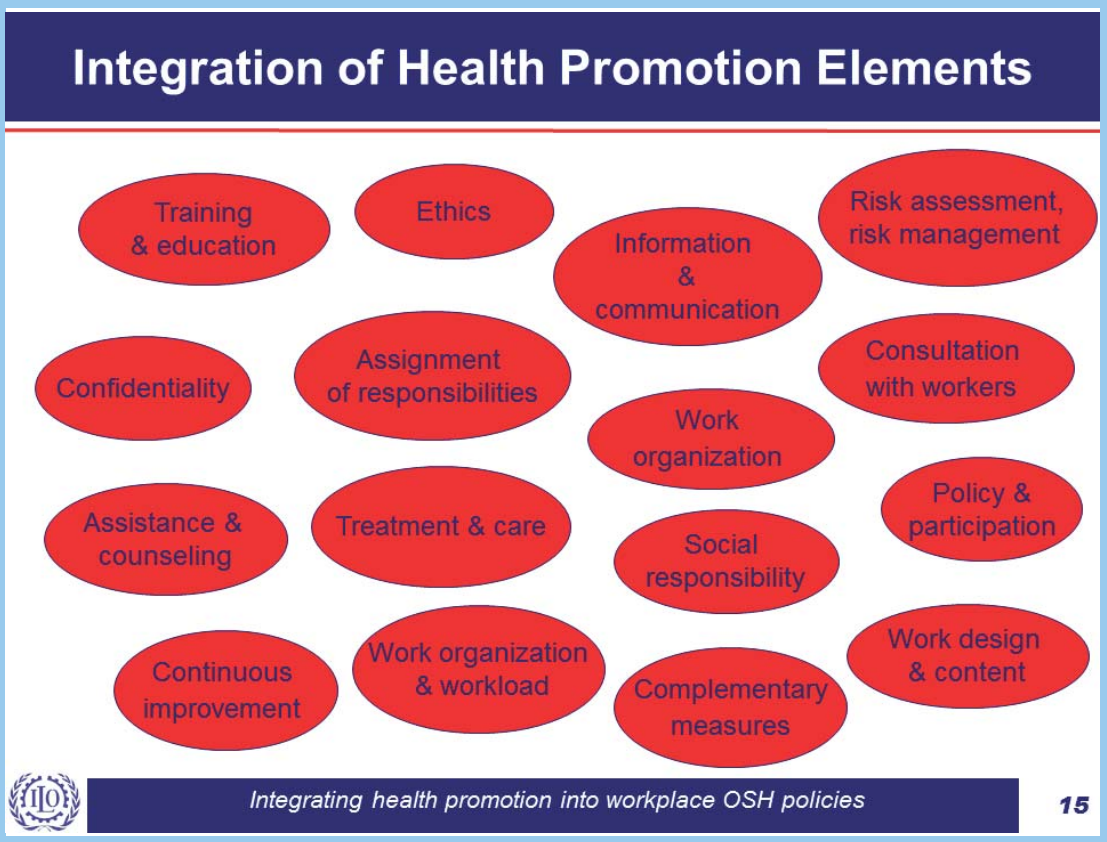
Exercise 4: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Alcohol and drugs at work*.

After that, use the checklist at the end of this module to choose the measures relevant to *Alcohol and drugs at work* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time.

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *Alcohol and drugs at work* from the PowerPoint slide shown to you. Note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Alcohol and drugs at work* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *Alcohol and drugs at work*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Alcohol and drugs at work* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their Occupational Health and Safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Handout 4.2 Frequently asked questions about alcohol and drugs in the workplace

How do alcohol and drugs affect work?

Drug and alcohol problems lead to the deterioration of workers heath, to absenteeism, increased safety risks and lowered productivity.

These problems have important implications for the employer, the family and for society at large in terms of a loss in national productivity and increased social costs.

What should be done to tackle problems of alcohol and drug abuse at work?

Employers, workers and their representatives should identify job situations that contribute to alcohol and drug-related problems and take appropriate action. They should also assess the effects of alcohol and drug use in the workplace and write a comprehensive policy for the organization or enterprise, which should include the prevention and management of alcohol and drugs abuse as other psycho-social risks.

How can we prevent alcohol and drug abuse?

It is important that a comprehensive strategy is jointly developed by all involved parties. The strategy should address all workers and not only those with problems. It should focus on prevention rather than treatment, but providing counselling and assistance in the workplace for referral to treatment and improving working conditions and the working environment. A policy should be designed to reflect the strategy. The policy statement should be clear, consistent, comprehensible and accessible.

What should a policy look like?

The emphasis of the policy should be the prevention of alcohol and drugs abuse as a health promotion element of a comprehensive policy on OSH. The policy should include information and procedures on:

- The assessment and management of psychosocial hazards (these may be contributing to the use and abuse of alcohol and drugs in the workplace);
- the improvement of the working conditions and the working environment;

- the provision of information sharing awareness raising campaigns, and training;
- measures for bringing about changes in attitudes and behaviours;
- the incorporation of specific preventive measures to avoid the abuse of alcohol and drugs in the workplace, such as the prohibition or restriction of availability of alcohol and drugs in the workplace;
- proper personnel management, i.e., good employment practices, proper arrangement of work tasks, consultation between management, workers, and their representatives;
- the identification, counselling and referral of those who have alcohol or drug-related problems, such as self-assessment measures; supervisory training and coaching; identification of treatment available for those in need, and assistance and control measures to avoid relapsing, such as counselling, access to treatment, rehabilitation and follow-up.

How is an alcohol and drugs policy enforced?

Prevention, counselling, treatment and rehabilitation should be used as the main steps to deal with alcohol and drug abuse. An assessment of working conditions is essential to evaluate their negative or contributing impact in the behaviours identified. Relapsing is closely related to workers going back to the same working conditions that caused or contributed to the problem before treatment. However, when measures taken have not succeeded, employers can establish disciplinary procedures for employment-related misconduct associated with alcohol and drugs when workers can put in danger their own or others' safety and health. Such measures should be clearly established in the policy statement to guarantee fairness and transparency.

How can workers with alcohol and drug-related problems be helped?

Co-workers and supervisors are the first to notice changes in behaviour or work performance. They can also play an important role in counselling and referral for treatment. It is important to remember that the stability of having a job can often be important to facilitate recovery from alcohol and drug-related problems, thus emphasizing the importance of the workplace as a setting for prevention and recovery. Workers who keep their jobs are less likely to relapse.

How can we avoid discrimination or stigmatization of workers with alcohol or drug problems?

Alcohol and drug-related addictions are health disorders. They should be dealt with without discrimination, like any other health impairment at work and be covered by the health care systems (public or private), as appropriate. The employer should not discriminate workers because of previous or current use of alcohol or drugs.

As with other health conditions, there should be strict confidentiality of information concerning alcohol and drug-related addictions and such information should only be stored and handled by medical personnel bound by the rules of medical secrecy. Workers should be informed of any exception to confidentiality which could arise and such exceptions should be based on ethical grounds. Therefore, medical data should not be communicated to third parties without the explicit consent of the worker unless:

- necessary to prevent serious and imminent threat to health or life;
- when in-patient or out-patient treatment is to take place;[3]
- required or authorized by law;
- necessary for the conduct of the employment relationship;
- required for the enforcement of criminal law.

Is alcohol and drug testing a good idea?

Testing workers for alcohol and drugs in the context of employment involves important and difficult moral, ethical and legal issues. Careful assessment of these implications should be done before deciding whether it is fair and appropriate to conduct such testing.

Rights of workers to privacy and confidentiality, autonomy, fairness and the integrity of their bodies must be respected, in harmony with national and international laws and jurisprudence, norms and values. Workers who refuse to be tested should not be presumed to be drug or alcohol users.

Adverse consequences of testing (e.g., harassment, unwarranted invasion of privacy) need also to be taken into account; workers should have the right to make informed decisions about whether or not to comply with requests for testing.

The need for testing should be evaluated with regard to the nature of the jobs involved. With some jobs, the privacy issue may be determined to outweigh the need to test.

As a protection to workers, positive test results should be subject to independent medical review.

[3] Only for practical reasons to the direct supervisor, if appropriate, in order to facilitate an understanding of the reasons for the worker's absence, and be taken into account and assist during the reintegration.

For those workers whose positive test results reflect problematic drug or alcohol use, participation in counselling, treatment, or a self-management programme should be encouraged and supported.

When a testing programme is being considered, it should be stated in a formal written policy indicating the purpose for testing, rules, regulations, rights and responsibilities of all the parties concerned.

Available data do not produce enough evidence to show that alcohol and drug testing programmes improve productivity and safety in the workplace.

On its own, testing for substances of abuse do not constitute a workplace substance abuse programme. Testing, when necessary, should be conducted only as part of a comprehensive programme.

What are the basic elements of a comprehensive alcohol and drug preventive programme?

A comprehensive alcohol and drug prevention programme in the workplace should include the following elements.

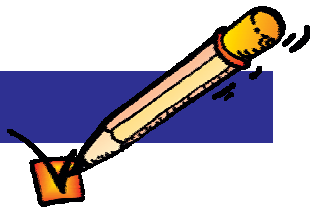
- **Participation:** Should be voluntary without, however, denying management the prerogative of recommending workers for assistance. Participation should not endanger a worker's job security or the chances of promotion. The worker should not be disciplined or discharged, as long as the person participates in a rehabilitation programme and is considered to be progressing towards an acceptable level of job performance.
- **Confidentiality**: Personal information on workers involved in the programme should be treated in a confidential manner.
- **A balanced programme**: Should include prevention, identification, counselling, referral for treatment, rehabilitation, and reinsertion components.
- **Communication strategy**: Information, education, and training are key elements for the success of the preventive programmes in the workplace.

How can we ensure the sustainability of alcohol and drug preventive programmes?

Programmes concerning the prevention of alcohol and drugs abuse should be integrated into the occupational safety and health policy, and in the programme of the enterprise, as part of a health promotion strategy.

Regular monitoring should take place to evaluate if the measures undertaken have succeeded, if new measures need to be incorporated as part of the OSH management system; the evaluation of the programme may lead to modifications of the comprehensive policy if necessary.

Checklist



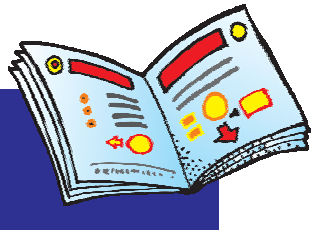
Action–oriented checklist for managing alcohol and drugs at work			
1. Policy and participation			
1.1	Adopt a comprehensive approach to alcohol and drugs at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit. When addressing alcohol and drug issues, include persons with personal experience in such problems, if they agree.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of prevention of alcohol and drugs abuse at work for workers' health, well-being and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and alcohol and drugs prevention in the health promotion programme, with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

1.11	Development or improve recreational and/or sport facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.12	Ensure that the organisation treats all workers, whether with or without alcohol or drug problems, in an equal and non-discriminatory manner.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.	**Training, Education, Information and Communication**		
2.1	Ensure that information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and alcohol and drugs abuse and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and the plan of action through means such as notice boards, mail, payslip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to alcohol and drugs abuse, including information on where support is available outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.5	Inform and guide workers about occupational risks associated with alcohol drugs, the effects of prescribed drugs at work, the legal implications of illicit drug use and the interaction of various substances.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.6	Distribute self-assessment brochures to all workers	Is action needed?	☐ Yes ☐ No ☐ Comment
2.7	Provide counselling services for workers who have drug and alcohol related problems	Is action needed?	☐ Yes ☐ No ☐ Comment
2.8	Inform workers about available services and programmes within and outside the workplace aimed at counselling and treatment concerning the use of drugs and alcohol.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.9	Ensure that treatment and rehabilitation are provided only after proper assessment, consultation and the consent of the affected workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.10	Promote workers' health and offer advice and assistance through occupational health or medical services.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.	Work organization, workload, design and content		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Ensure that tasks are clearly defined.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Ensure career development opportunities for all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Ensure that there are supportive relationships between supervisors and managers and all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	Reduce the availability of alcohol and drugs at work and adjacent to the workplace by limiting the sale of alcohol at work, providing non-alcoholic beverages in the enterprise and ensuring that drug dealers have no access to working premises.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.6	Allow for social contact among workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.7	Provide adequate pay for the work performed.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.8	Reinforce motivation by emphasizing the positive and useful aspects of the work.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.9	Encourage workers to discuss any conflicting demands between work and home and find solutions collectively with management.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.10	Ensure that workers with a previous history of alcohol or drug-related problems are not exposed to a working situation similar to that which, in the past, may have led to such problems.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.11	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment

4.	Complementary measures		
4.1	When a testing programme is being considered, a formal written policy should be developed indicating the purpose of testing, rules, regulations, rights and responsibilities of all the parties concerned.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Provide adequate support, counselling and referral for treatment, as appropriate, for people showing either physical or psychological symptoms of alcohol and drugs abuse.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Provide medical examinations of all workers including recommendations on how to avoid abuse of alcohol and drugs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.4	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs	Is action needed?	☐ Yes ☐ No ☐ Comment

Annex 1
STRAIGHT FACTS[4]



STRAIGHT FACTS... ABOUT ALCOHOL

Alcohol abuse is a pattern of problem drinking that has health consequences, social problems, or both. However, alcohol dependence, or alcoholism, refers to a disease that is characterized by abnormal alcohol-seeking behaviour that leads to impaired control over drinking.

Short-term effects of alcohol use include:

- Distorted vision, hearing, and coordination;
- altered perceptions and emotions;
- impaired judgment;
- bad breath;
- hangovers.

Long-term effects of heavy alcohol use include:

- Loss of appetite;
- vitamin deficiencies;
- stomach ailments;
- skin problems;
- sexual impotence;
- liver damage;
- heart and central nervous system damage;
- memory loss.

Some quick clues that may indicate someone has a drinking problem:

- Inability to control drinking;
- using alcohol to escape problems;
- a change in personality;
- a high tolerance level, drinking just about everybody under the table;
- blackouts, sometimes not remembering what happened while drinking;
- problems at work or in school as a result of drinking;
- concern shown by family and friends about drinking.

[4] Adapted from: *Straight Facts About Drugs and Alcohol*, 1996-2010 At Health, Inc. Available at: http://www.athealth.com/Consumer/disorders/Substanceabuse.html

STRAIGHT FACTS... ABOUT CANNABIS

Cannabis is the most widely used illicit drug in most countries and tends to be the first illegal drug teenagers use. The physical effects of cannabis use, particularly on developing adolescents, can be acute.

Short-term effects of using cannabis:

- Sleepiness;
- difficulty keeping track of time, impaired or reduced short-term memory;
- reduced ability to perform tasks requiring concentration and coordination, such as driving a car;
- increased heart rate;
- potential cardiac dangers for those with a pre-existing heart disease;
- bloodshot eyes;
- dry mouth and throat;
- decreased social inhibitions;
- paranoia;
- hallucinations.

Long-term effects of using cannabis:

- Enhanced cancer risk;
- decrease in testosterone levels for men; also lower sperm counts and difficulty having children;
- increase in testosterone levels for women; also increased risk of infertility;
- diminished or extinguished sexual pleasure;
- psychological dependence requiring more of the drug to get the same effect;
- marijuana affects the messages in your brain and alters your perceptions and emotions, vision, hearing, and coordination.

STRAIGHT FACTS... ABOUT AMPHETAMINE DERIVATIVES (METHAMPHETAMINE)

Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Methamphetamine is used in pill or in powdered form by snorting or injecting. Street names for the drug include "speed", "meth" and "crank". Crystallized methamphetamine, known as "ice", "crystal", or "glass", is a smokable and more powerful form of the drug.

The effects of methamphetamine use include:

- Increased heart rate and blood pressure;
- increased wakefulness, insomnia;
- increased physical activity;
- decreased appetite;
- respiratory problems;
- extreme anorexia;
- hypothermia;
- convulsions;
- cardiovascular problems which can lead to death;
- euphoria;
- irritability;
- confusion;
- tremors;
- anxiety;
- paranoia;
- violent behaviour;
- it can also cause irreversible damage to blood vessels in the brain, producing strokes.

Methamphetamine users who inject the drug and share needles are at risk for acquiring HIV and AIDS, Hepatitis B and other diseases transmitted by the use of dirty needles. Methamphetamine is an increasingly popular drug at raves (all-night dance parties) and as part of a number of drugs used by college-aged students.

Cannabis and alcohol are commonly listed as additional drugs of abuse among methamphetamine treatment admissions. Most of the methamphetamine-related deaths involve methamphetamine in combination with at least one other drug, most often alcohol, heroin, or cocaine. Researchers continue to study the long-term effects of methamphetamine use.

STRAIGHT FACTS... ABOUT ECSTASY[5]

Ecstasy first came into widespread use with the emergence of techno music and parties known as 'raves', where users stayed up all night dancing for hours on end. It is part of a new category of substances that have emerged with advances in chemistry, so-called "designer drugs", and taken in pill form. It is a stimulant derived from amphetamine and has similar properties, causing excitation and physical and mental prowess while suppressing fatigue, hunger and pain.

Physical Risks:

- Dehydration;
- irregular heartbeat, high blood pressure and other cardiovascular problems;
- hepatitis;
- brain damage;
- sudden death.

Psychological Risks:

- Anxiety and panic;
- mood swings and depression;
- aggressive behaviour.

Ecstasy can be especially dangerous for people taking other medications and for people with underlying health problems.

5 Adapted from: Ecstasy, Copyright 2010 CQLD.
Available at: http://www.cqld.ca/livre/en/en/11-ecstasy.htm

STRAIGHT FACTS... ABOUT COCAINE AND CRACK

Cocaine is a white powder that comes from the leaves of the South American coca plant. Crack is a smokable form of cocaine that has been chemically altered. Cocaine and crack are highly addictive. This addiction can erode physical and mental health and can become so strong that these drugs dominate all aspects of an addict's life. Cocaine belongs to a class of drugs known as stimulants which tend to give a temporary illusion of limitless power and energy that leave the user feeling depressed, edgy, and craving more. Cocaine is either "snorted" through the nasal passages or injected intravenously.

Physical risks associated with using any amount of cocaine and crack:

- Increases in blood pressure, heart rate, breathing rate, and body temperature;
- heart attacks;
- strokes;
- respiratory failure;
- Hepatitis B or HIV and AIDS through shared needles;
- brain seizures;
- reduction of the body's ability to resist and combat infection.

Even first-time users may experience seizures or heart attacks which can be fatal.

Psychological risks associated with using any amount of cocaine and crack:

- Violent, erratic, or paranoid behaviour;
- hallucinations and "coke bugs" – a sensation of imaginary insects crawling over the skin;
- confusion, anxiety and depression;
- loss of interest in food or sex;
- "cocaine psychosis" – losing touch with reality, loss of interest in friends, family, sports, hobbies, and other activities.

Cocaine and crack use has been a contributing factor in a number of drownings, car crashes, falls, burns, and suicides.

STRAIGHT FACTS... ABOUT HALLUCINOGENS

Hallucinogenic drugs are substances that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine, otherwise known as PCP; angel dust; loveboat; lysergic acid diethylamide, commonly known as LSD or acid; mescaline and peyote; and psilocybin or "magic" mushrooms.

Under the influence of hallucinogens, the senses of direction, distance, and time become disoriented. Hallucinogens can produce unpredictable, erratic, and violent behaviour in users which can ultimately lead to serious injuries and death. The effect of hallucinogens can last up to 12 hours. LSD produces tolerance: users who take the drug repeatedly must take higher and higher doses in order to achieve the same state of intoxication. This is extremely dangerous, given the unpredictability of the drug, and can result in increased risk of convulsions, coma, heart and lung failure, and even death.

Physical risks associated with using hallucinogens:

- Increased heart rate;
- increased blood pressure;
- sleeplessness;
- tremors;
- lack of muscular coordination;
- sparse, mangled, and incoherent speech;
- decreased awareness of the feeling of touch and pain that can result in self-inflicted injuries;
- convulsions;
- coma;
- heart and lung failure.

Psychological risks associated with using hallucinogens:

- A sense of distance and estrangement;
- depression, anxiety, and paranoia;
- violent behaviour;
- confusion, suspicion, and loss of control;
- flashbacks;
- behaviour similar to schizophrenic psychosis;
- catatonic syndrome whereby the user becomes mute, lethargic, disoriented and makes meaningless repetitive movements.

Everyone reacts differently to hallucinogens – there's no way to predict if you can avoid a "bad trip".

STRAIGHT FACTS... ABOUT INHALANTS

Inhalants refer to substances that are sniffed to give the user an immediate head rush or high. Inhalants include a diverse group of chemicals that are found in consumer products such as aerosols, cleaning solvents and paint. Inhalant use can cause a number of physical and emotional problems and even one-time use can result in death.

Using inhalants even one time can put you at risk for:

- Sudden death;
- suffocation;
- visual hallucinations and severe mood swings;
- numbness and tingling of the hands and feet.

Prolonged use of inhalants can result in:

- Headaches;
- muscle weakness;
- abdominal pain;
- decrease or loss of sense of smell;
- nausea and nosebleeds;
- hepatitis;
- violent behaviour;
- irregular heartbeat;
- liver, lung, and kidney impairment;
- irreversible brain damage;
- nervous system damage;
- dangerous chemical imbalances in the body.

Short-term effects of inhalants include:

- Heart palpitations;
- breathing difficulty;
- dizziness;
- headaches.

Even one single use of inhalants can cause death. According to medical experts, death can occur in at least five ways:

- Asphyxia – solvent gases can significantly limit available oxygen in the air, causing breathing to stop;
- suffocation – typically seen with inhalant users who use bags;
- choking on vomit;
- careless behaviours in potentially dangerous settings;
- sudden sniffing death syndrome, presumably from cardiac arrest.

STRAIGHT FACTS... ABOUT OPIATES

Opiates are narcotic drugs that briefly stimulate certain areas of the brain and then depress the central nervous system; they include opium, codeine, morphine and heroin. Opiates are produced from the seed pod of the Asian poppy, and codeine and morphine are derived from opium. Other drugs, such as heroin, are processed from morphine or codeine. Opiates can be smoked, injected or taken orally or rectally. Withdrawal symptoms from opiate abuse are severe and heroin is the most addictive of all abused substances.

Effects of opiate use include:

- A "rush" followed by a state of gratification;
- suppression of hunger, pain, sexual urges;
- nausea;
- vomiting;
- restlessness;
- drowsiness;
- slow to profound respiratory depression;
- slow reflexes;
- slow speech;
- dry skin;
- itching;
- in pregnant women: anaemia, cardiac disease, diabetes, pneumonia, hepatitis, high rates of spontaneous abortion, breech delivery, premature birth, still-births;
- withdrawal symptoms: uneasiness, yawning, tears, diarrhoea, abdominal cramps, runny nose, craving for the drug.

Long-term use can result in:

- Endocarditis (infection of heart lining and valves);
- HIV and AIDS (from use of dirty needles);
- abscesses;
- cellulitis;
- liver disease;
- brain damage;
- pulmonary complications.

Of special note:

Morphine and codeine can be ingredients in cough syrups, pain relievers and other prescription and non-prescription medication. Caution should be specially exercised in operating vehicles and in working with dangerous machines and materials.

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Violence at work

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for a response to violence at work.

Introduction

Long ignored, denied, or considered to be a harsh reality which just had to be accepted as a part of life, it is only recently that violence at work has started to receive the attention it deserves as a serious safety and health hazard with a high cost for victims and enterprises' performance alike.

For workers, violence can cause pain, distress, and even disability or death. Physical attacks are obviously dangerous but psychological attacks in the form of persistent verbal abuse or threats can also damage workers' health through anxiety or stress, which can in turn lead to an increased use of tobacco, the abuse of alcohol and drugs, other addictions, or unhealthy behaviour.

Workers often turn to one or more of these practices as a means of relief from the burden and stress of violence, in the same way that stress and the abuse of alcohol and drugs and the consequences of, for example, having unprotected sex, can lead to violence. The cumulative effects of such practices have a drastic effect on the physical and mental health of workers.

For employers, violence can lead to low morale and a poor image for the enterprise, making it difficult to recruit and keep staff. It can also mean extra costs with high absenteeism, higher insurance premiums, and compensation payments. It could lead to reduced productivity and competitiveness.

Key concepts of violence at work

1. The workplace can be a generator of violence.
2. Violence generated elsewhere can end up in the workplace.
3. All occupations appear to be affected.
4. The links between violence at work, in the family, and the community are increasingly becoming evident.
5. Workplace violence can have high human and economic costs.

Current Trends Relating to Violence at Work

1. Episodes of extreme violence, such as workplace shootings, attract attention from the public and media.
2. The importance of repeated acts of psychological violence, such as continuous harassment is increasingly being recognized.

3. Public authorities, workers, and employers are increasingly aware of the need to control violence.
4. International attention is progressively extending to this area.
5. There is insufficient reporting on the subject from developing countries.

Violence at work

What increases the risks of violence?

Workplace Status

Precarious employment is an aggravating factor.

Gender

Especially in the case of sexual harassment, women workers are more exposed.

Stress

The pressure within an organization to perform is increasing and can be seen as a factor exacerbating tension in the workplace.

What form does violence at work take?

The range of behaviour which may be included under the general heading of violence at work is very broad. But the borderline of what constitutes acceptable behaviour is often vague, and cultural attitudes to violence are so diverse that it is a very complex matter to define violence at work.

The ILO code of practice on "Workplace violence and measures to combat this phenomenon" defines work-related violence as follows:

"Any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed or injured in the course of, or as a direct result of, their work."

- **Abuse** is used to indicate all behaviour which departs from reasonable conduct and involves the misuse of physical or psychological strength.
- **Assault** generally includes any attempt at physical injury or attack on a person including actual physical harm.
- **Threats** encompass the menace of death, or the announcement of an intention to harm a person, or damage their property.

In real situations these types of behaviour often overlap, making very difficult any attempt to categorize different forms of violence. SOLVE considers both physical and psychological violence when addressing violence in the workplace.

See Handout 5.1 for further details on definitions.

Physical or psychological?

Not all violence is physical. In recent years, new evidence has emerged on the impact of and harm caused by psychological violence. Such psychological violence includes bullying, mobbing and sexual harassment.

Workplace bullying is one of the fastest-growing forms of workplace violence. It frequently comes from a supervisor, but it can also come from a co-worker. It constitutes offensive behaviour through vindictive, cruel, malicious or humiliating attempts to undermine an individual or groups of workers. This is done through activities such as making life difficult for those who have the potential to do the bully's job better; shouting at staff to get things done; insisting that the "bully's way is the right way;" refusing to delegate because the bully feels no one can be trusted; and punishing others by constant criticism or removing their responsibilities for being too competent. Such persistently negative attacks on their personal and professional performance are typically unpredictable, irrational, and unfair.

Violence may also consist of repeated actions which, by themselves may be relatively minor, but that cumulatively can come to constitute serious forms of violence such as sexual harassment, bullying, or mobbing.

Women at special risk

Why are women at a higher risk of violent behaviour in the workplace? Women are concentrated in many of the occupations with a high risk of violence, such as teaching, social work, health care, and the services sector (government public services, banks, shops). The continued segregation of women in low-paid and low-status jobs, while men predominate in better-paid, higher-status jobs, and supervisory positions, also contributes to the problem. Men tend to be at greater risk of physical assault, while women are particularly vulnerable to incidents of a sexual nature.

Many national surveys have found that between 40 and 90 per cent of the women questioned have suffered some form of sexual harassment during the course of their working lives (Hunt et al., 2007).

Many governments, employers and workers realized that sexual harassment was a workplace problem some time before becoming aware of the wider issue of violence at work. Therefore, at the beginning more studies were undertaken on sexual harassment, documenting its incidence and its impact on work performance, career opportunities, and on the mental and physical health of both women and men.

Sexual Harassment

Even if a single incident can be enough, sexual harassment often consists of repeatedly unwelcome, unreciprocated, and imposed actions which may have a very severe effect on the victim. Sexual harassment may include touching, inappropriate remarks, looks, attitudes, jokes, the use of sexually-oriented language, allusions to a person's private life, references to sexual orientation, remarks about dress or figure, or the persistent leering at a person or a part of her/his body. Although more women suffer from sexual harassment, men can be victims too; however, few men report it.

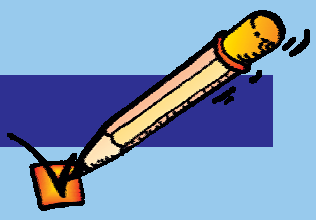
A 2002 survey carried out in Italy by ISTAT showed that more women were sexually harassed at work than on public transport or in the street. As the following table shows, 15.3 per cent of sexual violence (both actual and attempted) was carried out by somebody at work, with 11.8 per cent of violence taking place at work or nearby, and 12.1 per cent of sexual harassment was experienced at work.

Table 1: Sexual violence and harassment in the workplace (percentage values)

	Colleagues, employers, superiors		Workplace and surroundings	
Experienced:	**At least once in their lifetime**	**In the past three years**	**At least once in their lifetime**	**In the past three years**
Violence/attempted violence	15.3	8.8	11.8	9.9
Of which: Violence	4.4	3.9	1.6	3.9
Of which: Attempted violence	17.9	9.6	14.3	10.9
Physical harassment	10.4	11.6	12.1	15.1

Source: Italian Institute of Statistics (ISTAT). 2004. Molestie e violenze sessuali, Italia, see http://www.eurofound.europa.eu/ewco/2005/03/IT0503NU03.htm Accessed 6th May 2011.

Exercise 1: The Mad Dane



Read the case study and answer the questions on the next page.

You have 15 minutes to complete this exercise individually and 15 minutes to discuss it in plenary.

From Norway

Leif worked in a large Norwegian factory. His job, as a repairman, was to keep the machine park running. He was a skilled worker, earning a high salary. He had originally come from Denmark and his workmates often made fun of him as he spoke Norwegian with a Danish accent. This happened so often that his personal relations became seriously strained – he became isolated. On one occasion he became so irritated that he thumped the table with his fist and demanded an end to all further jokes about his accent. From that point, things became worse. His workmates intensified and widened the range of "jokes", one such being to send him to machines which did not need repairing. In time Leif gradually gained the reputation of being "The Mad Dane".

At the beginning, many workers and foremen did not know that his sudden appearances were the results of "jokes". His social contact network broke down, and more and more workmates joined in the hunt. Wherever he appeared, jokes and taunts flew around. His feelings of aggression increased and this drew the attention of the management. It was their impression that Leif was at fault, and that, in general, he was a low-performance worker (which he gradually became). He was admonished. His anxiety increased further and he developed psychosomatic problems and began to be frequently on sick leave. His employers reassigned him to less skilled work without discussing his problems; this Leif felt was unjust. He considered himself blameless. The situation gradually resulted in serious psychosomatic disorders and longer periods of sick leave. Leif lost his job and could not find another. There was nowhere and no one in society he could turn for help. He became totally unemployable – an outcast.

Please answer the following questions:

1. **Have you ever been in a similar situation? If you have, please briefly describe it.**

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2. **Have you ever witnessed or heard of a situation like this? If you have, please briefly describe it.**

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3. Which type of violence did Leif experience?

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4. What did the management do in response to the situation?

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5. Were there any health outcomes for the victim or any social consequences as a result of this violence?

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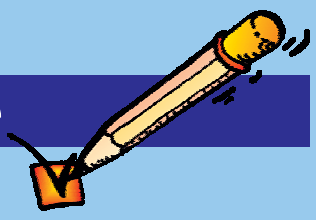
Exercise 2: Definition of violence



1. You have 10 minutes to work in groups and list in the space below the types of violence you have been exposed to or you have witnessed at work.

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2. How would you define violence?

Handout 5.1

GLOSSARY

Violence, both physical and psychological, emerges in different forms, which may often overlap. Terms related to violence are defined in the following way:

PHYSICAL VIOLENCE	
The use of physical force against another person or group that results in physical, sexual or psychological harm. It includes beating, kicking, slapping, stabbing, shooting, pushing, biting, and pinching, among others.	
Assault/Attack	Intentional behaviour that harms another person physically, including sexual assault (i.e., rape).

PSYCHOLOGICAL VIOLENCE (Emotional abuse)	
Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social states or development. Includes verbal abuse, bullying/mobbing, harassment, and threats.	
Abuse	Behaviour that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual.
Bullying / Mobbing	Repeated and, over time, offensive behaviour through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or groups of workers.
Harassment	Any conduct towards somebody that is unreciprocated or unwanted and which affects the dignity of men and women at work, based on their age, disability, HIV status, domestic circumstances, sex, sexual orientation, gender reassignment, ethnic group, language, religion, political, trade union affiliation, or other opinion or belief, national or social origin, association with a minority, property, birth, or other status.
Sexual harassment	Any unwanted, unreciprocated, and unwelcome behaviour of a sexual nature that is offensive to the person involved, and which causes that person to be threatened, humiliated or embarrassed.
Discrimination	Any threatening conduct that that is unreciprocated or unwanted and which affects the dignity of women and men at work, that is based on ethnic group, language, national origin, religion, association with a minority, birth or other status.
Threat	Promise to use physical force or power (i.e., psychological force) resulting in fear of physical, sexual, psychological harm, or other negative consequences in the targeted individual or groups.

Handout 5.2
The impact of violence at work

Violence at work not only has an immediate effect on the victim, but also affects other people (directly or indirectly), as well as the enterprise and eventually the community.

The impact and cost of violence at work need to be considered at different levels:

- At the **individual level**, the suffering and humiliation resulting from violence usually lead to a lack of motivation, loss of confidence, reduced self-esteem, depression and anger, anxiety and irritability. In the same way as with stress, if the causes of violence are not eliminated, or the effects contained by adequate intervention, the symptoms are likely to develop into physical illness, psychological disorders, or the abuse of tobacco, alcohol, or drugs. They may even culminate in occupational accidents, invalidity, and suicide.
- At the **workplace level**, violence causes immediate and often long-term disruption to interpersonal relationships, the organization of work, and the overall working environment. Employers bear the direct cost of lost work and improved security measures. They face difficulties in recruiting and retaining staff. They are also likely to bear the indirect costs of reduced efficiency and productivity, the deterioration of product quality, loss in company image and a reduction in the volume of business.
- At the **community level**, the costs of violence include health care and long-term rehabilitation costs for the reintegration of victims, unemployment benefits and retraining costs for victims who lose their jobs as a result of such violence, and disability and invalidity costs where the working capacities of the victims are impaired by violence at work.

Where does it concentrate?

Workplace violence (physical and psychological) has become a global issue, crossing borders, employment settings and occupational groups. No single occupation is immune to violence at work. However, workplace violence tends to be clustered in certain occupations, such as the public work force, agriculture, services, and health care.

The following table indicates the occupations at major risk in UK, according to British Crime Survey Interviews conducted in 2003-2005.

Risk of violence at work, by occupation, 2003-04 and 2004-05 BCS interviews				
Percentage victims once or more	**Assaults**	**Threats**	**All violence at work**	**Unweighted N**
Protective service occupations	8.8	1.2	9.7	460
Managers and proprietors in agriculture and services	2.6	2.3	4.6	1,351
Transport and mobile machine drivers and operatives	1.3	1.6	2.7	1,606
Leisure and other personal service occupations	1.0	1.7	2.5	835
Health and social welfare associate professionals	1.1	1.4	2.5	1,683
Health professionals	0.4	2.3	2.3	345
Business and public service professionals	0.4	1.3	1.7	1,044
Sales occupations	0.8	0.9	1.6	2,572
Corporate managers	0.8	0.9	1.4	4,730
Elementary administration and service occupations	0.8	0.6	1.4	3,269
Teaching and research professionals	0.8	0.6	1.3	2,045
Customer service occupations	0.3	0.9	1.1	581
Caring personal service occupants	0.5*	0.4	0.8	2,509
Business and public service associate professionals	0.2	0.5	0.7	2,103
Skilled metal and electrical trades	0.2	0.3	0.5	1,846
Textiles, printing and other skilled trades	0.5	0.1	0.5	838
Administrative occupations	0.1	0.4*	0.5*	3,943
Science and technology associate professionals	-	0.5	0.5	699
Elementary trades, plant and storage-related occupations	0.2	0.2	0.4	1,691
Secretarial and related occupations	0.2	0.4	0.4	1,234
Culture, media and sports occupations	0.1	0.3	0.4	798

Risk of violence at work, by occupation, 2003-04 and 2004-05 BCS interviews				
Percentage victims once or more	**Assaults**	**Threats**	**All violence at work**	**Unweighted N**
Science and technology professionals	0.1	0.4	0.4	1,231
Skilled construction and building trades	0.2	0.1	0.3	1,636
Process, plant and machine operatives	.1	0.3	0.3	1,543
Skilled agricultural trades	-	-	-	427
ALL	0.6*	0.7*	1.3*	41,19

* denotes a significant drop from 2001/02 and 2002/03 at p0.05
1. Source 2003/04 and 2004/05 BCS.
2. Based on adults of working age, in employment.
3. Full details of the SOC occupations within each of the groups are given in Appendix B in Online Report 04/04.
4. < 0.1 denotes a value under 0.05. - indicates there were no cases in the sample

Facts and figures[1]

- According to 2005 figures from the European Union, six per cent of all workers were subject to physical violence at work, and four per cent of workers suffered physical violence from people from outside their workplace. Another five per cent of workers in the European Union were subjected to bullying and harassment at work.
- Psychological violence is becoming increasingly recognized as a significant and wide-spread workplace phenomenon with a serious impact on work. In a study carried out by the US National Institute for Occupational Safety and Health (NIOSH) in 2004, there was bullying in 24.5 per cent of the companies surveyed in the previous year.
- An international study carried out by the ILO, WHO, and two international trade unions in 2005, found that the health-care sector is particularly vulnerable to violence. More than half of the health-care workers surveyed in eight different countries from six continents had experienced at least one incident of physical or psychological violence in the twelve months prior to the study. The results for different types of violence in the different countries are summarized in the table on the next page.

1 Chappell D., Di Martino V. (2006), "Violence at Work", International Labour Office, Geneva.

Country	Physical attack	Verbal abuse	Bullying/mobbing
Australia	12.0	67.0	10.5
Brazil	6.4	39.5	15.2
Bulgaria	7.5	32.2	30.9
Lebanon	5.8	40.9	22.1
Portugal	3.0	51.0 [a)] / 16.5 [b)]	23.1 [a)] / 16.5 [b)]
South Africa (private sector)	9.0	52.0	20.6
South Africa	17.0	60.1	-
Thailand	10.5	47.7	10.7

[a)] In health-care complex; [b)] In hospital

Source: Chappell; Di Martino, 2006.

Very little data on workplace violence is available from countries with economies in transition and developing countries, particularly concerning psychological violence. However, the information from the health-care sector above shows that although there is more bullying and mobbing in Brazil than in Australia, but there is more verbal abuse in Australia than in Brazil.

What does it cost?

Violence causes immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment. Cost factors will include direct costs such as those coming from absenteeism, turnover, accidents, illnesses, disabilities and deaths; as well as indirect costs, including diminished performance, quality and timely production, and competitiveness. Increasing attention is also given to the negative impact of violence on "intangible factors" such as company image, motivation and commitment, loyalty to the enterprise, creativity, working climate, openness to innovation, knowledge-building, learning, etc.

2 http://www.who.int/violence_injury_prevention/injury/en/WVsynthesisreport.pdf

Some examples of workplace violence costs are presented in the following box:[3]

Direct costs: such as workplace injuries, illnesses, absenteeism, and turnover

- Victims of bullying had 26 per cent more sick leave than other workers, according to a study in hospitals in Finland.

Indirect costs: such as reduced job satisfaction, morale and productivity

- The more Swedish nurses were exposed to violence at work, the less job satisfaction they experienced.

Overall costs:

- In an Australian study, each case of bullying cost employers at least AUD$ 16,977.
- The costs of bullying have been estimated to be close to GPB £2 billion annually in the United Kingdom.
- The annual total cost of workplace homicides in the USA was calculated to be US$ 970 million.

It has been estimated by a number of reliable studies that stress and violence possibly account for approximately 30 per cent of the overall costs of ill-health and accidents. Based on the above figures, it has been suggested that stress and violence may account for approximately 0.5 – 3.5 per cent of GDP per year (ILO, 2001).

Stress can be both a consequence of violence and the cause of it. Almost 40 per cent of workers reported experiences of bullying in a study of a British National Health Service Community Trust.[4] Other typical stress-related consequences of violence are a lack of self-confidence, difficulties concentrating, and fear. Mental health can also be affected, resulting in illnesses like anxiety and depression. The following four stressors were particularly likely to result in physical assaults on co-workers:

- limited job control;
- high levels of responsibility for people;
- limited alternatives in finding a new job;
- skill under-utilization.

Work-related suicide started to be documented in the 1990s. Recent developments related to restructuring, outsourcing and the loss of employment have shown an increase of cases of suicide in the workplace. The risk factors that can cause a suicide are multiple and inter-related: professional, economic, social, and family factors are likely to increase suicide tendencies. Research has found more negative factors for

3 Finland: Kivimaki, 2000; Sweden: Arnetz, 1996; Australia: Sheehan, 2001; UK: Health and Safety Executive, 2006; USA: Biddle, 2002.

4 Kivimaki; Elovainio, 2000.

workers than executives, and that the suicide rate mirrors inequalities in society. Nevertheless, recent studies examine the increase in the numbers of middle-aged businessmen committing suicide in Japan as a result of the pressure of work, which in some cases were related to attempts by surviving relatives to gain compensation.[5] A study by the OECD on the mental health situation of the working-age population for the years 1995, 2000, and 2005 assessed how it was affected by changes in labour market and working conditions. It highlighted effects on sick leave, morbidity and suicide rates in Australia, Canada, the Republic of Korea, Switzerland, and the UK.[6]

Economic stress, for example fear of losing one's job or actual termination, has been linked to one of the most dramatic forms of work-related violence: mass-shootings at work, often ending with the suicide of the aggressor.

The recognition and quantification of the cost of violence is of the highest importance in the shaping of anti-violence strategies for both the developing and developed countries. The growth of informal, precarious, and marginal work situations and arrangements require an economically self-sustainable response to the problem. The key role of programmes and actions which are cost-effective and fit into the socio-economic development of the enterprise or the sector should be highlighted and used to enhance further initiatives to avoid violence.

The increasing consequences of stress and violence at work call for National Strategies on health promotion and well-being at work.

How can violence be tackled?

There is growing recognition that:

- it is possible to prevent violence at work;
- violence is not just an individual problem;
- it is detrimental to the workplace itself;
- work organization and the working environment can be part of the problem;
- work organization and the working environment can be changed to prevent violence;
- combating violence is an integral part of the management culture of a sound enterprise;
- violence at work is linked to other psychosocial factors through a cycle of negative synergies.

5 *Far Eastern economic review*. Review Publishing Company, Limited. Vol. 163, No. 39, (28 Sept. 2000).

6 Organisation for Economic Co-operation and Development: "Are all jobs good for your health? The impact of work: status and working conditions on mental health". *OECD employment outlook*. Paris, 2008.

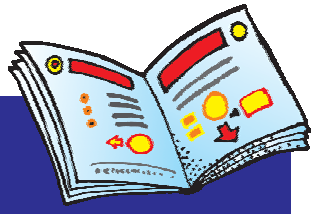
Therefore, to manage violence at work it is necessary to:

- tackle the causes, rather than the effects of violence;
- recognize that there cannot be a single "one size fits all" response, but solutions must be tailored to each workplace;
- preventive action is more effective, before the damage is done, including improving the interpersonal skills of management and workers alike;
- act systematically at all levels of intervention;
- involve all those concerned, particularly workers and their representatives to identify the problem and implement solutions;
- have an integrated OSH policy and good strategies to manage all related psychosocial hazards.

Violence at work can be managed and prevented using a variety of measures:

- administrative measures;
- adaptation of work organization and job design;
- training;
- modification of the physical layout and working environment;
- establishment of special measures to deal with violent incidents, diffusing aggression, and measures after violent incidents;
- monitoring and evaluation.

Handout 5.3
Causes of violence at work



There is a strong and natural desire to seek simple explanations and solutions to the violence which may be gripping our society and threatening the way we live.

The media are often the source of such explanations and convey lasting impressions of the types of people responsible for such violence. These impressions are often dominated by images of disgruntled workers, angry spouses or unhappy, desperate, often psychiatrically impaired people, venting their anger on colleagues in the workplace. These images affect public and official perceptions of violence and the policies which are adopted to address it.

Indeed, much of the current literature on the prevention of workplace violence reflects this approach and consists of the development of pre-employment tests to screen out and exclude potentially violent workers, combined with profiles to identify current workers who might become violent, as well as measures to deal with violence when it occurs.

Measures of this type, as well as broader measures to restrict access to firearms, may indeed assist in reducing the incidence of violence at the workplace and in the wider community and they therefore deserve careful consideration. But it should also be understood that they are measures which address limited symptoms of an extremely complex and diverse problem which defies easy explanations or solutions.

Recognition and understanding of the variety and complexity of the factors that contribute to violence at work are vital precursors to any effective prevention and control programmes.

Violence and aggression are deeply ingrained in the behavioural repertoire of humans. It seems originally to have served as an adaptive mechanism necessary for the survival of the species. However, it does not occur randomly across the human species, nor does it occur evenly throughout any given society.

Bearing in mind that the risk of violence depends on the interaction of a range of factors, the following have been identified as the most significant:

- **Child development and the influence of the family:** it is within the family that aggressive behaviour is first learnt and/or non-violent values instilled in children.
- **Cultural factors:** in general, the orientation of a culture, or the shared beliefs within a subculture, help define the limits of acceptable or tolerable behaviour. However, factors which are liable to lead to higher levels of violence can include widespread poverty and inequality. In societies where marginal members are particularly alienated, where the operational environment is discriminatory, and where gender inequality is deeply embedded, the risk of violence occurring is higher.

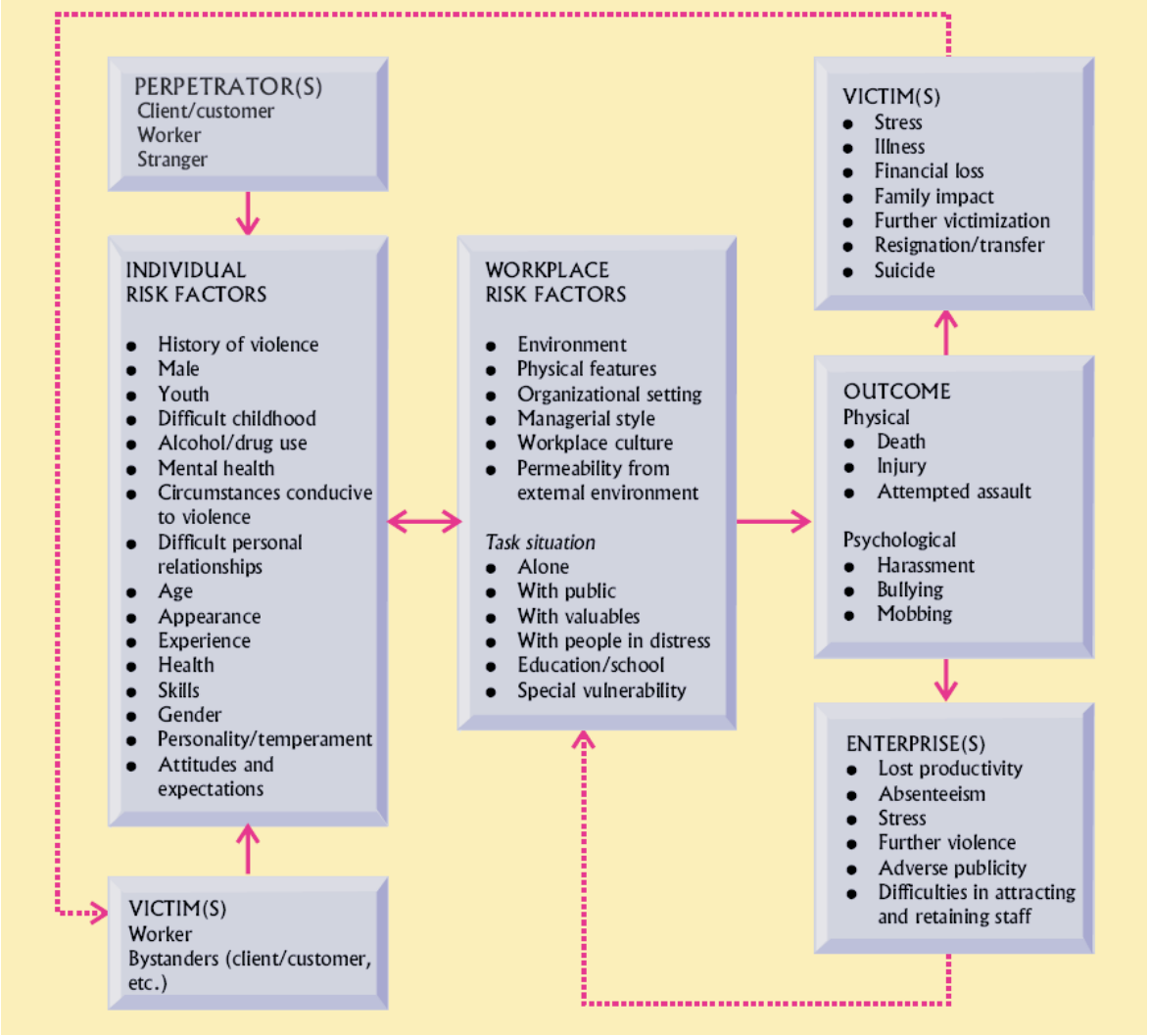
- **Personality factors**: including past aggressive behaviour, lack of empathy for the feelings of others, impulsiveness (or the inability to defer gratification) or, in contrast, unusually strong internal controls (over-controlled personalities).
- **Substance abuse**: while there is a close association between substance abuse and violence, the relationship is complex and probably has more to do with the inability to control one's impulses, coexisting psychological, social and cultural factors. In the case of illicit drugs, the violence associated with their trafficking and distribution, than with the pharmacological effects of the drugs or alcohol consumed.
- **Mental illness**: some forms of mental illness, notably paranoid schizophrenia, may occasionally result in violent acts, although violence perpetrated by the mentally ill is considered extremely difficult to predict.
- **Media influence**: research indicates that the relationship is bi-directional - the viewing of violence on television, video or at the cinema gives rise to aggression, and conversely aggression engenders violence.
- **Peers and schooling**: the company of delinquent or aggressive peers may influence individuals to become aggressive themselves.

As the above list shows, the most significant positive outcomes are likely to be achieved through a concentration on child development programmes linked to the family, as well as measures to deal with the range of cultural factors associated with violence including workplace measures. Communities and workplaces influence each other; making improvements at different levels can contribute to long-term strategies to tackle the general problem of violence in any society.

Nevertheless, current violence at work is closely related to the organizational culture of the world of work.

Each violent situation is unique and requires its own analysis. That is why the prediction of specific acts of violence is extremely difficult. Nonetheless, there are a number of working situations in which violence seems to occur more frequently and where special consideration towards prevention is needed.

The following table shows the most important workplace risk factors and the complex interactions that give rise to violence at work.



Working alone

Working alone means there are no witnesses to any potential violence; this in itself increases the likelihood of violence. More and more people are now working alone in a variety of sectors as a result of the increase in new work arrangements, such as sub-contracting, outsourcing, teleworking, and self-employment.

High-risk solitary work situations include work in small shops or kiosks, cleaners and maintenance staff working after hours, and taxi drivers. According to figures published in 2001, taxi drivers in the United States are 30 times more likely to suffer a fatal assault than the average worker in the United States (Chappell; Di Martino, 2006). A study in South Africa carried out in 2002, showed that around 60 per cent of surveyed petrol retailing sites (gas stations) had experienced violent crime in the previous 36 months (Hadland, 2002).

Working in contact with the public

Most occupations involve contact with the public, and workers can be exposed to violence from individuals intoxicated with a history of violence or mental illness. Such "random" aggression is difficult to predict but can have serious consequences.

Violence by members of the public can be triggered by dismissive and uncaring behaviour by the worker providing the service, or be a more general attack on the organization itself, based on a general non-fulfilment of the wishes and expectations of the customer, which has nothing to do directly with the actual conflict with the individual at a particular moment.

Working with valuables and cash handling

Whenever valuables are, or appear to be, within "easy reach" there is a risk that crime, and violent crime in particular, may be committed. Workers in many sectors are exposed to such a risk. At increased risk are workers in shops, post offices, and those in financial institutions, particularly those who handle cash.

Working with people in distress

Violence is so common among workers in contact with people in distress that it is often considered an inevitable hazard of the job.

Frustration and anger arising out of illness and pain, old-age problems, psychiatric disorders, as well as alcohol and substance abuse, can affect behaviour and make people verbally or physically violent. Furthermore, increasing poverty and marginalization in the community in which the aggressor lives, inadequacies in the environment where care activities are performed, or in the way these are organized, insufficient training and weak interpersonal skills of staff providing services to this population, and a general climate of stress and insecurity at the workplace, can all increase the risk of violence.

Dealing with violent incidents

While prevention is by far the best way of addressing violence at work, it is important for workers to be prepared and to establish procedures in order to defuse difficult situations and avoid violent confrontations.

Defusing aggression

Even in the most difficult situations, there is often some room to manoeuvre before violence is initiated. Many guidelines have been developed which recommend ways of minimizing the risk of a violent incident taking place. In this respect, personal attitudes and behaviour are extremely important.

A person who is on the brink of physical aggression has a number of choices: to attack, to retreat, or compromise. It is necessary to guide them towards the latter two by staying calm, speaking gently, slowly and clearly; trying to talk things through in a reasonable manner, and avoiding an aggressive stance, such as crossed arms, hands on hips, wagging a finger or raising an arm, all of which challenge and confront.

Immediate action after violent incidents

Depending on the nature and gravity of the violence, police intervention may be required, especially in the case of major incidents.

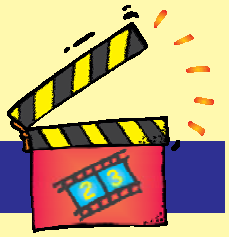
In any case, the importance of immediately recording and reporting workplace violence is emphasized by all experts. The recording and reporting system should cover all incidents, including both minor and potential incidents where no actual harm has resulted. Apparently trivial events should not be neglected, since they may become relevant later, for example to assist in detecting persistent patterns of behaviour or an escalation in aggression. Workers should know how and where to report violent acts or threats of violence, without fear of reprisal or criticism.

The victims of violence can experience a wide range of disturbing reactions and may need psychological help to deal with the distressing and often disabling after-effects of a violent incident. Debriefing is recommended in all but the most trivial cases, usually in the form of meetings, preferably run by staff and involving as many people as possible who were part of the incident. It is also generally recommended that trauma and crisis counselling be incorporated into the post-incident response, either through qualified staff or outside specialists. Especially in the case of major incidents of violence, some victims may need long-term support, which can include extended professional counselling, legal assistance with compensation procedures, rehabilitation and help in redeployment.

Monitoring and evaluation

Finally, it is necessary to periodically review and check the effectiveness of measures which are taken to prevent and deal with violence at work. This should take the form of monitoring the results of the introduced changes, using a system through which workers can provide regular feedback, so that the impact of the changes can be evaluated and, any remaining problems, or any change in the nature of the problems, be detected.

Violence presentation



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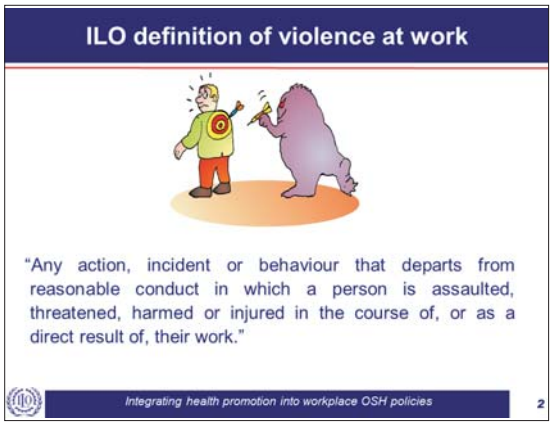

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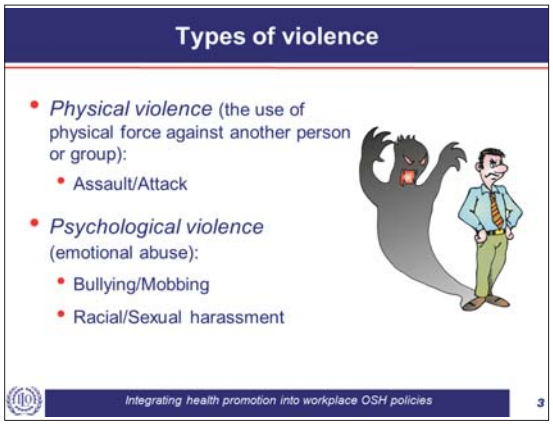

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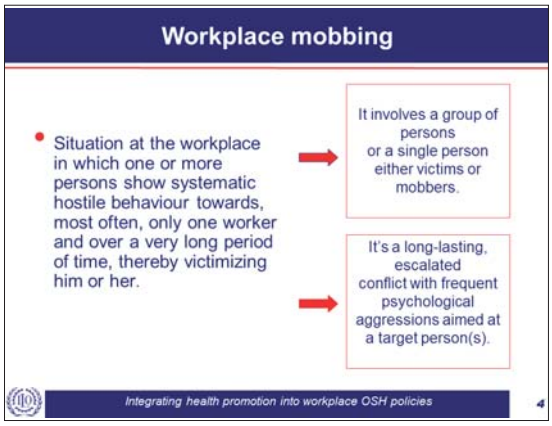

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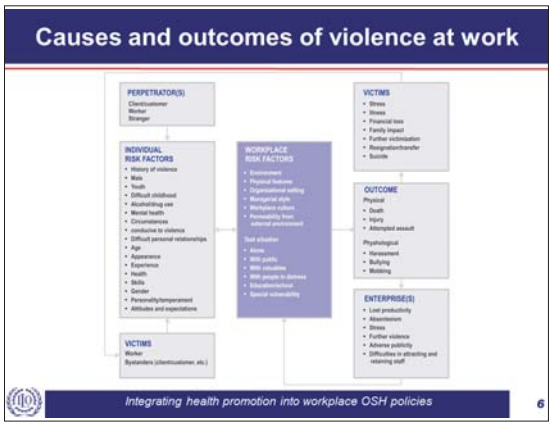

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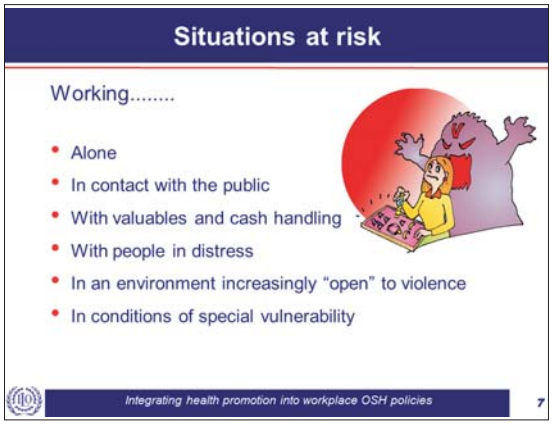

Slide 8

What increases the risks of violence?

- Status: precarious employment is an aggravating factor
- Gender: female workers are more exposed
- Stress: factor exacerbating tension in the workplace

Integrating health promotion into workplace OSH policies 8

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Slide 9

Examples of the impact of violence

Country	Physical attack	Verbal abuse	Bullying/mobbing
Australia	12.0	67.0	10.5
Brazil	6.4	39.5	15.2
Bulgaria	7.5	32.2	30.9
Lebanon	5.8	40.9	22.1
Portugal	3.0	51.0 [a] / 16.5 [b]	23.1 [a] / 16.5 [b]
South Africa (private sector)	9.0	52.0	20.6
South Africa	17.0	60.1	-
Thailand	10.5	47.7	10.7

[a] In health-care complex; [b] In hospital

Source: Chappell; Di Martino, 2006.

Integrating health promotion into workplace OSH policies 9

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Slide 10

Impact and cost of violence

- At the **individual level**: lack of motivation, reduced self-esteem, depression, anger, anxiety and irritability
- At the **workplace level**: increased security measures, absenteeism, turnover, accidents, illness, disability and death
- At the **community level**: health care and long-term rehabilitation costs, unemployment benefits and re-training costs

Integrating health promotion into workplace OSH policies 10

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Slide 11

Interrelationships

Integrating health promotion into workplace OSH policies 11

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Slide 12

– END OF PRESENTATION –

Integrating health promotion into workplace OSH policies 12

Slide 13

Integration of Health Promotion Elements

Integrating health promotion into workplace OSH policies 13

Slide 14

How can violence be tackled?

Governments, employers and workers need to:

- Tackle the causes, rather than the effects
- Recognize that there cannot be a single "one size fits all" response
- Act preventively, before the damage is done
- Act systematically at all levels of intervention
- Have an integrated OSH policy and good strategies to manage all related psychosocial hazards

Integrating health promotion into workplace OSH policies 14

Slide 15

Managing violence at work

Measures to prevent violence at work:

1. Administrative measures
2. Work organization and job design
3. Training
4. Information and communication
5. Physical layout and adequate working environment
6. Immediate action after violent incidents
7. Monitoring and evaluation

Integrating health promotion into workplace OSH policies 15

Slide 16

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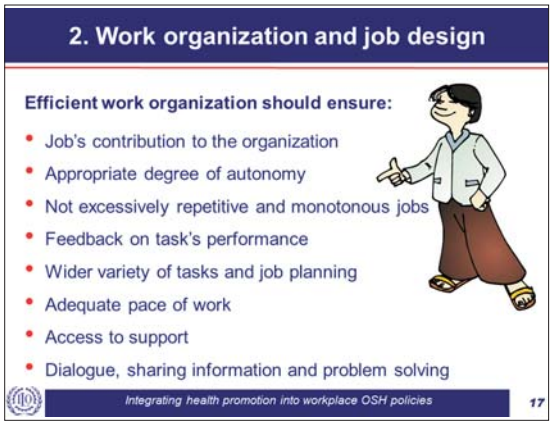
Slide 17



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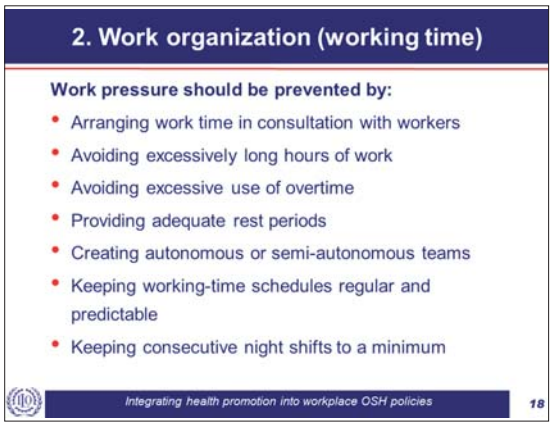

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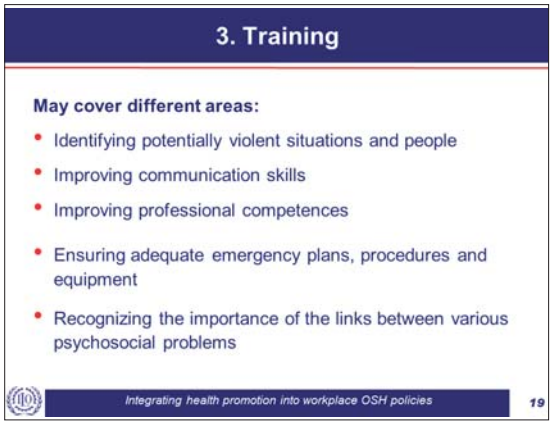

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Slide 20

4. Information and communication

- Information about the policy
- Information to clients
- Information on sexual harassment, bullying and mobbing
- Information about changes in the organization
- Adequate channels of communication between workers and management
- Communication and rotation systems for staff to avoid isolation

Integrating health promotion into workplace OSH policies 20

Slide 21

5. Physical layout and working environment

- Control of entrances
- Protective barriers and security screens
- Adequate waiting areas
- Relaxing colours
- Adequate lighting
- Toilet facilities
- Comfortable temperature
- Low noise levels

Integrating health promotion into workplace OSH policies 21

Slide 22

6. Immediate action after violent incidents

- Policy intervention may be required
- Reporting and recording system covering all incidents (included minor and potential incidents)
- Psychological help and eventually professional counseling

Integrating health promotion into workplace OSH policies 22

Slide 23

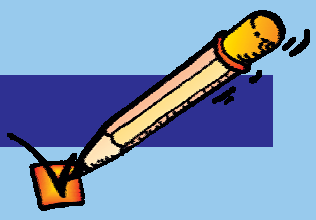
7. Monitoring and evaluation

Monitoring, evaluation and continuous improvement are key components of an OSH management system

- Periodically review and check the effectiveness of measures taken
- Monitor the results of the changes that have been introduced
- Evaluate the impact of the changes
- Incorporate new changes, if necessary

Integrating health promotion into workplace OSH policies 23

Exercise 3: Simulation - Violence



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* module, in this simulation exercise, you and your management team will continue to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 20 April.

The production manager reports that all operations are functioning normally and the orders are on time.

The sales manager reports that last month a new contract was signed that will require a doubled capacity.

The production manager complains that a new contract without consideration of additional production capacity is out of the question.

The workers' representative states that the workers have heard of this new contract and are quite upset about the additional work.

The director of human resources declares that the hiring freeze is lifted; however, there are almost no skilled workers in the area.

The executive director asks if there are any other problems.

The director of human resources states that a senior secretary resigned last week, leaving an important vacancy in the production manager's office. In his exit interview the secretary stated that he was the victim of mobbing, as he was the person who informed the others of decisions about production. He also stated that he had been socially excluded to the point where he could no longer work. Even at the pub after

hours, which he started to frequent more often for companionship, he was left to drink alone.

There were also threats made by several young workers that if there were layoffs, some of the senior management "would be sorry".

Incidents were also reported of workers purposely bumping physically into white collar workers with the intention of provoking a confrontation.

There is also a sexual harassment case currently under investigation.

1. The managing director asks if there is possibility that the victims may become aggressive. If so, what should be done to prevent this from happening?

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2. What action should be taken to resolve the current problems?

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3. Are stress, the use of alcohol and drugs, and violence interrelated? Why?

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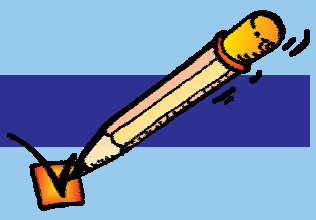
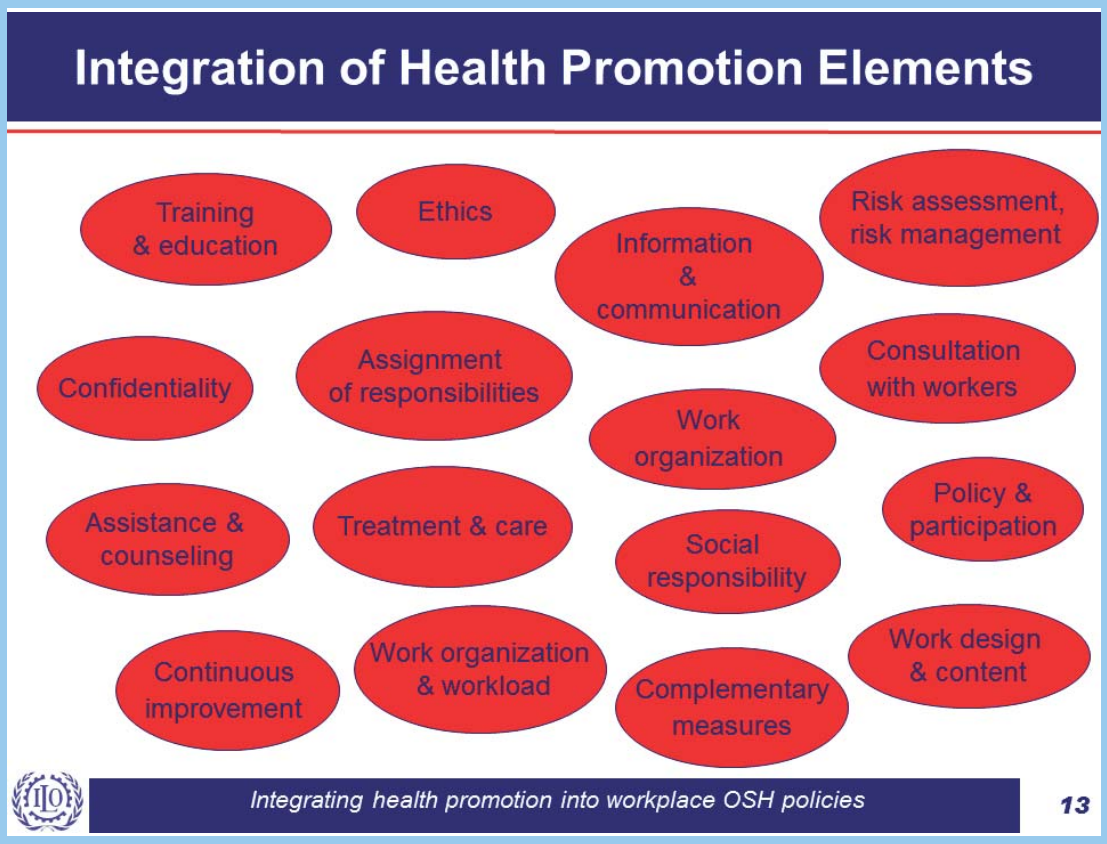
Exercise 4: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Violence at work*.

After that, use the checklist at the end of this module to choose the measures relevant to *Violence at work* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *Violence at work* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Violence at work* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *Violence at work*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Violence at work* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their Occupational Health and Safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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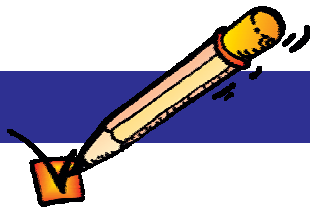
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist



Action–oriented checklist for addressing violence at work			
1.	**Policy and participation**		
1.1	Adopt a comprehensive approach to deal with both physical and psychological violence at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of both physical and psychological violence at work for workers' health, wellbeing and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and the prevention of workplace violence in the health promotion programme, with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

2.	**Training, Education, Information and Communication**		
2.1	Ensure that information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and workplace violence and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and plan of action through all means possible such as notice boards, mail, payslip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to physical and psychological violence, including information on where support is available outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.	**Work organization, Workload, Design and Content**		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Ensure that tasks are clearly defined.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Assign tasks according to experience and competence.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Ensure that there are supportive relationships between supervisors and managers and all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	Allow for social contact among workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.6	Ensure that working hours are predictable and reasonable.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.7	Make sure that designation of shift and night work is fair and reasonable.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.8	Rotate staff on particularly demanding jobs.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.9	Limit client dissatisfaction.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.10	Provide courteous, speedy, and efficient customer service.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.11	Schedule more staff during peak periods keeping waiting times to a minimum.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.12	Screen and select workers for violence-prone jobs using written tests, interviews, performance tests and simulation exercises.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.13	Regularly assess time requirements and assign reasonable deadlines.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.14	Provide a safe and healthy working environment (safety, hygiene, health surveillance, and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Ensure that there is adequate ventilation and thermal control at the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Provide adequate, clean toilet facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.4	Make sure that waiting areas are adequately large and comfortably furnished.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.5	Provide alarm systems, security screens, protective barriers, surveillance systems and security guards.	Is action needed?	☐ Yes ☐ No ☐ Comment

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HIV and AIDS at work

6

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for a response to HIV and AIDS at work.

Introduction

AIDS is not only a health epidemic, but it also has complex social, economic, and political implications. People's perception is deeply rooted in cultural beliefs and attitudes, with concrete and serious implications for the world of work. It has traditionally been seen as a public health concern. Therefore, only in recent years, employers, workers and governments have started to develop the necessary technical and institutional capacities to adequately and effectively respond to this epidemic in the workplace.

Today, denial is still a major problem, both in society at large and in the world of work. Certain cultures encourage fear, shame and guilt; in many countries, silence about HIV and AIDS has deprived people of information and services that could have saved their lives or those of their loved ones.

What is HIV and what is AIDS?

HIV stands for the human immunodeficiency virus. The virus is a micro-organism that infects cells of the human immune system and destroys or impairs their function. The immune system includes white blood cells that help protect the body from infections and diseases. Over time, HIV attacks and destroys these cells leaving the body without the protection of the immune system, and vulnerable to infections and illnesses. HIV can be present for years without the person knowing that is infected. People living with HIV can look and feel perfectly healthy; you cannot tell whether someone has HIV just by looking at them. HIV is a fragile virus, which can only survive in a limited range of conditions. The virus does not survive well outside the body and is killed by bleach, strong detergents and very hot water. HIV is transmitted through unprotected sexual intercourse (anal or vaginal), transfusion of contaminated blood, sharing of contaminated needles, and between a mother and her infant during pregnancy, childbirth and breastfeeding.

AIDS stands for acquired immunodeficiency syndrome. Acquired indicates that is not an inherited condition. Immunodeficiency indicates that the body's immune system has been damaged and that it has become vulnerable to a range of opportunistic infections which the body would normally be able to fight off. Syndrome refers to a group of signs and symptoms that characterize a particular health condition. In the absence of treatment, HIV generally takes 10 to 15 years or longer to progress to AIDS.

Early symptoms of AIDS include: chronic fatigue, diarrhoea, fever, mental changes such as memory loss, weight loss, persistent cough, severe recurrent skin rashes, herpes and mouth infections, and swelling of the lymph nodes. The term AIDS refers to the most advanced stages of HIV related infections and illnesses. These may include more than 20 opportunistic infections (for example tuberculosis and pneumonia) and HIV-related cancers. Appropriate medical treatment and care, in combination with

proper nutrition, slow down the progression of AIDS, reduce symptoms, prevent opportunistic infections and prolong and improve the quality of life of the person living with AIDS. Although periods of illness may be interspersed with periods of remission, AIDS is almost always fatal.

Research into vaccines is currently under way, but none is viable to date. Antiretroviral (ARVs) drugs are available to slow the progression of the disease and prolong life; at present these are very expensive and consequently unavailable to most sick persons, However, the situation is changing rapidly with the intervention of some governments to promote the production of generic drugs for the treatment of people living with AIDS through their national health care systems.

How is HIV transmitted?

HIV can only be transmitted in the following ways:

- unprotected sex (anal, vaginal or oral between partners of either sex) with an infected partner);
- sharing of contaminated needles, syringes and other body-piercing instruments;
- transfusion of contaminated blood and blood products;
- transmission from a pregnant woman living with HIV to her child during pregnancy, delivery, or as a result of breast-feeding;
- occupational exposure to blood or blood products, or to contaminated needles, syringes, body piercing instruments or surgical instruments.

HIV cannot be transmitted by:

- shaking hands, touching, hugging, or sharing toilets;
- eating food prepared by someone who is living with HIV, sharing eating and cooking utensils or crockery; working alongside someone who is living with HIV;
- kissing, including deep kissing; although HIV has been found in saliva in extremely small quantities, no-one has ever become infected by kissing;
- mosquito bites; mosquitoes can carry malaria and other diseases, but cannot transmit HIV.

How is HIV Prevented?

HIV prevention involves:

- the provision of HIV testing and counselling services;
- treatment for sexually transmitted infections (STIs);

- the promotion of safer sex practices;
- delaying sexual debut;
- the provision of male and female condoms and promotion of their correct and consistent use;
- information and education concerning HIV and AIDS prevention and adequate protection from the virus, for example protective equipment such as gloves and masks (where appropriate), sterilized dental and skin-piercing equipment.

There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an effective intervention for HIV prevention in countries and regions with high HIV epidemics and low male circumcision prevalence[1].

However, it is important to note that evidence from UNAIDS and WHO shows that condoms, when used correctly and consistently, are the single, most efficient, available means to reduce the sexual transmission of HIV and other sexually transmitted infections (STIs). A large body of scientific evidence shows that male latex condoms have an 80 per cent or greater protective effect. Condoms are a key component of comprehensive HIV prevention.

HIV and AIDS at Work

HIV and AIDS is a workplace issue because it has a marked impact on workers, their families, enterprises and national economies. It threatens enterprise performance by increasing costs related to health-care, absenteeism, recruitment, training and re-training. For smaller firms in both the formal and informal sectors, the loss of workers has major implications, while in the rural sector loss of lives due to HIV and AIDS reduces food production. Enterprises in sectors such as transport, tourism and mining are the most vulnerable.

Discrimination and stigmatization against both women and men living with HIV threaten fundamental principles and rights at work, and undermine efforts to provide prevention, treatment, care and support. Therefore, prevention and non-discrimination are two vital elements of a workplace strategy concerning HIV and AIDS.

What managers must know: the impact of HIV and AIDS on enterprises

Managers must know that people leaving with HIV are often subject to stigmatization, discrimination, and even open hostility in the community and at work.

[1] WHO, Male Circumcision for HIV Prevention
http://www.who.int/hiv/topics/malecircumcision/en/index.html

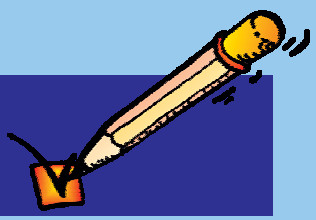
People leaving with HIV have rights, such as the right to non-discrimination, and equality before the law; the right to privacy, liberty of movement, work, access to education, housing, health-care, social security, assistance and welfare. People living with HIV and AIDS are often discriminated on the sole basis of their known or presumed HIV status. A high degree of stigmatization and discrimination are signals of a high degree of ignorance about HIV and AIDS. Workers who suffer discrimination and a lack of human rights protection are more vulnerable and less able to cope with the burdens of HIV and AIDS.

The workplace has a vital role to play in the wider struggle to limit the spread and effects of the pandemic. It can facilitate access for all workers in every country to HIV prevention and referral for treatment, care and support. HIV infection is wholly preventable if timely action is taken. If workers living with HIV have access to effective treatment, they can continue leading a normal productive life for many years.

Effective workplace HIV and AIDS strategies include (a) measures to prevent workers from becoming infected with HIV, and (b) measures to support those who are already living with HIV. Only if both elements are addressed adequately will it be possible to reduce significantly the impact of HIV and AIDS on enterprise performance. An effective workplace HIV and AIDS programme takes into account the legal, ethical, social, and economic dimensions of HIV and AIDS. Programmes vary according to company size, resources, structure, and employee culture, as well as public policy. Typically, an effective workplace strategy on HIV and AIDS includes the following elements:

- A written company policy on Occupational Safety and Health (OSH) that includes HIV and AIDS, should be communicated to all staff members and include non-mandatory (voluntary) HIV testing and confidentiality measures; it should be developed in collaboration with workers and their representatives and staff living with HIV, if any;
- Provision of information and education to workers on the prevention of HIV and AIDS, including making condoms available
- Provision of the means of protection for workers exposed due to their job,
- Referral for early diagnosis and treatment of sexually transmitted diseases;
- Procedures for a supportive environment and assistance to workers living with HIV and AIDS;
- Referral to HIV and AIDS activities in the community.

Exercise 1:
What seems to be the problem?



Read the case study below. Then please answer the questions that follow.

You have 10 minutes to complete this exercise individually and 20 minutes to discuss it in groups.

A case to consider

You are visiting a small town in rural Sub-Saharan Africa. You are introduced to the owner of a small company with 20 workers which manufactures machine parts. Most of the workers are skilled; it takes two to three years for a new worker to acquire the necessary skills to become a fully productive member of the team. The community is isolated. The owner mentioned that most of the enterprises in the community have a number of people who are HIV-positive. Although there is growing concern on the part of the public health officials that the number of HIV and AIDS cases is increasing, HIV/AIDS has not yet hit the enterprise.

Over the past months the owner has observed that one of her key workers, who has been with the enterprise for the past ten years, has fallen sick frequently. He is 40 years old, married with two children. The owner has also noticed that he has lost some weight, and that he avoids her. His behaviour has inexplicably changed over the past few months. When he was asked what was wrong, he replied that he had an infection and that he would be well again soon. He did not give any further explanation. The owner felt something was wrong. At a party the owner learned from a mutual friend that the worker is HIV-positive.

1. Describe the possible impact of this situation on the enterprise regarding:

Productivity.....

Absenteeism .....

Recruitment.....

Training.....

2. Describe what action the owner should take:

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3. Will these actions have a psychosocial impact on other workers?

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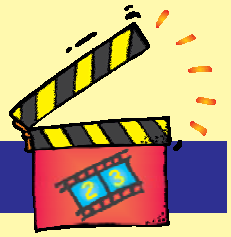
HIV and AIDS presentation



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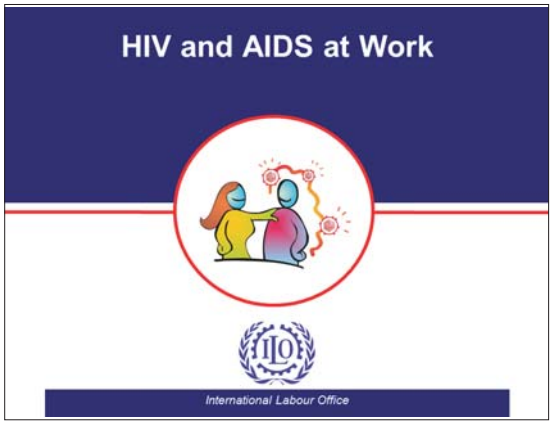

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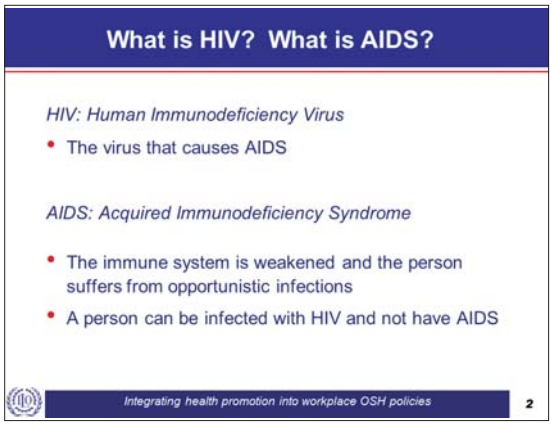

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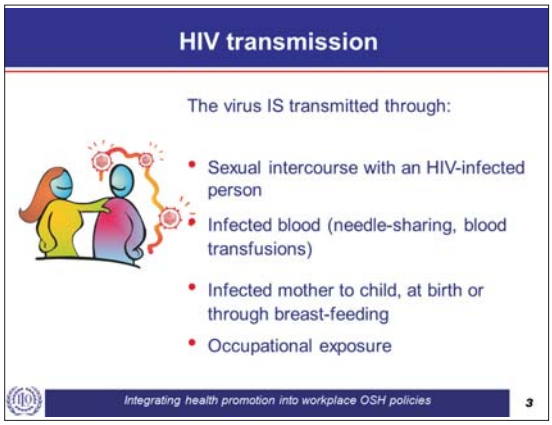

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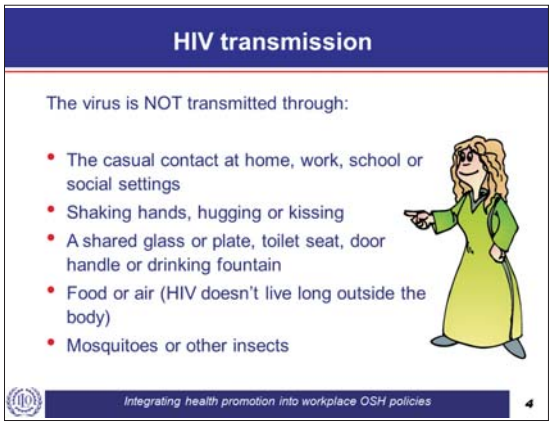

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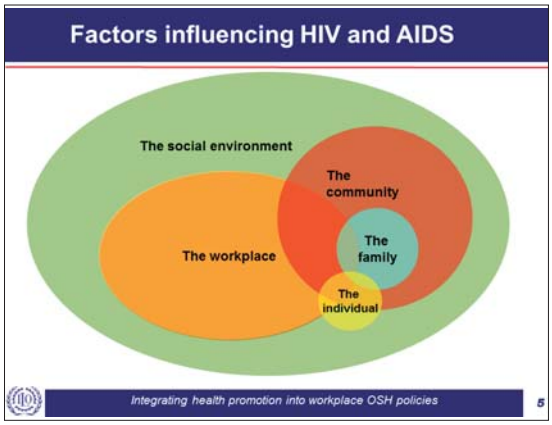

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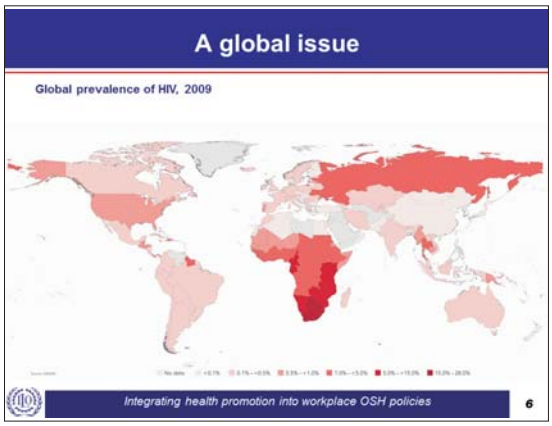

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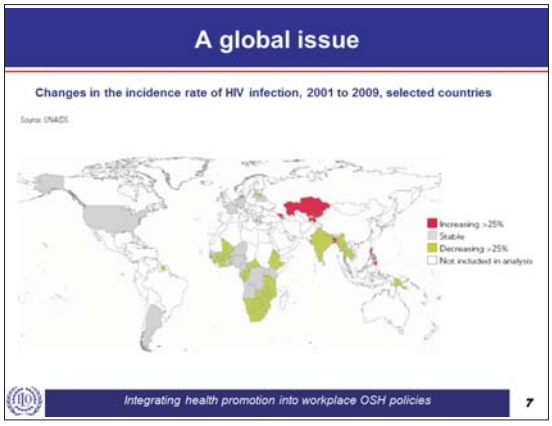

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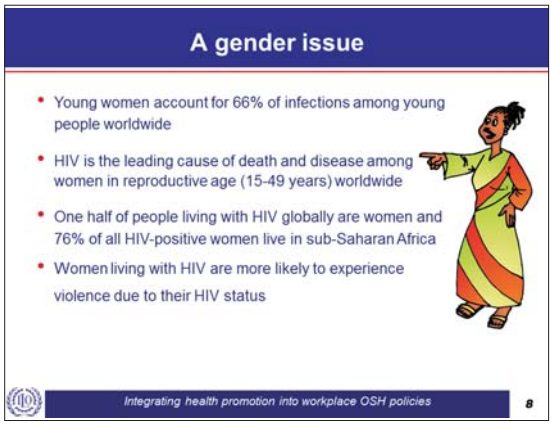

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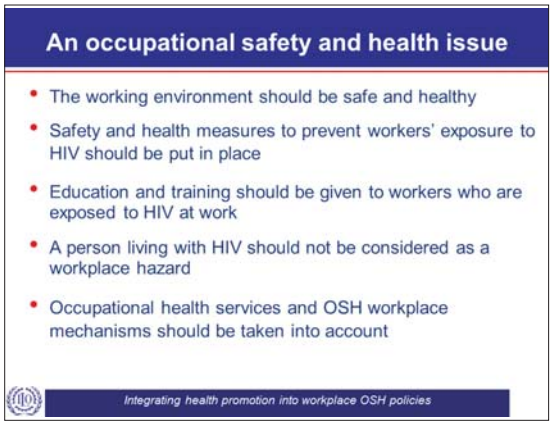

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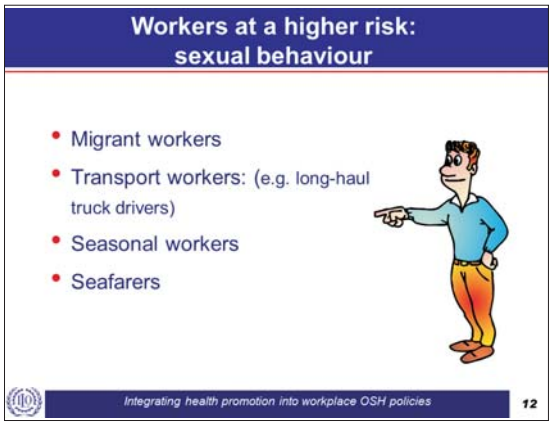

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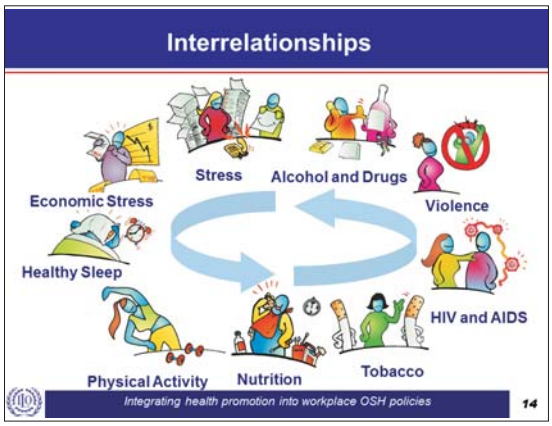

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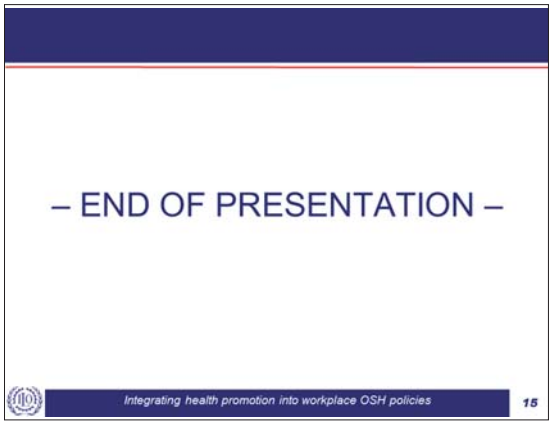

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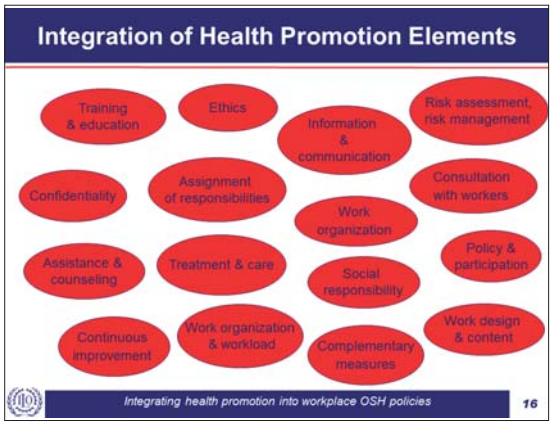

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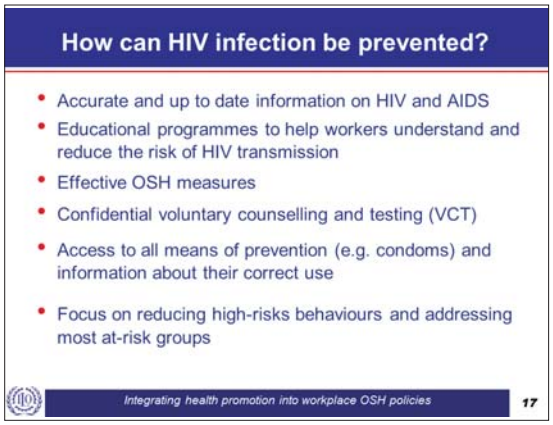

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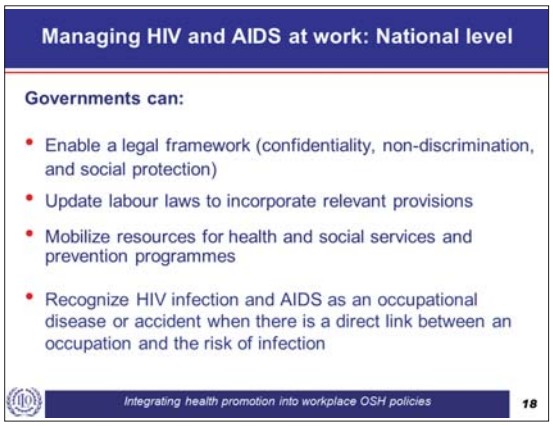

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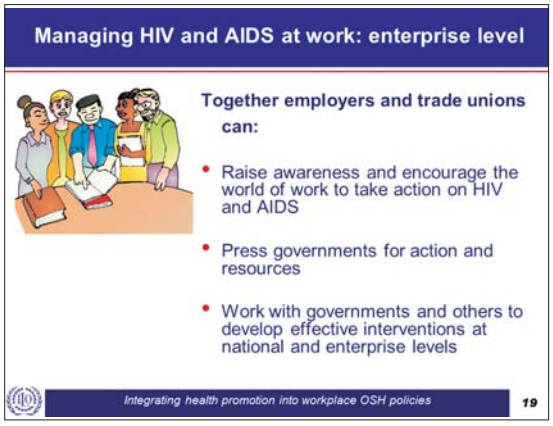

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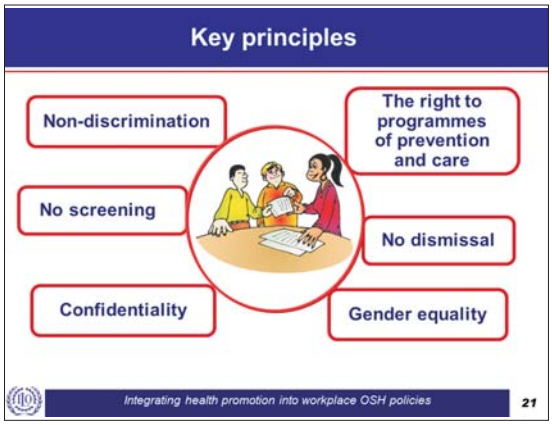

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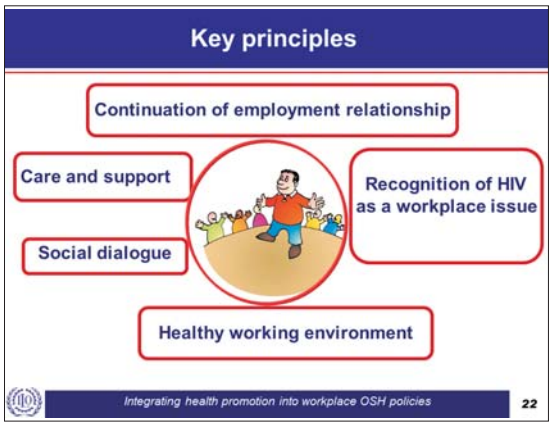
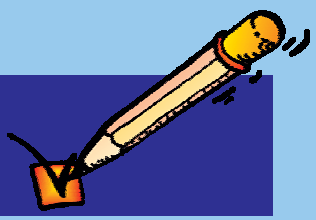


Exercise 2: Rights and fears with HIV in the company



You have 15 minutes to complete this exercise individually and 15 minutes to discuss it in plenary.

A senior sales manager at a medical equipment supplier was admitted to hospital where he was diagnosed as being HIV positive.

The executive director was informed of this.

Two colleagues who had visited sex workers on a night out with the senior sales manager are very distressed after he spoke to them.

The executive director has asked the senior sales manager to consider leaving the company. The executive director feels that the sales manager will now become regularly ill; also, if the clients come to know of the sales manager's medical status, the company will have a poor image.

The executive director does not know about the other two colleagues.

The senior sales manager seeks advice from the union. His colleagues are very stressed and drink heavily after work. Their work is being affected.

1. Differentiate between legal, cultural, and ethical issues for the senior sales manager and the two colleagues:

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2. What rights, if any, of the senior manager have been breached?

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3. What would be your advice to the managing director, as the senior sales manager has threatened legal action on the grounds of unfair dismissal if his services with the company are terminated?

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4. If the two colleagues confide in you about their fears, what would be your advice to them?

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Handout 6.1

Human rights and HIV and AIDS

Fundamental rights of people living with HIV, such as the right to non-discrimination, equal protection and equality before the law, to privacy, to liberty of movement, to work, to equal access to education, housing, health-care, social security, assistance and welfare among others are often violated based on their known or presumed HIV status.

Individuals who suffer discrimination and a lack of human rights protection are both more vulnerable and less able to cope with the burdens of HIV and AIDS. People exposed to HIV will not seek testing, counselling, treatment and support if this means facing discrimination, a lack of confidentiality, loss of employment or other negative consequences. Several years of experience in addressing the HIV and AIDS epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing the transmission of HIV and reducing the impact of HIV and AIDS.

The incidence and spread of HIV and AIDS is significantly higher among groups that already suffer from discrimination and a lack of human rights protection, or that are marginalized because of their social or legal status; groups such as women, children, people living in poverty, minorities, indigenous peoples, migrants, people with disabilities, sex workers, homosexuals, drug users, and prisoners. This often means that they have less access to education, information and health-care because of the discrimination they face with regards to economic opportunities, political and social power, or gender and sexual relations. Such disadvantages render them more vulnerable both to infection with HIV and to the impact of HIV and AIDS. Their lack of human rights protection affects the exercise of their economic, social, cultural, civil and political rights, as well as the success of various HIV and AIDS interventions. Without a rights-based response, the impact of, and vulnerability to HIV and AIDS will increase.

Human rights violations

People's experience of HIV and AIDS-related stigmatization and discrimination is affected by commonly held beliefs, forms of societal stigmatization, and factors such as the extent to which individuals are able to access supportive networks of peers, family and kin. It may also be influenced by the stage of the epidemic and whether individuals feel they can be open about their sero-status (infected or sick).

Attitudes and behaviour should also be recognized as factors that may increase risk. HIV can be transmitted through intravenous injection of drugs with equipment contaminated by needle sharing. There is also evidence that drug and alcohol abuse can

impair an individual's ability to practice safer sexual and injecting behaviour. The stigmatization of people living with HIV (PLHIV) and AIDS fuels a natural desire to keep quiet about ones HIV status, thus abetting transmission. Cultural pressures and denial mask HIV prevalence locally and nationally, making it harder to plan an effective response for communities as well as individuals.

Overall, the negative depiction of PLHIV reinforced by the language and metaphors used to talk and think about the disease, has reconfirmed fear and resulted in the avoidance and isolation of affected individuals, in some cases even with their families and friends. In a highly stigmatizing environment, people may withdraw from society as a means of self-preservation. This isolation can extend to exclusion from social and sexual relationships and - in extreme circumstances - can lead to premature death through suicide. More often stigmatization causes a kind of social death in which individuals no longer feel part of civil society, and are no longer able to access the services and support they need.

Who to tell, how and when, can be a potential source of fear and anxiety among many PLHIV and may prevent individuals from accessing treatment and care. Even where laws have been enacted to protect the rights and confidentiality of PLHIV, few people are prepared to litigate in case their identity will become widely known. Those who are identified as belonging to marginalized or minority groups may also worry about the reactions of others, regardless of their sero-status.

Fear of rejection and stigmatizations within the home and local community may prevent PLHIV from revealing their sero-status to family members. Families may reject HIV-positive members not only because of the stigma associated with HIV and AIDS, but also because of the connotations of homosexuality, drug use, and promiscuity that HIV and AIDS carries.

The family's efforts to "manage" stigmatization within the wider community also have consequences for quality of care. Families may shield affected members from the wider community by keeping them within the house or by protecting them from questioning. The extent to which such strategies are successful may depend upon the wealth of the household concerned and its capacity to provide care without calling on other community members for support.

Therefore, a climate of discrimination and lack of respect for human rights leaves workers exposed to HIV transmission and less able to cope with AIDS, because it makes it difficult for them to seek voluntary testing, counselling, treatment or support; they will also not be in a position to take part in advocacy and prevention campaigns.

Law and practice

A number of countries have enacted legislation with a view to controlling the actions of HIV and AIDS-affected individuals and groups. Such restrictive and coercive measures – frequently enacted to protect society from HIV and AIDS – discriminate against or exclude those who are already infected.

Laws that insist on the compulsory notification of HIV and AIDS cases and the restriction of a person's right to anonymity and confidentiality, as well as the right to movement of those infected, have been justified on the grounds that the disease constitutes a public health emergency. In the case of an already highly stigmatized condition such as HIV and AIDS, these measures result in punitive procedures that further discriminate against people living with HIV and which may drive those infected and the most vulnerable, further underground.

Some laws, rules, policies and procedures, often resulting in, or contributing to the stigmatization of people living with HIV (PLHIV), include:

- the compulsory screening and testing of groups and individuals;
- the prohibition of PLHIV from certain occupations and types of employment;
- the medical examination, isolation, detention and compulsory treatment of infected persons;
- limitations on international travel and migration;
- the restriction of certain types of behaviour such as injecting drugs and prostitution.

Experience shows that such measures increase and reinforce the stigmatization of PLHIV and those with the greatest risk of HIV infection.

Discriminatory practices such as the compulsory screening of certain populations or "risk groups" cause both the further stigmatization of such groups and a misplaced sense of security among those who do not see themselves as belonging to these sections of the population.

Other countries have enacted legislation and designed policies to protect the right of people living with AIDS. Growing number of countries have now adopted legislation which deals specifically with employment aspects of HIV and AIDS. Some have opted to do this in the framework of specific AIDS laws, equality laws, disability laws or employment or labour relations acts, including codes of conduct adopted under such acts. However, in a number of countries, even where supportive legislation exists, its application is often partial, uneven, or ignored.

Employment

While HIV is not readily transmitted in most workplace settings, the supposed risk of transmission or the associated cost of treatment has been used by numerous employers to terminate or refuse employment.

There is also evidence that where PLHIV are open about their sero-status at work, they are likely to experience stigmatization and be ostracized by others.

Pre-employment screening takes place in many industries – particularly in countries where the resources for testing are readily available and affordable. In poorer countries screening has also been reported as taking place, especially in industries where health benefits are available to workers. Employer-sponsored insurance schemes providing medical assistance and pensions for workers have come under increasing pressure in countries seriously affected by HIV and AIDS. Some employers have used this pressure to deny employment to PLHIV.

The health-care system

Many reports reveal the extent to which individuals are stigmatized and discriminated by the health-care system.

There are numerous accounts of treatment being withheld: lack of care on the part of hospital staff; patients left lying in their beds; HIV testing without consent; breaches of confidentiality, and denial of hospital facilities and medications. Contributing to such responses are ignorance and a lack of knowledge about HIV and AIDS transmission, fear, moralistic assumptions of guilt, and the perceived lack of a treatment for AIDS.

All of these conspire to make it appear pointless to offer good-quality care. In addition, many health-care workers treating AIDS patients experience stress because of the extra burden and lack of support.

A lack of confidentiality has been repeatedly cited as a particular problem in health-care settings. Wide variations in practice exist among countries and between health-care facilities within countries. In some settings signs have been placed near people living with HIV (PLHIV) with words such as “HIV-positive” and “AIDS” written on them. In others, registers of HIV-positive people have been compiled and their names released to media and police without permission. Principles of confidentiality also vary between countries and cultures. In some places confidentiality may be less an individual issue than a community and collective concern. The term “shared confidentiality” describes a situation where family and community members feel they have the right to know whether family members, neighbours, or friends are HIV-positive.

Misinformation

Ignoring the existence of HIV and AIDS, neglecting to respond to the needs of those living with HIV, and failing to acknowledge burgeoning epidemics in the belief that HIV and AIDS "can never happen to us" are some of the most widely reported responses to denial.

This denial fuels stigmatization by making those few individuals acknowledged to have HIV lose their sense of self-worth and appear abnormal and exceptional. They do little to enable people to develop a more realistic appreciation of individual vulnerability, and contribute instead to increasing vulnerability to the epidemic.

Attitudes in the community

Stigma and discrimination, both real and perceived, may also arise from a variety of community-level responses to HIV and AIDS. The harassing and scapegoating of individuals suspected of being infected, or of belonging to a particular group, have been widely reported. This is often stimulated by the need to blame and punish and can, in extreme circumstances, result in acts of violence and even murder. Attacks on men who are presumed to be gay have increased in many parts of the world and have been associated with the growing HIV and AIDS epidemic.

Sex workers and street children have likewise been singled out for violence and abuse. HIV and AIDS-related murders have been reported in many countries.

Handout 6.2

HIV and AIDS and vulnerable workers

Which workers can be at risk?

Occupational exposure to HIV

Some workers come into contact with human blood and other body fluids in the workplace. They face a risk of becoming infected with HIV because of their work. In such cases, appropriate safety and health measures should be put in place in order to prevent those workers from being infected.

Other workers can also face risks both inside and outside the workplace if they come into contact with infected blood or other body fluids as the result of an accident or from contaminated equipment or materials. Therefore, training for all workers on first-aid and accident response should include elements on HIV and AIDS prevention.

Examples of workers who may be exposed to human blood and body fluids:

- Health-care and other care staff;
- Emergency workers and first aiders;
- Mortuary workers and funeral staff;
- Nursery workers;
- Cleaners and hotel workers;
- Laundry workers;
- Waste disposal operatives;
- Prison staff;
- Aid workers;
- Tattooists, barbers and others using unguarded needles or blades.

Migrant workers

Many migrant workers are particularly vulnerable to HIV infection, because they often have little control over their lives in their new place of residence. Social, economic and political factors in origin and destination countries influence the risk of HIV infection of international labour migrants. The migrant worker vulnerability increases by the separation from spouses, families and social and cultural norms on ones side, and by language barriers, substandard living conditions, exploitative working conditions and sexual violence on the other (UNAIDS, ILO, IOM, 2008).

Women migrant workers may be at higher risk of HIV as they often have limited or no access to HIV prevention and health-care services (ILO, 2009). In addition, in some places, AIDS is viewed as a disease brought in by outsiders and such misguided and easy associations between migrant workers and AIDS add to the discrimination and stigmatization.

Transport workers

Some groups of workers are at particular risk of HIV infection because of the nature and conditions of their work. Mobility and long absences from home make transport workers and seasonal workers more vulnerable to HIV infection. In a number of African and some Asian countries, HIV prevalence is higher among transport workers than in the general population, especially among long-distance drivers in some of the major transport 'corridors' (ILO,2005b). Many transport and seasonal workers are hard-to-reach populations because of the highly mobile nature of their jobs. Hard-to-reach populations are at a dramatically increased risk of HIV infection because of the itinerant nature of their work or physical isolation.

Without strong ties to mainstream society, they are excluded from national public health outreach and have limited access to HIV prevention, AIDS treatment and care and support services. Furthermore, because of little knowledge on how to protect themselves from HIV, many engage in high-risk behaviour such as having unprotected sex with numerous partners.

Long-haul truck drivers constitute another hard-to-reach population, whose lifestyle puts them at high risk of contracting HIV. Along major trucking routes are truck stops where commercial sex is freely available 24 hours a day. Many truckers who frequent these establishments have unprotected sex with multiple partners. Truck drivers, just as any other highly mobile population, are hard to target in regard to HIV and AIDS information and education.

Seasonal workers

Many people is forced to accept temporary jobs away from home in order to survive. During harvesting seasons in plantations, at large construction sites and in the mining sectors, men and women are found living in often overcrowded camps with minimal sanitary facilities and health services.

The use of alcohol and drugs is usually rampant. Commercial sex is readily available. Recreation facilities are not always available. The contractual status and often the legal status of the workers are unclear, making them powerless and vulnerable to abuse of all kinds, including sexual abuse.

The socio-economic situation of seasonal workers makes them highly vulnerable to HIV infection. The often illegal nature of their work makes them avoid government officials. They are therefore out of reach of governmental prevention campaigns.

Seafarers

In many countries seafarers, and particularly fishermen, are highly vulnerable to HIV transmission. Their occupation calls for continuous travel to numerous destinations in different countries. After being at sea for months, boats dock for fuel, supplies, rest, repairs, or to sell fish. During these visits in ports seafarers may engage in high-risk behaviours, such as unprotected sex. Wives of fishermen are at a high risk of sexually transmitted infections. They have little means to protect themselves from any disease

their husbands might bring home. As a result, many women will continue to contract sexually transmitted diseases and HIV infection from their husbands.

The gender dimension

On the social and cultural side, much of the problem lies in the fact that in many societies, women have an inferior status both in law and in practice. Inequality in personal and working relations leads to unwanted sex in conditions of risk because women have weak negotiating power. This often means that women have less control over their own sexuality, and less access to wider options including information and treatment, than do men. The greater the discrimination against women in society generally, the more negatively they are affected by HIV, and that more equal gender relations and the empowerment of women are vital to prevent the transmission of HIV infection and enable women to cope with HIV and AIDS.

This discrimination also operates in the workplace. The world of work is unequal in many ways. Women still face unequal hiring standards, unequal opportunities for training and retraining, unequal pay for equal work or work of equal value, segregation and concentration in a relatively small number of "women's jobs", unequal access to productive resources including credit, unequal participation in economic decision-making, unequal promotion prospects, and greater likelihood of being unemployed. They are also subject to workplace violence and sexual harassment, including rape, as a form of sexual blackmail, in the workplace or on their way to or from work. This is sometimes even considered as being justified in the case of women who work outside the home, when this violates some traditional notions about the role of women. Efforts to allow women to achieve greater economic, social and political equality generally must continue if the HIV epidemic is to be halted and reversed.

In addition, concern with gender is not simply about the situation of women. The pressures on men and boys, the norms that influence them, and their attitudes and behaviour are of critical importance. For this reason gender-aware responses do not only focus on the personal, social, economic and political empowerment of women, but also on working with men and boys to take responsibility in their sexual lives. They also need to address the implications of sexual practices linked to work (sexual favours provided as entertainment to clients, sexual harassment, and sex as a trade-off for services). The combat of HIV and AIDS from a gender perspective concerns working men and women.

Handout 6.3

International labour standards on HIV and AIDS and the world of work

Recommendation concerning HIV and AIDS and the World of Work, 2010 (No.200)

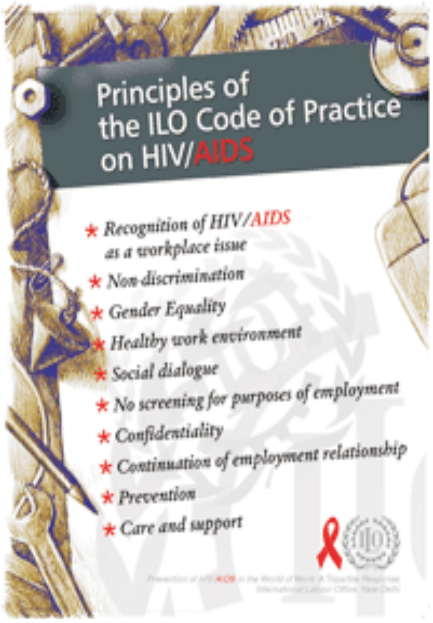
A new international labour standard on HIV and AIDS and the world of work was adopted by the International Labour Conference in June 2010: the Recommendation concerning HIV and AIDS and the World of Work (No. 200). It establishes key principles for the development of national tripartite policies and programmes on HIV and AIDS building on the ten key principles of the ILO code of practice on HIV/AIDS and the world of work (2001). While the Recommendation, as an international labour standard, is the main reference, the code of practice remains a valid instrument which provides useful guidance and complements it.

The Recommendation calls for those policies and programmes to be integrated into national strategies and development plans to ensure inclusion of the workplace and world of work actors in the response. The Recommendation provides for the policies and programmes to be developed, adopted, implemented and monitored through an inclusive participatory process engaging representatives of government, employers and workers' organizations, associations of persons living with HIV and other relevant stakeholders, including the health sector. The Recommendation also calls for workplace measures to promote the active participation of both women and men in the HIV response, as well as the involvement and empowerment of all workers, regardless of their sexual orientation or whether or not they belong to a vulnerable group.

The ILO Code of Practice on HIV/AIDS

The ILO Code of Practice on HIV/AIDS and the world of work, developed in 2001 through tripartite consultations, establishes the fundamental principles for policy development and provides practical guidance for strategy implementation at national, sectoral and workplace levels. It covers the following key areas of action:

- prevention of HIV/AIDS;



- management and mitigation of the impact of HIV/AIDS on the world of work;
- care and support of workers infected and affected by HIV/AIDS;
- elimination of stigma and discrimination on the basis of real or perceived HIV status.

Key principles of the HIV and AIDS: Recommendation No. 200 and Code of Practice:

Recognition of HIV and AIDS as workplace issues:

HIV and AIDS are workplace issues, and should be treated like any other serious illness/health condition in the workplace. The workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.

Non-discrimination:

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV and AIDS, there should be no discrimination or stigmatization against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV inhibits efforts to promote HIV and AIDS prevention.

Gender equality:

The gender dimensions of HIV and AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by HIV and AIDS than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV and AIDS.

All measures taken in and through the workplace should ensure gender equality. The protection of sexual and reproductive health and sexual and reproductive rights of women and men should be promoted.

Healthy working environment:

All workers should receive education and training on modes of HIV transmission and measures to prevent exposure. All infection and awareness-raising measures should emphasize that HIV is not transmitted by casual physical contact and that the presence of a person living with HIV should not be considered a workplace hazard.

Social dialogue:

The successful implementation of an HIV and AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government officials, where appropriate, with the active involvement of workers infected and affected by HIV and AIDS.

NO mandatory HIV testing or screening for purposes of exclusion from employment:

HIV and AIDS testing or screening should not be required of job applicants or persons in employment. Prohibition of testing for employment and provision of confidential Voluntary Counselling and Testing (VCT) should be applied to avoid discrimination.

Confidentiality:

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO code of practice on the protection of workers' personal data, 1997.

The results of HIV testing should be confidential and not endanger access to jobs, tenure, job security or opportunities for advancement.

HIV testing: key principles

HIV testing should **only** be carried out in accordance with the HIV and AIDS Recommendation No.200 and the ILO code of practice on HIV/AIDS:

- On the basis of voluntary, informed consent;
- under conditions of strict confidentiality; and
- with pre- and post-test counselling by a trained HIV counsellor.

HIV testing should **not** be required:

- at the time of recruitment;
- as a condition of continued employment, or
- if it affects terms and conditions of employment

Disclosure of status

- No employee, or job applicant, should be required to disclose their HIV status at work;
- confidentiality must be strictly observed when handling sensitive personal information and health records;
- managers should seek to support workers who freely choose to disclose their HIV status.

Reasonable accommodation

- Measures should be taken to reasonably accommodate the workers with AIDS-related illnesses;
- reasonable accommodation refers to any modifications or adjustment to a job or to the workplace that are reasonably practicable and will enable a person living with HIV/AIDS to have access to or participate or advance in employment:
- it could include rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return-to-work arrangements.

Source: ILOAIDS, 2011.

Continuation of employment relationship:

HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

Prevention:

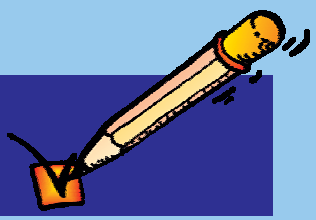
HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions, culturally sensitive measures and socio-economic factors. Prevention can be achieved through changes in behaviour and knowledge through the provision of information and education; or through treatment and the creation of a non-discriminatory environment. The social partners (employers, workers and governments) are in a unique position to promote prevention efforts in the workplace.

Prevention strategies should be adapted to the type of workplace and to national conditions, and should take into account gender, cultural, social and economic concerns.

Treatment, care and support:

Solidarity, care and support should guide the response to HIV and AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services, personal and family counselling and assistance. There should be no discrimination against them and their dependants in access to treatment and benefits from statutory social security schemes.

Exercise 3:
Simulation – HIV and AIDS



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* **module, in this simulation exercise you and your management team will continue to make operational decisions on solving problems related to health promotion in your "virtual" enterprise.**

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 5 December.

The executive director has asked to meet with the team behind closed doors. Here is a summary of her briefing:

One year ago, during the production crisis, management had to work long hours under considerable stress.

After a particularly busy and stressful day, one of the junior managers invited her secretary for drinks in her office. One thing led to another and after several drinks, they had unprotected sex. The junior manager has a husband and children. Her secretary is also married with a wife and three children. The affair lasted several months but is now over. Before coming to work for the enterprise, the secretary had used intravenous drugs but did not know he was HIV-positive. During a medical examination outside of the office the junior manager and her husband have been tested to be HIV-positive. She informed her secretary. He is also HIV positive.

HIV and AIDS is a problem in the community.

What should have been done?

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Now, the director of human resources has heard rumours that five of the production line workers have AIDS.

It is suspected that these five workers are drug users and that some of their workmates are also using drugs.

A large number of the other workers are socially isolating these five workers. There have been threats that if these five workers do not leave they will be hurt.

The director of human resources reports that he met with the workers' representative.

She has explained that:

- The five workers did not have AIDS but were HIV positive.
- She is concerned about discrimination against these five workers.
- However, she is troubled as most of the workforce was ready to take action, such as walking out unless something was done about the five workers in question.
- Although her advice was sought, she could offer no solution to the problem.

Several workers have come to the medical doctor stating that:

- Their spouses and families are afraid that AIDS would be brought home from work,
- The problem with AIDS is causing tension and fear amongst the workers, and
- As a result, some of the workers are drinking during and after working hours.

What should be done?

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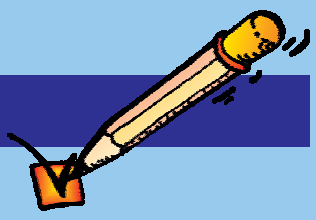
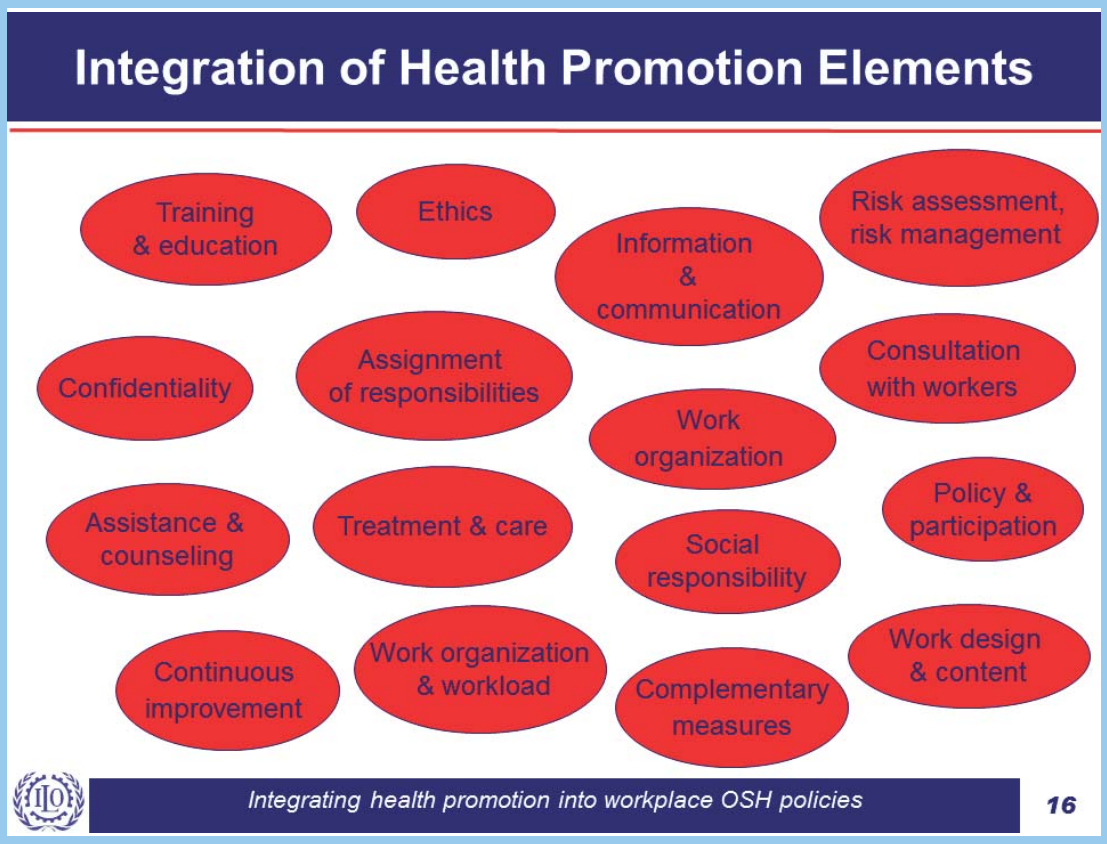
Exercise 4: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *HIV and AIDS at work*.

After that, use the checklist at the end of this module to choose the measures relevant to *HIV and AIDS at work* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *HIV and AIDS at work* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *HIV and AIDS at work* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *HIV and AIDS at work*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *HIV and AIDS at work* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their occupational health and safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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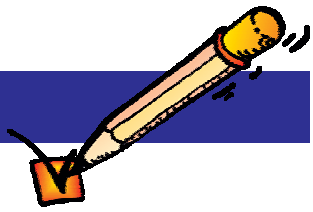
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist



Action–oriented checklist for managing HIV and AIDS at work			
1.	**Policy and participation**		
1.1	Adopt a comprehensive approach including information and preventive measures on HIV and AIDS at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit. When addressing HIV and AIDS issues, include persons living with HIV, if they agree.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of prevention of HIV and AIDS and non-discrimination of people living with AIDS at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive and non-discrimination strategies.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and the prevention of HIV and AIDS in the health promotion programme, with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

1.11	Ensure that the organisation treats all workers, whether HIV-positive or not in a non-discriminatory manner, including job application, hiring, training advancement, discharge, as well as or other conditions and privileges of employment.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.12	There should be no obligation on the worker to inform the employer regarding his or her HIV and AIDS status or that of a co-worker.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.	**Training, Education, Information and Communication**		
2.1	Ensure that information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and HIV and AIDS and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and plan through means such as notice boards, mail, pay slip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to HIV and AIDS, including information on where care and support are available outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.	**Work organization, Workload, Design and Content**		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Ensure that tasks are clearly defined.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Ensure that there are supportive relationships between supervisors and managers and all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Take measures so that the organisation or enterprise does not conduct HIV testing at the time of recruitment or as a condition of employment; but only refer workers seeking assistance to relevant services to ensure the availability of pre and post counselling on a voluntary and confidential basis including after perceived occupational exposure.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	If fitness to work is impaired by HIV related illness, take measures to ensure that reasonable alternative arrangements are made.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.6	Ensure that HIV infection is not a cause for termination of employment.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.7	Develop procedures so that in any situation requiring first aid in the workplace, precautions are taken to reduce the risk of blood borne infections and HIV transmission.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.8	Ensure that where a worker with an AIDS related condition is too ill to continue to work and where alternative working arrangements and extended sick leave have been exhausted and employment relationship has to cease, this should be done in accordance with anti-discrimination and labour laws and with respect for general procedures and full benefits.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.9	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Ensure that there is adequate ventilation and thermal control at the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Provide adequate, clean toilet facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.4	Make sure that resting areas are adequately large and comfortably furnished.	Is action needed?	☐ Yes ☐ No ☐ Comment

International
Labour
Office
Geneva

Tobacco and workplace second-hand smoke

7

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for a response to tobacco use and smoke exposure at work.

Introduction

The impact of tobacco use on health

The increasing evidence of the impact on people's health from exposure to tobacco smoke requires stronger protection of non-smokers, as well as smokers, from the dangers of tobacco smoke. There is no safe level of exposure to environmental tobacco smoke. The only option is to promote appropriate legislation on smoke-free public places and workplaces.

- Tobacco use is a contributing risk factor for six of the eight leading causes of death in the world: cardiovascular diseases, chronic obstructive pulmonary disease (COPD), lower respiratory infections, tuberculosis and cancer (WHO, 2008).
- Tobacco is a growing epidemic. In the 20th century, the tobacco epidemic killed 100 million people worldwide; today 5.4 million people a year die from lung cancer, heart disease, and other illnesses associated with tobacco consumption. That number will increase to over 8 million a year in a few decades (WHO, 2008).
- Unless urgent action is taken, tobacco could kill one billion people during the 21st century. By 2030, more than 80 per cent of tobacco related deaths will occur in developing countries (WHO, 2008).
- Exposure to second-hand tobacco smoke is also a significant health risk around the world. At least 200,000 workers die every year from second-hand smoke (SHS) exposure, and numerous studies have documented the devastating health impact of exposure in individual countries (WHO, 2008).

TOBACCO AND PRODUCTIVITY

A survey of 156 workplaces in Scotland in 1996 revealed that the estimated cost of smoking-related absences in Scotland was GBP 7 million per year. Total productivity losses were estimated to £827 million per year.

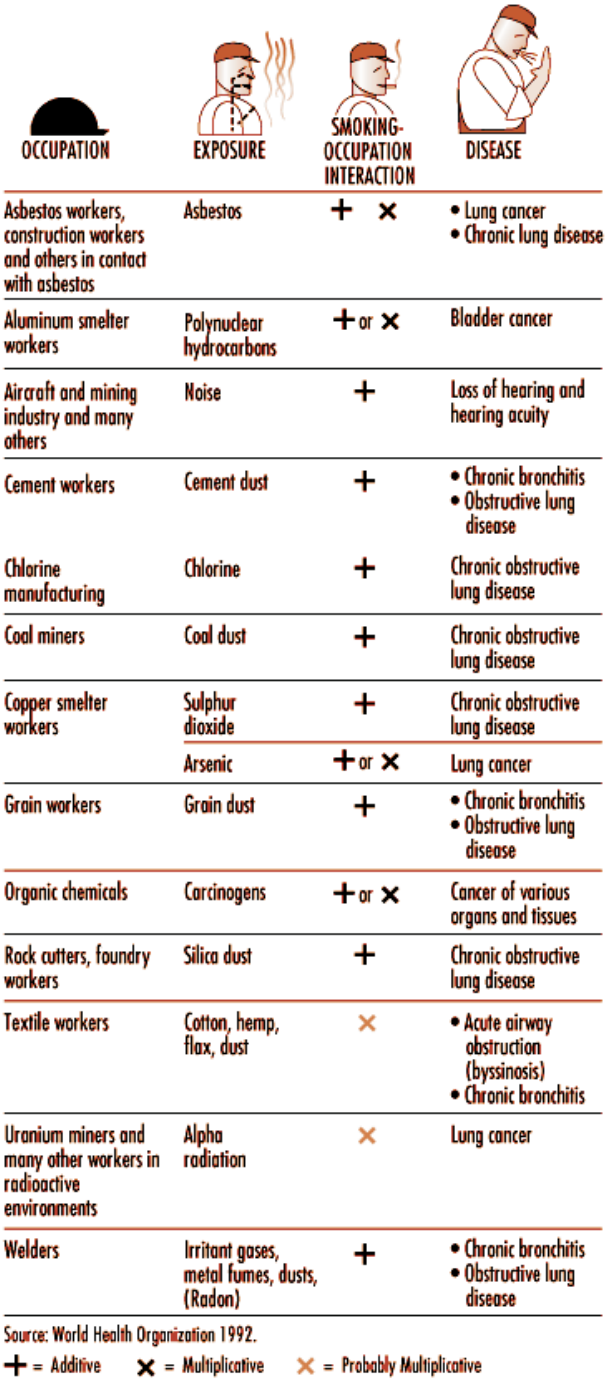
In addition, there were costs caused by smoking-related fires at approximately £74 million per year, as well as costs related to smoking-related deaths and smoking-related damage to premises.

Source: Parrott et al, 2000.

Special occupational considerations

There is an increased health risk from exposure to tobacco in certain occupations and industries:

- Coal mining;
- pesticide handling;
- rubber and petroleum;
- exposure to cotton and wood dusts;
- indoor areas with heavy concentrations of smoke.



OCCUPATION	EXPOSURE	SMOKING-OCCUPATION INTERACTION	DISEASE
Asbestos workers, construction workers and others in contact with asbestos	Asbestos	+ ×	• Lung cancer • Chronic lung disease
Aluminum smelter workers	Polynuclear hydrocarbons	+ or ×	Bladder cancer
Aircraft and mining industry and many others	Noise	+	Loss of hearing and hearing acuity
Cement workers	Cement dust	+	• Chronic bronchitis • Obstructive lung disease
Chlorine manufacturing	Chlorine	+	Chronic obstructive lung disease
Coal miners	Coal dust	+	Chronic obstructive lung disease
Copper smelter workers	Sulphur dioxide	+	Chronic obstructive lung disease
	Arsenic	+ or ×	Lung cancer
Grain workers	Grain dust	+	• Chronic bronchitis • Obstructive lung disease
Organic chemicals	Carcinogens	+ or ×	Cancer of various organs and tissues
Rock cutters, foundry workers	Silica dust	+	Chronic obstructive lung disease
Textile workers	Cotton, hemp, flax, dust	×	• Acute airway obstruction (byssinosis) • Chronic bronchitis
Uranium miners and many other workers in radioactive environments	Alpha radiation	×	Lung cancer
Welders	Irritant gases, metal fumes, dusts, (Radon)	+	• Chronic bronchitis • Obstructive lung disease

Source: World Health Organization 1992.

+ = Additive × = Multiplicative × = Probably Multiplicative

Fig. 7.1 Examples of interactions between occupation and cigarette smoking causing disease.

Source: Encyclopaedia of Occupational Health and Safety. 4th edition. Geneva : International Labour Office, 1998, page, 15.37.

In some occupations, smoking can interact with other dangerous substances with negative synergistic effects. Examples of such substances are: coal, grain, welding materials, asbestos, petrochemicals, aromatic amines, ethanol, pesticides, cotton dust, silica dust, and ionising radiation.

Research showed that an asbestos-worker who smokes runs a 50 times larger risk of lung cancer than a non-smoking worker not working with asbestos (Wallace, 2008).

Uranium miners that are smokers, and workers in radioactive environments exposed to radon, also run a higher risk of lung cancer than non-smokers.

Smoking is also a leading cause of fires and explosions at work, especially where flammable and explosive chemicals are used.

Tobacco products can also cause burns and reduce visibility. Because of its distracting effects when lighting a cigarette, smoking can also be a factor in motor vehicle accidents.

Handout 7.1

What are the risks associated with smoking cigarettes?[1]

- diminished or extinguished sense of smell and taste;
- frequent colds;
- smoker's cough;
- gastric ulcers;
- chronic bronchitis;
- increase in heart rate and blood pressure;
- premature and more abundant face wrinkles;
- emphysema;
- heart disease;
- stroke;
- cancer of the mouth, larynx, pharynx, oesophagus, lungs, pancreas, cervix, uterus, and bladder.

Although many people smoke because they believe cigarettes calm their nerves, smoking releases epinephrine, a hormone which creates physiological stress to the smoker, rather than relaxation. The addictive quality of the drug makes the user feel he must smoke more to calm down, when in effect the smoking itself is causing the agitation.

The use of tobacco is addictive. Most users develop tolerance for nicotine and need greater amounts to produce the desired effect. Smokers become physically and psychologically dependent and will suffer withdrawal symptoms when smoking is stopped.

Physical withdrawal symptoms include:

- changes in body temperature and heart rate;
- problems with digestion;
- increased appetite.

[1] Adapted from: *HERE ARE THE STRAIGHT FACTS... About Cigarette Smoking*, Copyright © 1996-2010 At Health, Inc. Available at: http://www.athealth.com/Consumer/disorders/Substanceabuse.html

Psychological symptoms include:

- irritability;
- anxiety;
- sleep disturbances;
- nervousness;
- headaches;
- fatigue;
- nausea;
- cravings for tobacco that can last days, weeks, months, years, or even an entire lifetime.

Women and Tobacco: Health Effects and Mortality

- Cigarette smoking kills an estimated 178,000 women in the United States annually. The three leading smoking-related causes of death in women are lung cancer (45,000), heart disease (40,000), and chronic lung disease (42,000).
- Ninety per cent of all lung cancer deaths in women smokers are attributable to smoking. Since 1950, lung cancer deaths among women have increased by more than 600 per cent. By 1987, lung cancer had surpassed breast cancer as the leading cause of cancer-related deaths in women.
- Women who smoke have an increased risk for other cancers, including cancers of the oral cavity, pharynx, larynx (voice box), oesophagus, pancreas, kidney, bladder, and uterine cervix. Women who smoke double their risk of developing coronary heart disease and increase tenfold their likelihood of dying from chronic obstructive pulmonary disease.
- Cigarette smoking increases the risk of infertility, preterm delivery, stillbirth, low birth weight, and sudden infant death syndrome (SIDS).
- Postmenopausal women who smoke have lower bone density than women who never smoked. Women who smoke have an increased risk of hip fractures than women who have never smoked.

Source: Center for Disease Control and Prevention (CDC). Available at: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/populations/women/

Handout 7.2

Frequently asked questions about second-hand smoke[2]

Second-hand smoke (SHS) results from the "side-stream" smoke that comes from the burning tip of a cigarette and the "mainstream" smoke that is exhaled by the smoker. Second-hand smoke, passive smoking, involuntary smoking, or exposure to environmental tobacco smoke (ETS) all refer to the phenomena of breathing other people's smoke.

Second-hand smoke is the smoke that individuals breathe when they are located in the same air space as smokers. Second-hand smoke is a mixture of exhaled mainstream smoke from the tobacco user, side-stream smoke emitted from the smouldering tobacco between puffs, contaminants emitted into the air during the puff, and contaminants that diffuse through the cigarette paper and mouth between puffs. It is a complex combination of thousands of chemicals in the form of particles and gases. According to the US Surgeon General Report (2006), at least 250 of the chemicals in SHS are known to be toxic or carcinogenic.[3]

Second-hand smoke includes irritants and systemic poisons, such as hydrogen cyanide, sulphur dioxide, carbon monoxide, ammonia, and formaldehyde. It also contains carcinogens and mutagens such as arsenic, chromium, nitrosamines, and benzo(a)pyrene. Many of the chemicals, such as nicotine, cadmium and carbon monoxide, damage reproductive processes. Second-hand smoke is a major indoor air pollutant. It has been classified by the United States Environmental Protection Agency as a "class A" human carcinogen for which there is no safe level of exposure.

How does second-hand smoke affect health?

Non-smokers who breathe second-hand smoke suffer many of the same diseases as regular smokers. Deaths from heart disease, as well as lung and nasal sinus cancers, have been causally associated with second-hand smoke exposure. Second-hand smoke also causes a wide variety of adverse health effects in children including bronchitis and pneumonia, development and exacerbation of asthma, middle ear infections, and "glue ear", which is the most common cause of deafness in children.

2 This whole section is adapted from: Second-hand smoke kills. Let's clear the air. World No Tobacco Day, 31 May 2001, Pan American Health Organization/ World Health Organization. Available at: http://www.paho.org/english/ad/sde/ra/wntd-factsheet1.doc. When a different source is also used, it is specified.

3 US Surgeon General (2006). *The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General.* Atlanta GA, US Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Exposure of non-smoking women to second-hand smoke during pregnancy reduces foetal growth, and post-natal exposure of infants to second-hand smoke greatly increases the risk of sudden infant death syndrome (SIDS). Tobacco smoke also causes immediate effects such as eye and nasal irritation, headaches, sore throats, dizziness, nausea, cough, and respiratory problems.

What is the extent of the problem of second-hand smoke?

Exposure to second-hand smoke is a widespread problem that affects people from all cultures and countries. This exposure occurs throughout ordinary situations in daily life: in homes, at work and school, on playgrounds and public transport, in restaurants and bars, literally everywhere people go. Surveys conducted around the world confirm widespread exposure.

One survey estimated that 79 per cent of Europeans over the age of 15 were exposed to second-hand smoke. Another estimated that 88 per cent of all non-smokers in the United States were exposed to second-hand smoke. Recent data from South Africa shows that 64 per cent of children below age five in Soweto live with at least one smoker in the house. The Cancer Society of New Zealand reports that second-hand smoke is the third largest killer in the country, after active smoking and alcohol use.

Are well-ventilated non-smoking sections the answer?

No. Although good ventilation can help reduce the irritability of smoke, it does not eliminate its poisonous components.

When smoking sections share ventilation with non-smoking areas, the smoke is dispersed throughout. Smoking sections only help protect non-smokers when they are completely enclosed, have a separate ventilation system that goes directly outdoors without re-circulating air in the building, and when employees are not required to pass through them. Nevertheless, smokers are overexposed.

So how can we protect people from second-hand smoke?

Governments can legislate and regulate smoking by banning it in public places, educating people about the dangers of second-hand smoke, and providing support to those who wish to quit smoking. Employers can initiate and enforce smoking bans in workplaces. Parents can stop smoking in the house and car, particularly around children, and ask others to do the same.

They can also ensure that their children's day-care, school, and after-school facilities are smoke-free. Individuals can let their family, friends, and co-workers know that they do mind if they smoke near them. You can work with your local organizations to initiate actions on second-hand smoke.

Are smoking restrictions hard to enforce?

Most of the public (even smokers) support smoke-free spaces. Smoking bans in workplaces and public places are successful when people are aware of them. The public should know in advance that smoking bans are being implemented, and they should be informed about the health reasons for smoking bans. Good education and advance planning lead to self-enforcement and to the success of smoking restrictions.

Do smoking restrictions hurt business?

No. Most employers who go smoke-free save money by increasing productivity, lowering maintenance and cleaning costs, and lowering insurance coverage. A recent study in the US shows that smoke-free policies had no negative impact on the revenues of restaurants and bars in 80 localities; indeed, in some cases, business increased!

Then why there are no smoke-free places everywhere?

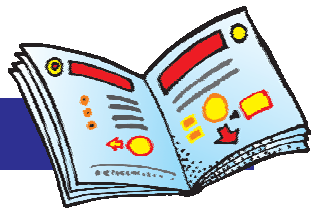
The tobacco industry spends millions to fund misinformation campaigns on second-hand smoke. Scientists and consultants have been hired to not only confuse the public about the validity of scientific data, but also to create doubt about the researchers who produce the data, and the scientific evidence itself. In addition to attacking legitimate studies, bogus research projects that downplay the seriousness of second-hand smoke are funded and promoted.

Tobacco lobbyists and lawyers deflect government regulation of second-hand smoke, and this has been aided by huge tobacco contributions to political campaigns. When money and misinformation do not work, the industry promotes false solutions to control second-hand smoke.

Although evidence shows that ventilation is not an effective solution to the problem of second-hand smoke, the industry continues to push for this option, even forming indoor air consulting "front groups" who downplay the risks of second-hand smoke.

A campaign to promote "courtesy of choice" as an alternative to banning smoking in public places has been launched worldwide. This implies that the serious problem of second-hand smoke can be solved merely by smokers asking for permission before they light up, or by having separate smoking and non-smoking sections. Second-hand smoke is thus portrayed as a mere annoyance for non-smokers, rather than a very real health hazard. The industry also funds smokers' rights movements to create so-called independent opposition to smoking bans.

Handout 7.3



How does second-hand smoke harm and kill non-smokers?[4]

Second-hand smoke is a complex mix of thousands of chemicals. At least 40 substances in second-hand smoke have been shown to cause cancer. Tobacco smoke also contains large quantities of carbon monoxide, a gas that inhibits the blood's ability to carry oxygen to body tissues including vital organs such as the heart and brain, as well as other substances that contribute to heart disease and stroke.

Exposure to second-hand smoke can cause both immediate and long-term effects on human health. Immediate effects include irritation of the eyes, nose, throat, and lungs. Non-smokers, who are generally more sensitive to the toxic effects of tobacco smoke than smokers, may experience headaches, nausea, and dizziness. Second-hand smoke places extra stress on the heart and affects the body's ability to take in and utilize oxygen. The long-term health impact of second-hand smoke is an increased risk of cancer and heart disease after years of exposure. In asthma sufferers, however, tobacco smoke can immediately trigger attacks. The majority of asthma sufferers report symptoms from exposure to second-hand smoke ranging from discomfort, to acute distress.

Second-hand smoke and children

Children's vulnerability to second-hand smoke is a particular concern, both for medical and ethical reasons. Children's lungs are smaller, and their immune systems are less developed, which make them more likely to develop respiratory and ear infections triggered by second-hand smoke. Because they are smaller and breathe faster than adults, they breathe in more harmful chemicals per pound of their weight than an adult would in the same amount of time. Finally, children simply have less choice than adults: they are less likely to be able to leave a smoke-filled room if they want to; infants cannot ask; some children may not feel comfortable asking; and others may not be allowed to leave if they do ask.

Extensive studies of the health effects of second-hand smoke on children found the following:

- Exposure to tobacco smoke causes an increase in bronchitis, pneumonia, and other respiratory illnesses;
- it causes both acute and chronic middle ear infections and deafness in adult life;

[4] Adapted from: *Second-hand smoke kills. Let's clear the air.* World No Tobacco Day, 31 May 2001, Pan American Health Organization/ World Health Organization. Available at: http://www.paho.org/english/ad/sde/ra/wntd-factsheet2.doc

- it triggers asthma attacks in children who already have asthma, and some authorities have concluded that it actually induces asthma in healthy children;
- exposure to second-hand smoke substantially increases the risk of Sudden Infant Death Syndrome (SIDS), also known as crib or cot death; this may be due to in utero exposure to tobacco smoke or exposure to second-hand smoke as infants;
- smoking by pregnant women and exposure of non-smoking pregnant women to tobacco smoke reduces the average birth weight of their babies. Babies with low birth weight may face an increased risk of developing medical problems and learning disabilities.

Second-hand smoke in the workplace

Second-hand smoke also poses a threat in the workplace. Toxins and carcinogens spread quickly throughout offices, hotels, restaurants, and other indoor places of work. Most workers are not in a position to change their work environment or leave their jobs to protect their health. In many cases, where smoke-free workplaces are not guaranteed, employees find themselves obliged to spend the majority of their working lives in a health-threatening situation.

What can be done about second-hand smoke?

Smoke-free homes

The best place to begin is right at home: make your home smoke-free. Let your loved ones and visitors know that you care about their health and about your own. Affix posters and cards reminding your guests that they are in a smoke-free area.

Smoke-free workplaces

Advocate for smoke-free workplaces. If your own workplace is not yet smoke-free, contact employee groups, management, building owners and others to let them know how smoking restrictions in the workplace can benefit everyone. There are many sound reasons for protecting employees' health and creating workplaces free from second-hand smoke:

- Employee health, productivity and morale are higher in smoke-free workplaces;
- smoking restrictions encourage some employees to smoke less or even quit smoking altogether, leading to lower absenteeism, lower health-care costs, and increased productivity;
- smoke-free workplaces mean lower insurance and cleaning costs, less damage to furniture and equipment, and a lower risk of fire;

- smoke-free workplaces often reduce the risk from other industrial hazards, particularly from chemical products. In many workplaces, smoking is a serious fire and safety hazard.

Smoke-free workplaces can help employers avoid smoking-related workers' compensation claims. In several countries, employees have applied to the courts to obtain smoke-free workplaces.

Smoke-free enterprises

In countries around the world, smoke-free policies are being developed and implemented. There are many studies and success stories that can help dispel the fears of declined revenues due to smoking restrictions.

A non-smoking workforce has lower absenteeism, lower maintenance and cleaning costs, lower fire risks, lower health-care costs, lower property insurance costs, lower fire and life insurance costs, as well as health insurance costs. A smoke-free workplace is also at a lower risk of having to pay workers' compensation payments in cases of disability stemming from exposure to second-hand tobacco smoke.

Smoke-free policies are not only for manufacturing enterprises or factories. Hotels, airlines, rental car agencies, department stores, taxis, and public transportation agencies around the world have successfully implemented their own policies, protecting the health of customers and employees, lowering maintenance costs and improving business.

Build partnerships within the community

Second-hand smoke affects virtually everyone. Many diverse groups are ready and able to act. Look within your community to gather support for the development of smoke-free places.

Groups working in community health and health-care are often the most experienced in information campaigns on the many aspects of tobacco use.

Teachers and other educators are in a privileged position to inform young people about the dangers of second-hand smoke and to help mobilize youth advocacy campaigns. They are often particularly sensitive to the issues of youth smoking and child health.

Environmentalists are likely supporters of clean indoor air legislation. The similarities between second-hand smoke and other forms of pollution are clear: second-hand smoke is a by-product of a highly profitable industry that makes individuals, governments, and businesses bear the health and financial costs of its actions.

Sports clubs and coaches are also well-placed to know how tobacco and second-hand smoke lowers physical performance and debilitates the body.

One should turn to community, business, and spiritual leaders for support, as these leaders often have influence and access to infrastructure that reach many people with their messages.

Cooperation and goodwill will prove very helpful, but may not be sufficient to provide protection from second-hand smoke.

Call on your elected officials and urge them to create and support legislation, as well as to ensure enforcement of existing laws that guarantee smoke-free workplaces.

Help with quitting

When a workplace becomes totally smoke-free or confines smoking only to designated smoking areas, it is important to support those smokers who want to stop.

Quitting smoking can be a difficult decision to make and a difficult process to go through, various elements are important:

- the occupational nurse or doctor should be involved in providing advice and referrals to services outside of work;
- counselling groups, workers' assistance programmes, and workers' organizations are some of the initiatives that can support workers in this process;
- unassisted quitting can be done through information to the smoker on how to prepare mentally and physically, and then gradually stop smoking;
- assisted methods include programmes and courses on how to quit smoking together with different types of therapy;
- nicotine replacement products can be useful, for instance nicotine patches or nicotine gum;
- pharmacological products help keep the addiction at bay, for example Buproprion.

Handout 7.4

The international legal framework for countries to create smoke-free workplaces

The WHO Framework Convention on Tobacco Control (FCTC) is the first step in the global fight against the tobacco epidemic. This treaty presents a blueprint for countries to reduce both the supply of and the demand for tobacco. The WHO Framework Convention establishes that international law has a vital role in preventing disease and promoting health.

Countries endorsing the WHO Framework Convention have committed to protect the health of their population by joining the fight against the tobacco epidemic through the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to second-hand tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

The WHO Policy Recommendations for protection from exposure to second-hand tobacco smoke based on scientific evidence and best practices recommend that in order to protect workers and the public from exposure to second-hand tobacco smoke the countries should "remove the pollutant (tobacco smoke) by implementing 100 per cent smoke-free environments.

The WHO FCTC Guidelines and WHO policy recommendations clearly state that:

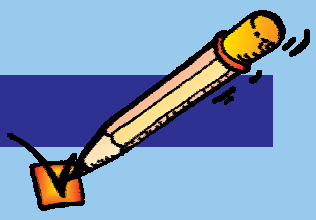
- second-hand smoke causes disease, death and ill health in non-smokers;
- effective protection from exposure to tobacco smoke requires the total elimination of tobacco smoke in a given building or area;
- approaches other than the total elimination of tobacco smoke, including ventilation, air filtration and the use of designated smoking areas (whether with separate ventilation systems or not), have repeatedly been shown to be ineffective; and
- legislation requiring the elimination of tobacco smoke, at least in all indoor public places and workplaces, is necessary to ensure universal protection, as voluntary policies are less effective.

There are numerous international human rights instruments that protect the right to health, right to life and the right to a healthy environment, among others, supporting the WHO policy recommendations and guidelines.

Impact of Smoke Free Legislation

In addition to protecting health, the implementation of smoke-free legislation carries significant additional benefits, including reduced economic costs and reduced tobacco use. Examples from different parts of the world in national, state, or local smoke-free workplace legislation, show that such legislation is feasible to implement and leads to the significant decline in environmental tobacco smoke exposure of workers in the short and long term when compared with situations where there is no or limited voluntary smoking restrictions. Smokers' attitudes have begun to change in favour of smoking restrictions. Evidence suggests that the legislation has led to reduced active smoking, which in turn added to the potential public health benefit.

Exercise 1: The smoking debate



The participants will be divided into two groups:

- **one group will be designated as smokers;**
- **the other group will be designated as non-smokers.**

You have 10 minutes to read the Handouts 7.1 - 7.4 individually, and 30 minutes to complete this exercise in groups.

Debate preparation for each group

Three groups will be created:

- Smokers
- Non-smokers
- Observers

Group 1 will develop as many arguments as possible to support the position that smoking should be allowed at work.

Group 2 will develop as many arguments as possible to support the position that smoking should not be allowed at work. Issues such as workers' health and safety, discomfort, time away from the workstation, productivity, quality control, and building maintenance should be brought into the argument.

Each group will record the main points of each argument on a transparency.

Each group will select a reporter and develop an opening statement using the arguments.

Group 3 will prepare as an auditing team and will identify both types of arguments in the handouts and take notes.

The debate

Step 1

The reporter for the smokers will present an opening statement and display the transparency which lists the main points. (The opening statement will be restricted to three minutes).

- The reporter for the non-smokers will present an opening statement and display the transparency which lists the main points (maximum three minutes).
- Group 3 will observe and take notes.

Step 2

Groups 1 and 2 will meet again in separate rooms for five minutes to develop responses and to challenge the arguments of the opposition.

- Group 3 will consult on their findings.

Step 3

The reporter for the smokers (Group 1) will challenge one argument of the non-smokers (Group 2), giving the reasons why they disagree with the argument (one minute).

- The non-smokers (Group 2) will respond to the challenge (two minutes).
- The reporter for the non-smokers (Group 2), will challenge one argument of the smokers, (Group 1) giving the reasons why they disagree with the argument (one minute).
- The smokers (Group 1) will respond to the challenge (two minutes).
- The auditing team (Group 3) will observe the debate and take notes.
- The debate will continue in this manner until each side has had an opportunity to present three challenges and arguments.
- At the end the reporter for the auditing team (Group 3) will present their assessment on the debate.

Smoking should be allowed at work because:

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Smoking should NOT be allowed at work because:

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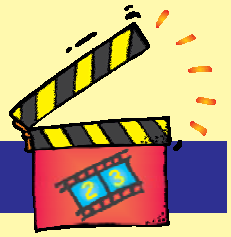
Tobacco presentation



Slide 1

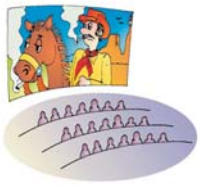
Slide 2

Slide 3

Slide 4

Tobacco addiction

- Processed tobacco contains the addictive substance nicotine
- When nicotine is withheld, people exhibit:
  - Physical withdrawal symptoms
  - Psychological withdrawal symptoms



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Slide 5

Young people and smoking

- Smoking is appealing to many young people
- It is considered a way of coping with stressful situations
- Cigarettes are marketed with an image of being grown-up and "cool"

Integrating health promotion into workplace OSH policies 5

Slide 6

Women and smoking

- Women are an increasing share of smokers in most countries of the world
- Smoking has particularly bad consequences for pregnant women
- Children should also be protected from exposure to tobacco smoke

Integrating health promotion into workplace OSH policies 6

Slide 7

Women and smoking: health effects

- 90% of all lung cancer deaths attributable to smoking
- Increased risk of infertility, preterm delivery, stillbirth, low birth weight, and sudden infant death syndrome
- Lower bone density in post-menopausal women
- Double risk of developing coronary heart disease

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Slide 8

Second-hand smoke

- Smoke that individuals breathe when they are located in the same air space as a smoker:
  - Passive smoking
  - Involuntary smoking
  - Exposure to environmental tobacco smoke

Integrating health promotion into workplace OSH policies 8

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Slide 9

Second-hand smoke

- It is a combination of over 4,000 chemicals in the form of particles and gases
- It includes irritants and systemic poisons
- It causes to non-smokers many of the same diseases as regular smokers

Integrating health promotion into workplace OSH policies 9

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Slide 10

Major health risks for the non-smoker

Adults:
- Heart disease
- Lung and nasal sinus cancers

Children:
- Bronchitis
- Pneumonia
- Asthma

Pregnant women:
- Reduces fetal growth
- Sudden infant death syndrome

Integrating health promotion into workplace OSH policies 10

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Slide 11

Special occupational considerations

Smoking increases the risks of occupational diseases in certain occupations such as:

- Coal mining
- Uranium mining
- Pesticide handling
- Working with rubber and petroleum
- Working with cotton and wood dusts
- Working in radioactive environments

Integrating health promotion into workplace OSH policies 11

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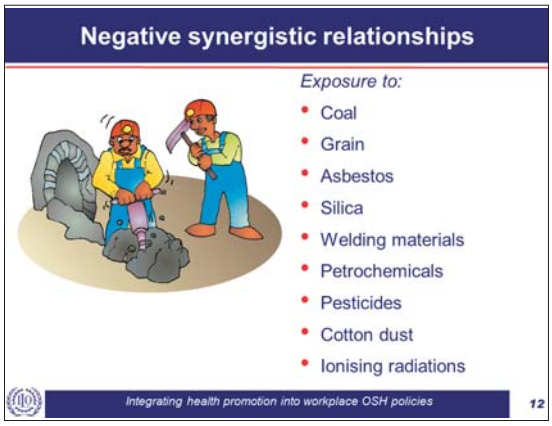
Slide 12



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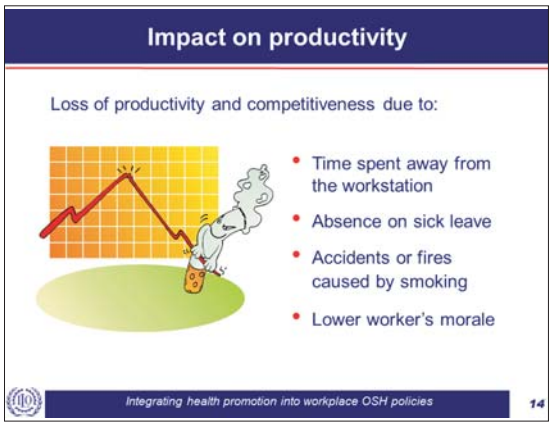

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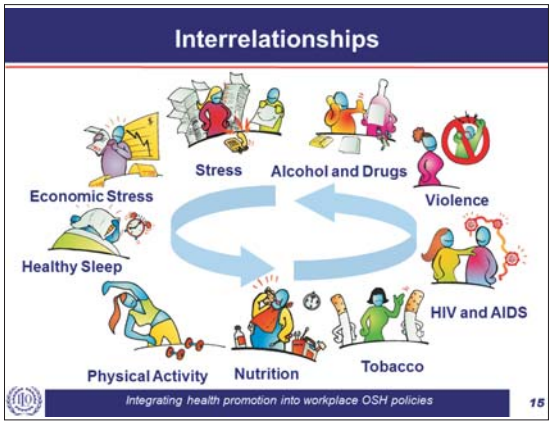

Slide 16

– END OF PRESENTATION –

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Slide 17

Integration of Health Promotion Elements

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Slide 18

Managing tobacco at work

Employers can save money with a non-smoking workplace strategy. It can lower:

- Absenteeism
- Maintenance and cleaning costs
- Fire risks
- Health-care costs
- Life, fire & property insurance costs

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Slide 19

Managing tobacco at work

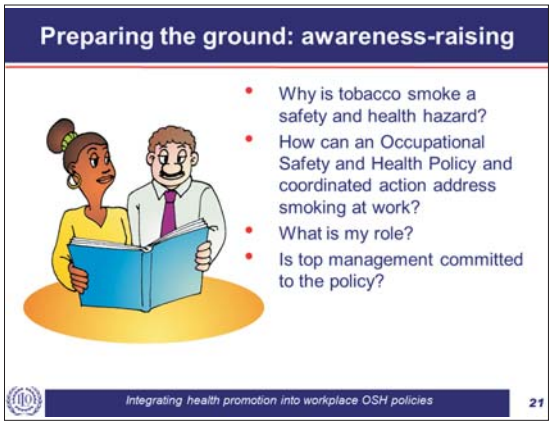
What can be done?

- Inform and educate
- Introduce a policy of non-smoking in all working areas
- Prevent discrimination

Integrating health promotion into workplace OSH policies 19

Slide 20

Slide 21



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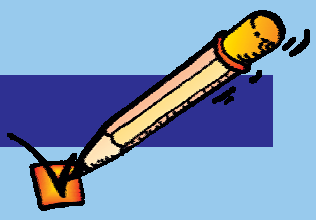
Slide 23

Exercise 2: Simulation - Tobacco



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* module, in this simulation exercise, you and your management team will continue to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.

This simulation exercise takes place before the exercise on policy integration at the end of each module, and which runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 15 April.

The executive director has called a meeting.

She expresses her appreciation for the excellent work carried out by the group. She feels that the problems relating to stress, alcohol and drugs, and violence are under control but will need constant scrutiny. She feels the situation with HIV and AIDS is delicate but that it can be effectively dealt with.

She also reports that the occupational safety and health inspectorate has congratulated the enterprise on the means used to address these issues. The local employers' association is already asking members of the management team to share their knowledge in solving problems in other enterprises.

However, there is another issue. The medical doctor has put up a poster in his office from the World Health Organization that says "Second-hand smoke kills." The workers and their families ask the doctor many questions about second-hand smoke.

The director of human resources reports that he has been approached by the staff union on the creation of a smoke-free workplace. On the other hand, a group of workers who smoke (an average of 20 cigarettes a day) has come to the director of human resources and the production manager (also a smoker) suggesting that a smoke-free workplace

will negatively impact on productivity by forcing workers to leave their workstations to smoke (resulting in prolonged absences during the working day).

The executive director asks you to sort through these arguments and come up with an action plan taking into account both productivity and workers' health.

Proposed Action:

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The executive director asks for the management group's opinion on the following question: How are all of these issues of stress, alcohol and drugs, violence, HIV and AIDS and smoking interrelated?

You have 10 minutes to complete this exercise.

Please summarize the responses from your management team for the executive director:

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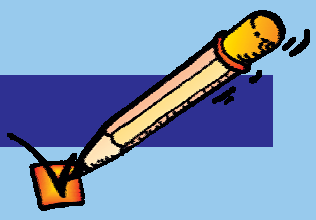
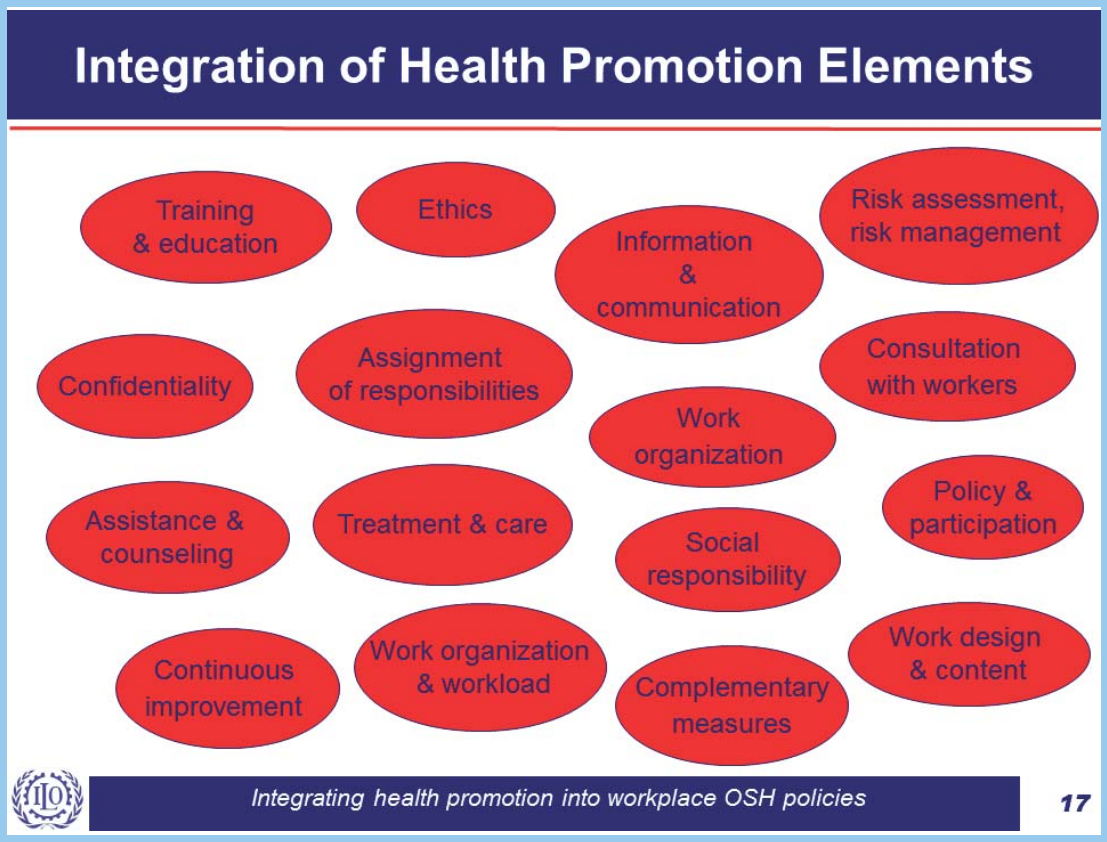
Exercise 3: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Tobacco and workplace second-hand smoke*.

After that, use the checklist at the end of this module to choose the measures relevant to *Tobacco and workplace second-hand smoke* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *Tobacco and workplace second-hand smoke* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Tobacco and workplace second-hand smoke* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *Tobacco and workplace second-hand smoke*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Tobacco and workplace second-hand smoke* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their occupational health and safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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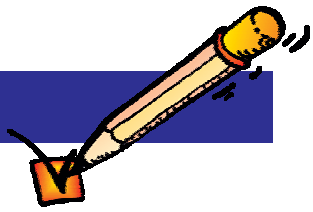
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist



Action–oriented checklist for addressing tobacco at work			
1. Policy and participation			
1.1	Adopt a comprehensive approach to tobacco at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit. When addressing tobacco issues, include both smokers and non-smokers if they agree to participate.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of preventing tobacco exposure at work for workers' health, well-being and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces, for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and its preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and tobacco-related issues in the health promotion programme, with a timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly, in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

2.	**Training, education, information and communication**		
2.1	Ensure information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards, and of the negative impact of smoking tobacco and second-hand smoke to workers' health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and the plan of action through all means possible, such as notice boards, mail, payslip inserts, special meetings, induction courses, and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to tobacco smoking, including information on where support is available outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.5	Make all workers aware of the dangers of smoking and the dangers within their occupation/industry specifically. Also explain any possible negative synergistic effects with elements such as chemicals or radiation.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.6	Make cessation assistance available for all workers, as well as informing them about the availability of these programmes outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.	**Work organization, workload, design, and content**		
3.1	Ensure good relationships between smokers and non-smokers in the workplace, in order to avoid stress and violence.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Ensure that customers' or the community's expectations regarding tobacco are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Where the workplace is not smoke free, work towards the designation of smoking areas and the proper installation of ventilation as a transitional measure. In risk assessment measures, consideration should be paid to increased health risks in certain occupations due to synergistic relationships with chemicals, radiation and other exposures.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment

4.2	Ensure that there is adequate ventilation and thermal control at the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Provide adequate and clean toilet facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment

International
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Office
Geneva

Nutrition at work

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for adequate nutrition at work.

Introduction

Many people spend a large proportion of their time awake at work, and most of us need to eat during the working day. Changing attitudes to nutrition at work can also lead to changing attitudes at home, improving not only workers' health, but the health of the members of the community as well. A worker eating a balanced diet is likely to be healthier and more productive.

The consequences of unbalanced nutrition

The consequences for health of an unbalanced nutritional intake vary considerably, depending on whether people are eating too much or not enough, or eating too many or too little macro and micronutrients.

Not eating a balanced diet often has a serious impact on health and can lead to:

- obesity;
- iron deficiency;
- anaemia; and
- heart disease.

The "nutritional transition"

In countries experiencing the so-called "nutritional transition", parts of the population have made a rapid switch from traditional diets to high-energy, high-fat diets, while other parts of the population may suffer from malnutrition. Countries in a nutritional transition have a higher risk of nutrition-related diseases.

What is balanced nutrition?

Eating a healthy and balanced diet means getting the right amount of energy and nutrients from the food we eat to live a healthy life.

The food triangle

The food triangle is often used to show balanced proportions of the different categories of food. Experts generally agree that eating large quantities of carbohydrates, such as rice, bread, potatoes, and smaller quantities of the food groups showed in the triangle represents a healthy diet.

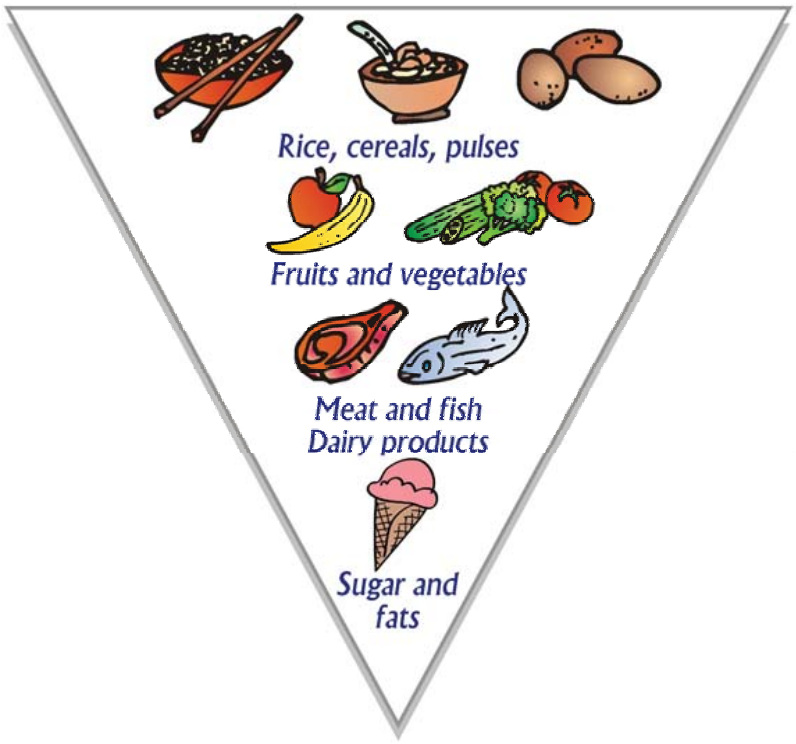


Fig. 8.1 The food triangle

Eating food in these healthy proportions means eating the right proportions of **macronutrients** and **micronutrients**. There are four main types of macronutrients: **carbohydrates, proteins, fats and oils, and water**. Macronutrients are found in large proportions in food. Micronutrients, such as **vitamins and minerals**, are present in much smaller quantities but each of them has a vital function for healthy living and is essential for the body to process food.

The "healthy" dish

To have a balanced meal, we should remember when we eat to include in our meal all different types of food groups and to combine them in the recommended proportions. As an example, 2/5 of carbohydrates (e.g., rice, cereals, potatoes), 2/5 fruits and vegetables and 1/5 proteins (e.g., fish, meat, eggs, dairy products) will provide a balanced meal. This way, essential nutrients such as calcium, food fibres, or fatty acids such as omega-3 are ensured.

To keep your body properly hydrated drink 1.5 to 2 litres of water a day.

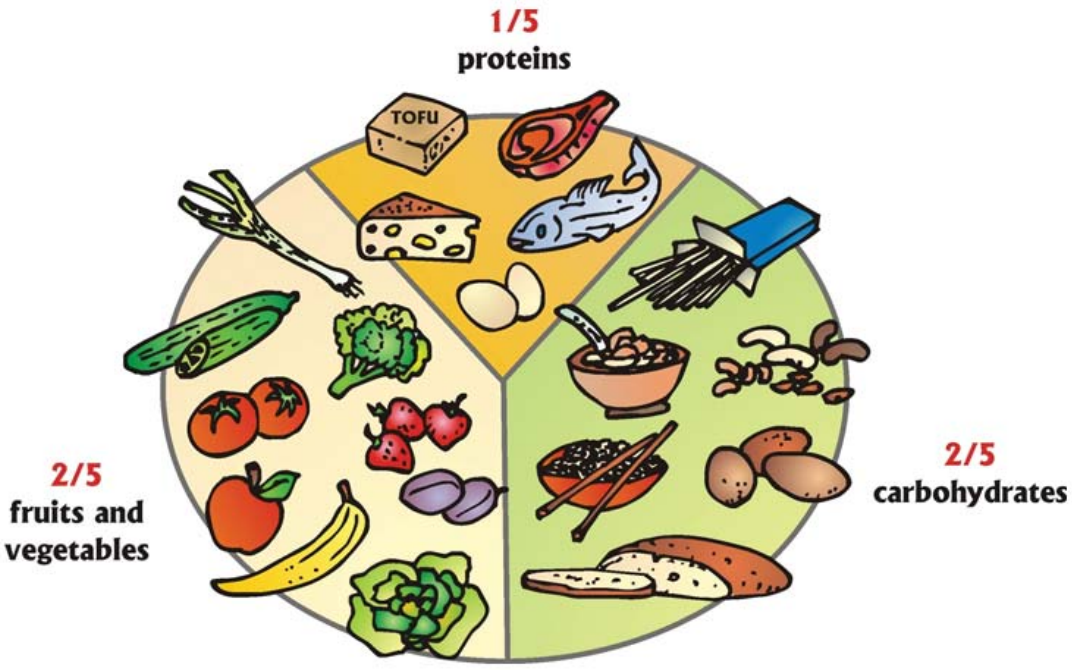


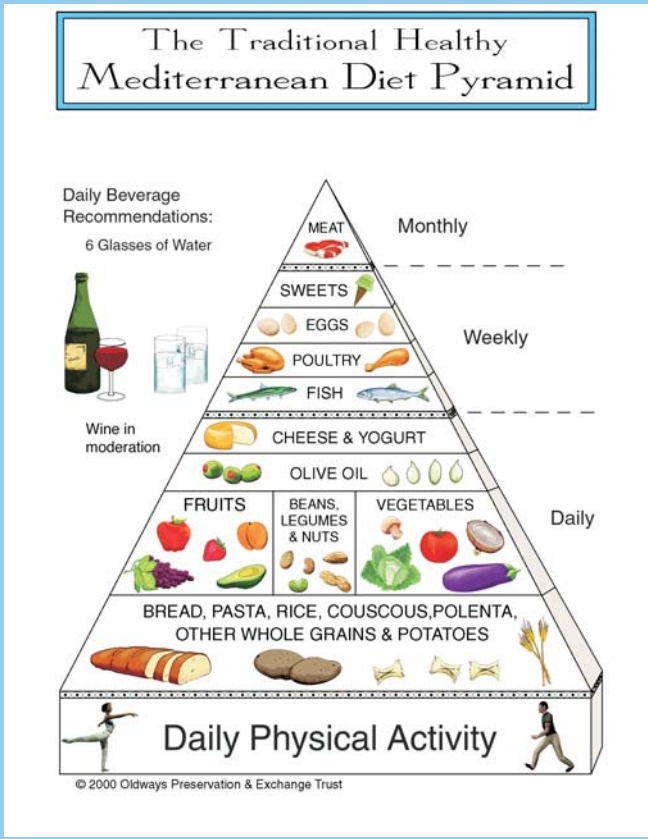
Fig. 8.2 The "healthy" dish. Adapted from: Société Suisse de Nutrition (SSN). Table de composition nutritionnelle suisse, Office fédéral de la santé publique, Ecole polytechnique fédérale de Zurich, 2009.

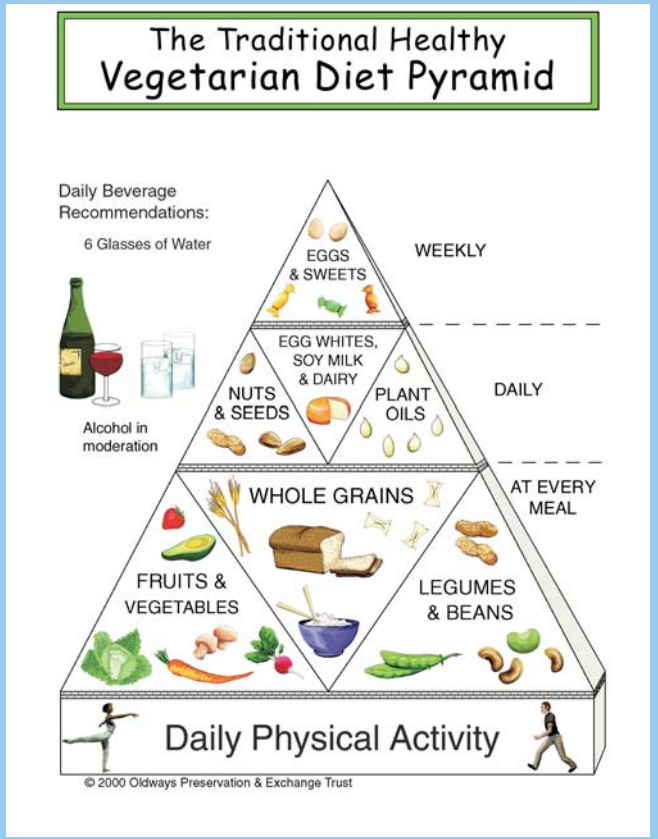
Nutrition and exercise

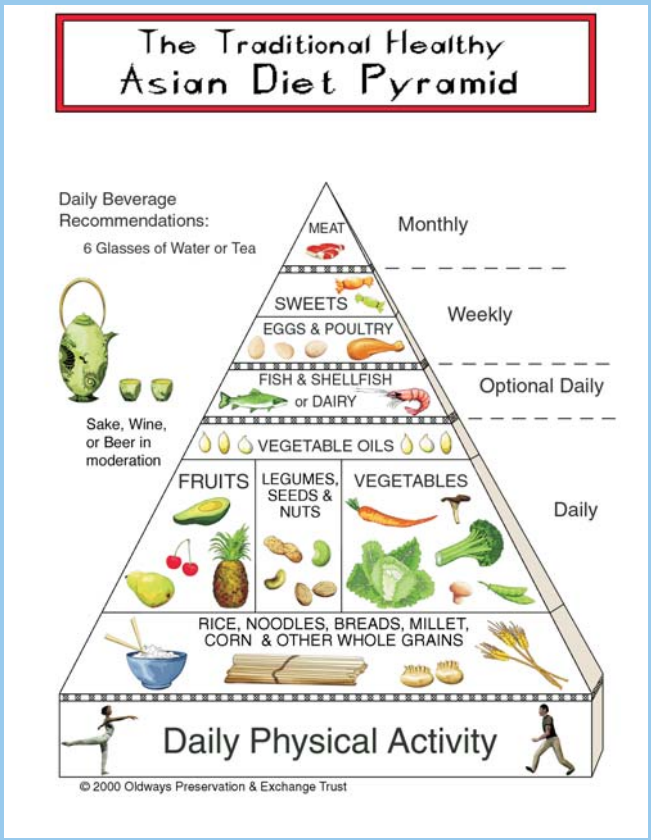
It goes without saying that eating a healthy diet is only half of the story when it comes to achieving and maintaining a healthy weight. Without appropriate exercise, efforts to manage nutrition are unlikely to succeed. If an enterprise addresses nutrition as part of its health promotion activities, they must also address exercise or other types of physical activity for health to have a good chance of success.

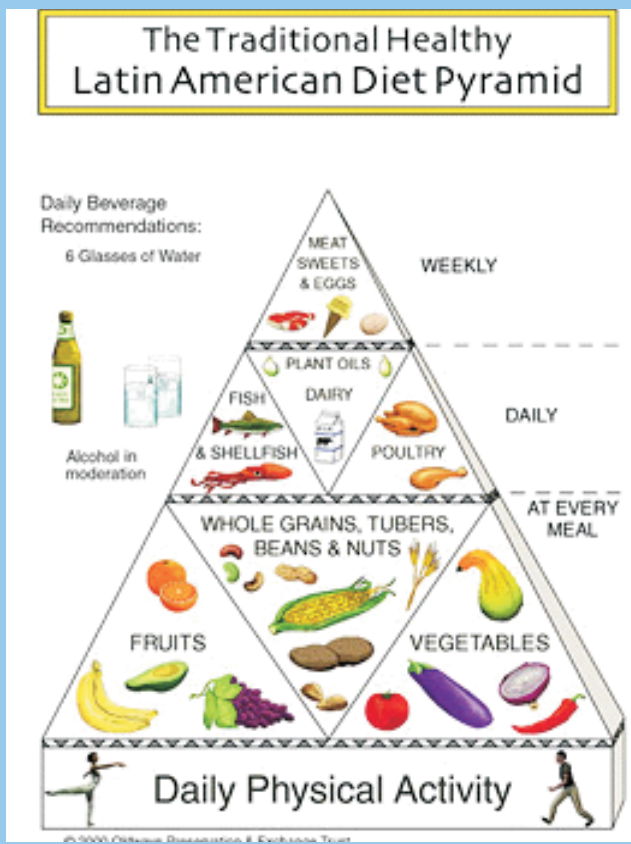
Exercise 1: Food at Work

Look at these four nutrition pyramids:









You have 15 minutes to answer the following questions individually.

The answers will be then discussed in plenary.

1. Which of these diets is closest to your own? If none of them resemble the way you eat, draw your own pyramid.

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2. How much of your daily intake of food do you eat at work?

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3. How does the way you work determine the food you choose to eat?

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4. **Where does physical activity fit into your daily routine? Is it influenced by work?**

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5. **What, if anything, would you like to change about your eating habits? What would help you make those changes?**

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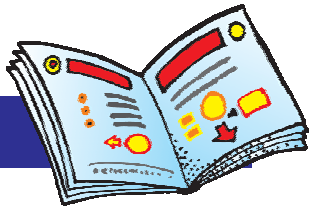
Handout 8.1



DIET

- Nutritionally adequate
- Includes a variety of foods
- Hypocaloric
- Meets contemporary dietary recommendations
- Provides satiety
- Can be followed for long enough to lose weight
- Affordable
- Allows flexibility and individual adaptations
- Teaches new eating habits and facilitates the adoption of them for long-term weight control

EXERCISE

- Appropriate for the individual
- Teaches lifelong exercise habits
- Convenient and fun
- Permits year-round participation
- Affordable

BEHAVIOUR MODIFICATION

- Teaches new weight control habits and strategies for achieving them
- Encourages social suppport
- Provides rewards
- Teaches how to deal with challenging and difficult times

ILO Encyclopedia of Occupational Safety and Health, 1998.

Handout 8.2

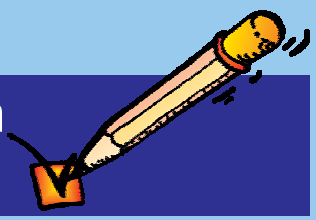
LIST OF SUBSTITUTE HEALTHY FOOD

Here is a list of the kinds of changes that can be made in *ad hoc* food provision to reduce saturated fat and calories.

CHOOSE...	INSTEAD OF...
For Beverages	
bottled water (filtered, mineral, flavoured without sugar,) teas, coffee, or 100 per cent fruit and vegetable juices	soda pop or fruit-flavoured drinks
low-fat or skim milk	whole milk or cream
For Breakfasts	
fresh fruit, dried fruits, unsweetened juices	sweetened canned fruit and fruit drinks
low-fat yogurt (plain with fresh fruit)	regular yogurt (pre-sweetened)
small bagels, smaller than 3.5 inches (9 cm)	regular bagels, 4.5 inches (12 cm)
small or mini-muffins, 2.5 inches (6.5 cm)	regular muffins
low-fat granola bars	croissants, doughnuts, sweet rolls, pastries
light margarine, low-fat cream cheese, natural jams or fruit spreads	butter, regular cream cheese
unsweetened or low-sugar cereals	sweetened cereals
whole-grain waffles, French toast	regular (white flour) waffles or French toast
lean ham or turkey bacon, vegetarian sausages or bacon substitutes	bacon or sausage
For Lunch or Dinners	
salads with dressings on the side	salads with added dressing
low-fat, fat-free dressings, flavourful vinegars or extra virgin olive oil	regular salad dressing
soups made with vegetable puree or skim milk	soups made with cream or half-and-half
For Lunch or Dinners	
pasta salads with low-fat dressing	pasta salad with mayonnaise or cream dressing
sandwiches on whole grain breads	sandwiches on croissants or white bread

CHOOSE...	INSTEAD OF...
For Lunch or Dinners	
lean meats, skinless poultry, fish, tofu	high-fat and fried meats, bacon, poultry with skin, cold cuts, oil-packed fish
steamed vegetables	vegetables fried or cooked in cream or butter
whole-grain bread or rolls	croissants or white bread
margarine without trans-fatty acids	butter
low-fat, low-calories desserts, such as fresh fruit, low-fat ice cream, low-fat frozen yogurt, sherbet, sorbet, angel food cake with fruit topping	high-fat, high-calorie desserts, such as ice cream, cheese cake, pies, cream puffs, and large slices of cake
For Receptions	
cut fresh vegetables or "baby" vegetables served with low-fat dressing, salsa or tofu dip	deep-fried vegetables
cut fresh fruit	fruit tarts, pie, cobblers
grilled or broiled skinless chicken strips	fried chicken, chicken with skin
miniature meatballs from lean meat, turkey	large meatballs made with fatty meat, or meatballs served in gravy or heavy sauces
broiled or poached seafood	deep-fried seafood, seafood in high-fat sauces
mushroom caps with low-fat stuffing	mushrooms with high-fat cheese or creamy stuffing
miniature pizzas with mozzarella and vegetables	large pizzas with pepperoni, Italian sausage or other high-fat meats
vegetable spring rolls, fresh and not fried	fried egg rolls
small cubes of cheese, 0.75 inches (2 cm)	large slices of cheese
whole-grain, low-fat crackers	regular crackers with trans-fats
low-fat, air-popped popcorn with no butter	oil-popped popcorn or popcorn with butter
baked or low-fat chips, pretzels	regular chips
dips made of salsa, hummus, or low-fat cottage cheese	dips made of mayonnaise, sour cream, cream cheese or cheese sauce
small slices of cake, 2 inches (5 cm)	large slices of cake

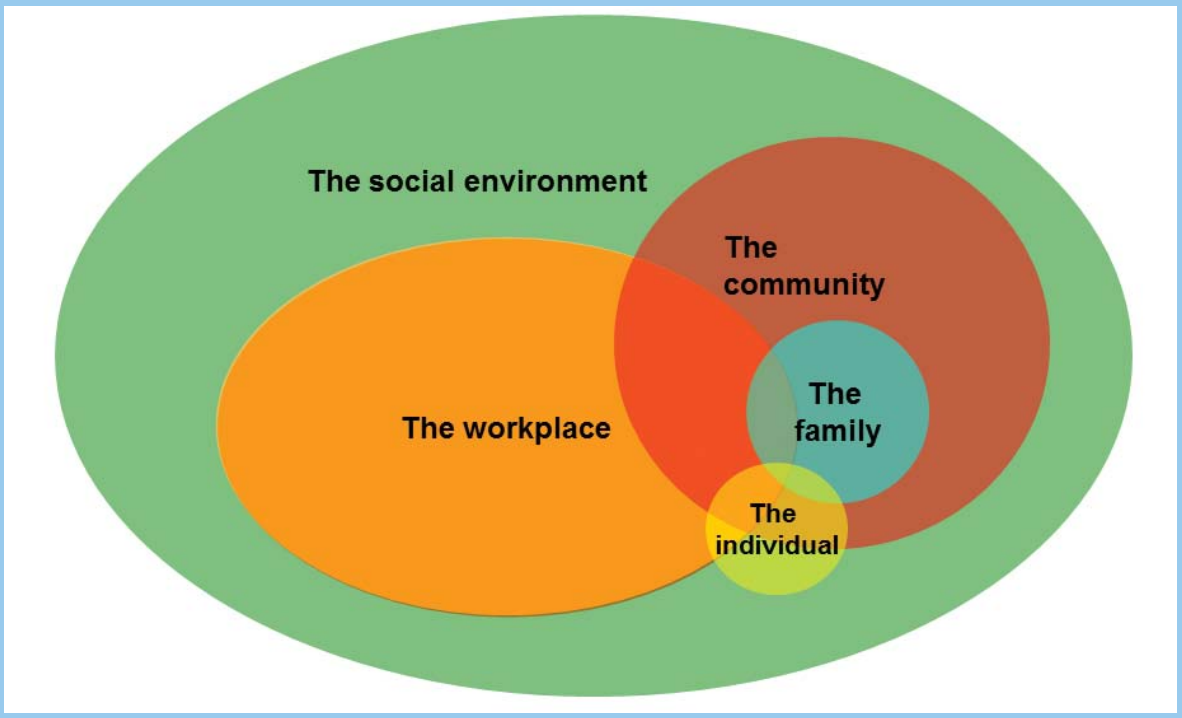
Exercise 2: Food and work, health and productivity



You have 15 minutes to complete this exercise in groups.

Nominate a spokesperson who will present the results in plenary.

Please note that the trainer will draw one group at random for the presentation.



The Ecological Model

In small groups, develop a rationale explaining the best reasons for improving nutrition at work. You might want to consider health and personal benefits, as well as productivity and other economic advantages. Occupational safety and health may play a role in your thinking too. Bear in mind the links between the different circles on the model, for example how better nutrition at work helps not just the individual worker but the workplace and the family too, as well as how the community and the social environment can influence diet.

Prepare a brief presentation with your team on the most important points in your discussion. You may want to draw the ecological model on the transparency and show the links between the different spheres.

Notes for presentation

Handout 8.3

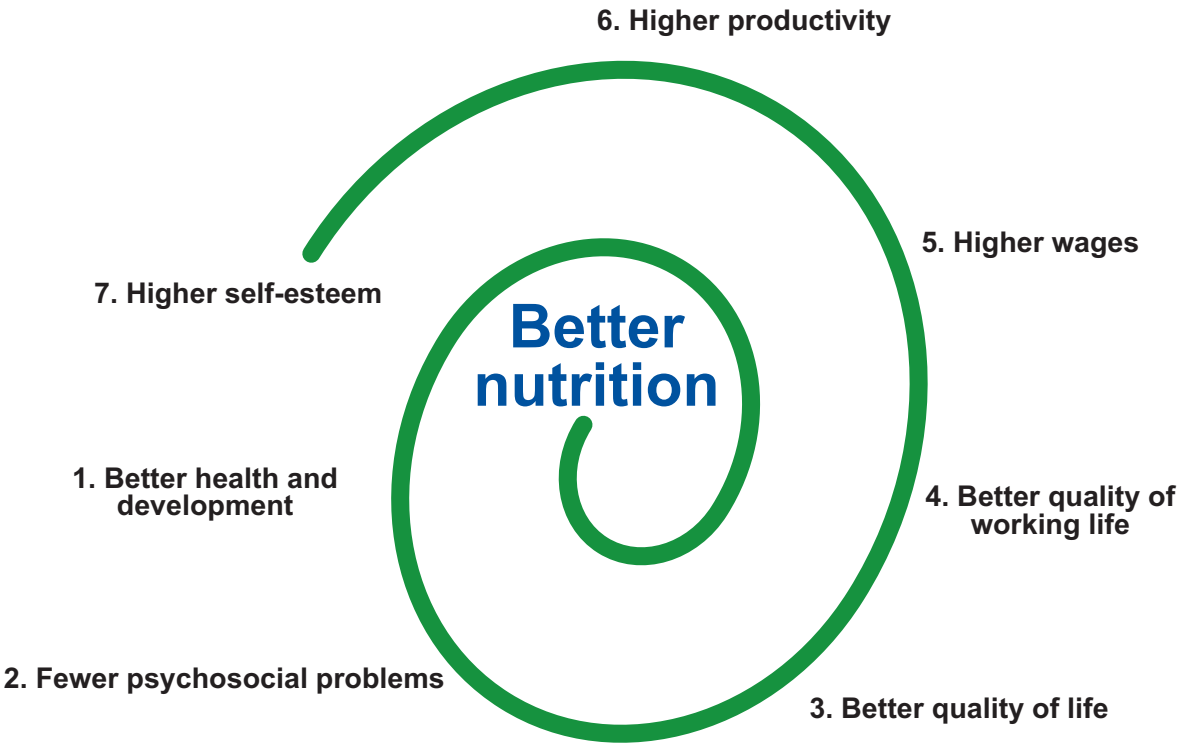
The health consequences of inadequate nutrition have an impact on work. Nutrition-related impairment and ill-health affect workers' lives; employers see productivity decrease, while governments and society have higher health-care expenses and poorer economic returns.

DIET AND EXERCISE

- There were 58 per cent less cases of diabetes as a result of improved lifestyles (eating less fat and more fibre combined with taking more exercise) in a study carried out over 4 years in Finland (Tuomilehto et al., 2001).
- The WHO estimates that:
  - 80 per cent of cases of coronary heart disease;
  - 90 per cent of type 2 diabetes;
  - 33 per cent of cancers could be prevented by improvements in diet and exercise regimes (WHO, 2003a).
- A 20 per cent increase in national productivity can be achieved by reducing iron deficiency (WHO, 2003b).
- Undernutrition has been conservatively estimated to account for a 3 per cent reduction of a countries potential GDP. Where undernutrition at earlier stages in life the cost of lost GDP can be expected to be greater (Haddad, 2002).

Changing your lifestyle will help you to break the vicious circle of non-balanced nutrition at work; by improving nutrition and exercise habits, as well as reducing alcohol and cigarette consumption there is less likelihood of heart disease and diabetes, as well as improved well-being and productivity.

Those changes are the key to move from the negative to the positive spiral and towards better nutrition.



Source: based on a diagram by WHO, 2000.

Fig. 8.3 Nutrition and work productivity graph. Source: Based on a diagram by WHO, 2000.

What can be done?

As everyone benefits from improvements in workers' nutrition, it makes sense for all to contribute to improvements.

- **Workers** could change eating (and exercise) habits in order to enjoy healthier, happier, and longer lives.
- **Employers** can implement low-cost solutions; for example including the provision of food in the work environment and then reaping the benefits of higher productivity.
- **Governments** can also play a key role in providing policies, advice, and health promotion measures for nutrition at work.

Good Practices: food provision for good nutrition

Companies can complement their policy framework with measures related to providing adequate food for workers and facilities for this purpose. These include canteens, mess rooms, kitchens, vending machines, mobile vendors, voucher systems, and snacks at meetings.

Canteens (cafeterias)

A canteen is an on-site facility where food is prepared and sold. The advantages of a canteen are:

- workers save time by eating on-site;
- workers can be provided with the opportunity to eat healthily on a regular basis;
- the employer can subsidize food.
- Subsidizing meals has a number of advantages:
- workers eat the food provided which may be healthier and safer than food available outside the worksite;
- for the employer, this is a social benefit and can be regarded as an enticement to employment, which may improve the company's corporate image and the pool of potential job applicants.

Mess rooms or kitchens

Having a mess room has a number of advantages:

- workers remain on-site, leaving more break time for resting;
- low-cost options for encouraging healthy eating are open to the employer or the workers' representatives, for example providing free fruit or nutritious snacks;
- the mess room can be the focal point for information and education about nutrition and a contribution towards improving community health too.

Snacks at meetings and vending machines

There are a variety of other ways in which the workplace can serve as a setting to influence people's eating habits. For example, snacks may be provided at meetings, while vending machines are a low-cost way of making food available to workers. In paying attention to health and healthy eating, it makes sense to ensure that the snacks and foods in vending machines meet the dietary needs of the workers.

In meetings, this means replacing soft drinks with high sugar content with water and fruit juices instead, and serving high grain content snacks rather than biscuits made from refined white flour with high sugar content.

Mobile vendors

Many workplaces provide access to mobile food vendors in their premises. A supplier of sandwiches may be granted access to the premises to sell food. In negotiating with a supplier, there is the opportunity of ensuring that the food provided is not just clean and safe in the short term, but also healthy in the long term, concerning adequate micronutrient content and appropriate energy supply.

Vouchers

Employers can consider the option of meal vouchers. Voucher systems involve employers providing workers with coupons, or slips of paper entitling them to food for a specific stated value at certain suppliers. The advantage for the employer is that a certain amount of money will be dedicated to food, and potentially to health improvements. The advantage for the worker is that the voucher may be supplied in addition to the salary.

Combined with the other policy options such as education, information, and health promotion, making a change in the ad hoc food provision can be a useful way to promote good nutrition and encourage workers to change their eating habits.

Nutrition presentation

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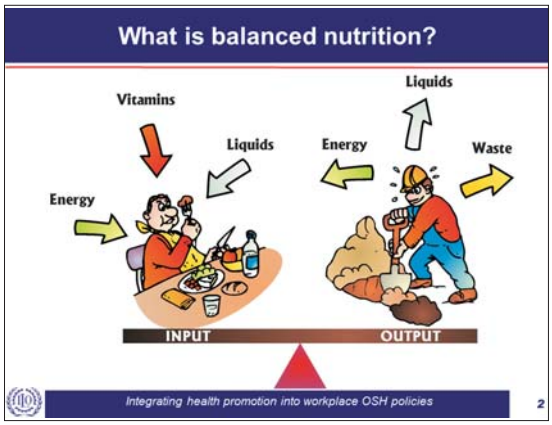
Slide 2



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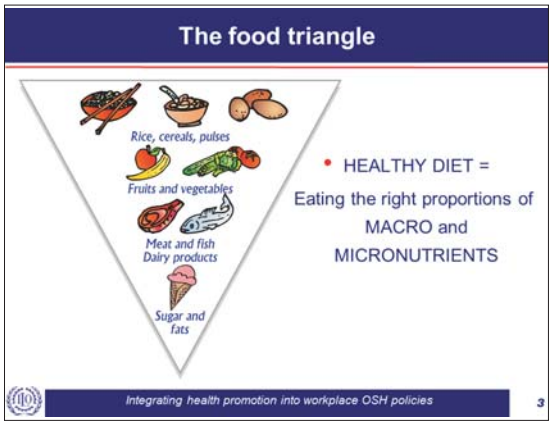

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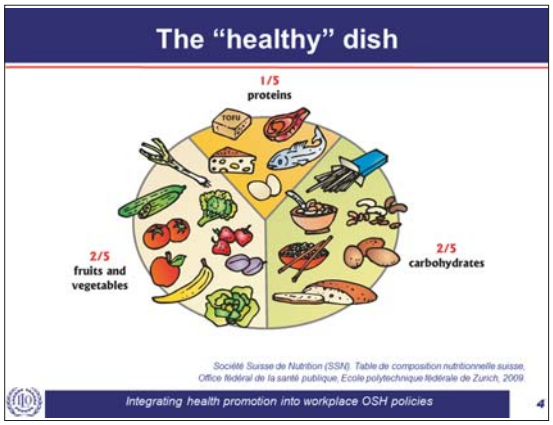

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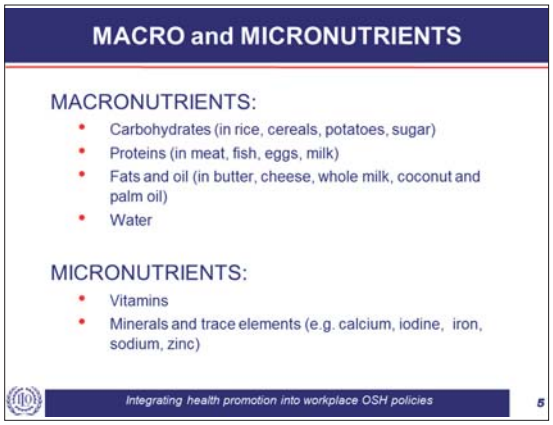

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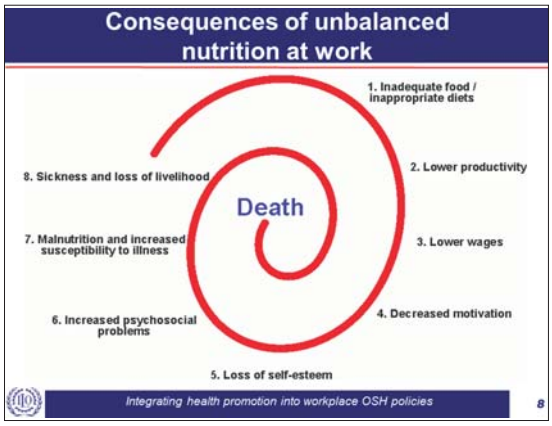

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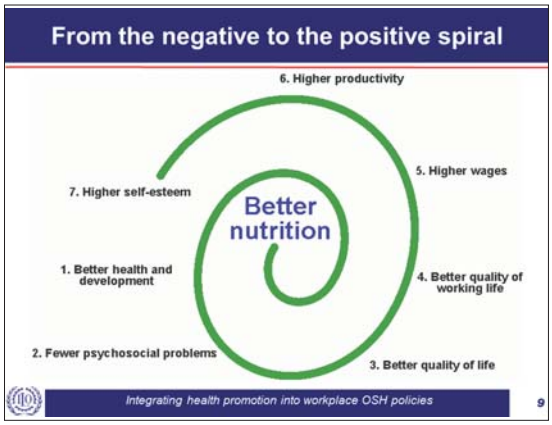

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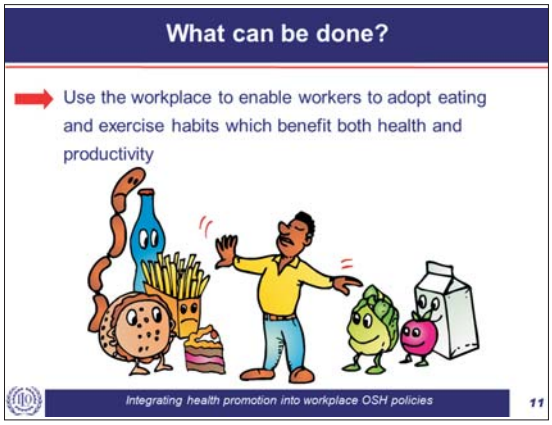

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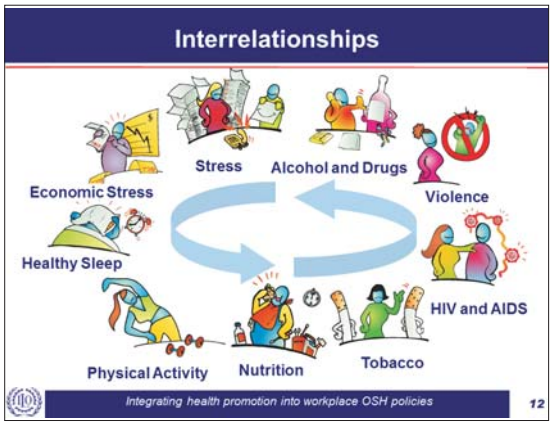

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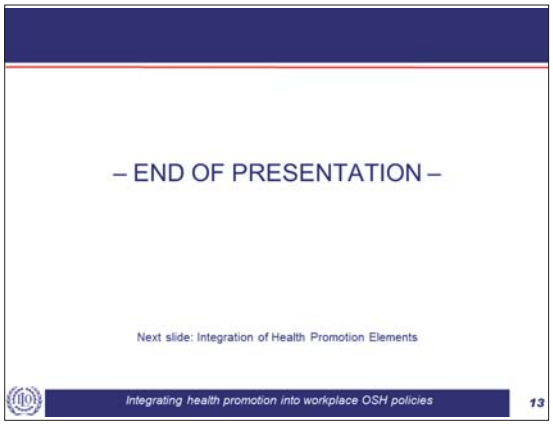

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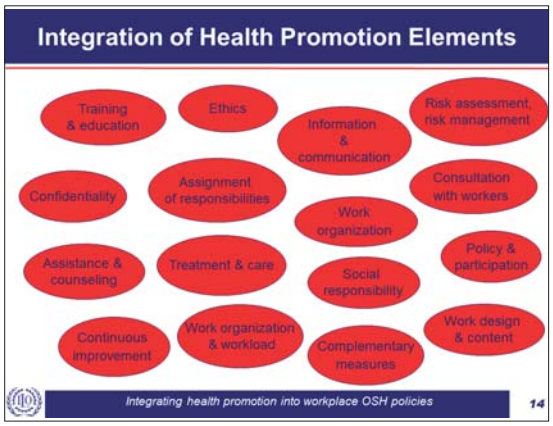

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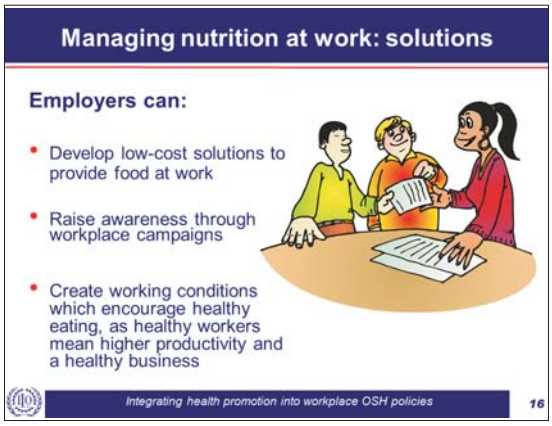

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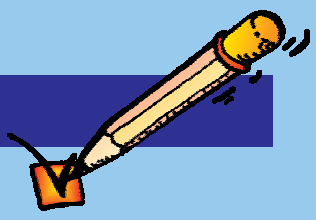
Exercise 3 : Simulation - Nutrition



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* module, in this simulation exercise, you and your management team will continue to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 7 June.

In a routine management meeting, the executive director reports that she is satisfied with the action plan drawn up on managing tobacco consumption at work, and is confident that it will help improve health and productivity in the company.

She has nevertheless included "increased sickness leave" on the agenda, and has distributed an analysis of the company's sick leave data to the members of the team, which details increasing absences for long-term health conditions such as heart disease and diabetes, particularly among workers who are more sedentary. The production manager is also reporting increased accidents which seem to be linked to fatigue.

Since the production crisis of a year and half ago was overcome, the economy has seen a downturn and overall revenues are down. Due to severe exchange rate fluctuations, the company's export market has been particularly hard-hit. Some rationalization has already taken place within the company (e.g. not replacing workers who retire or leave) which has left fewer staff to cope with production demands. Overtime is increasing, and lunch breaks seem to be getting shorter. One of the production managers points out that the pressure to save time, for example by cutting lunch and surviving on snacks, is increased by the absence of colleagues on sick leave. Some workers are comparing the current situation with previous times of economic difficulty, when similar methods were used.

The medical doctor who provided the analysis of sick leave data has said in her report that some of the reasons for the long-term health conditions which have caused these high levels of absence are poor nutrition and unhealthy eating habits.

The Executive Director wishes to address this particular issue in conjunction with the other measures necessary to deal with the impact of the economic crisis, in order to ensure the long-term sustainability of the enterprise. He also feels he could boost workers morale in difficult times as well as contributing to the company's image in the community.

1. Discuss the executive director's proposal and decide what action is to be taken.

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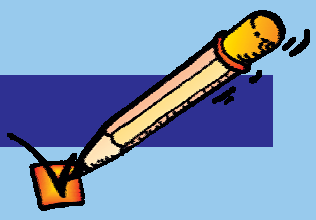
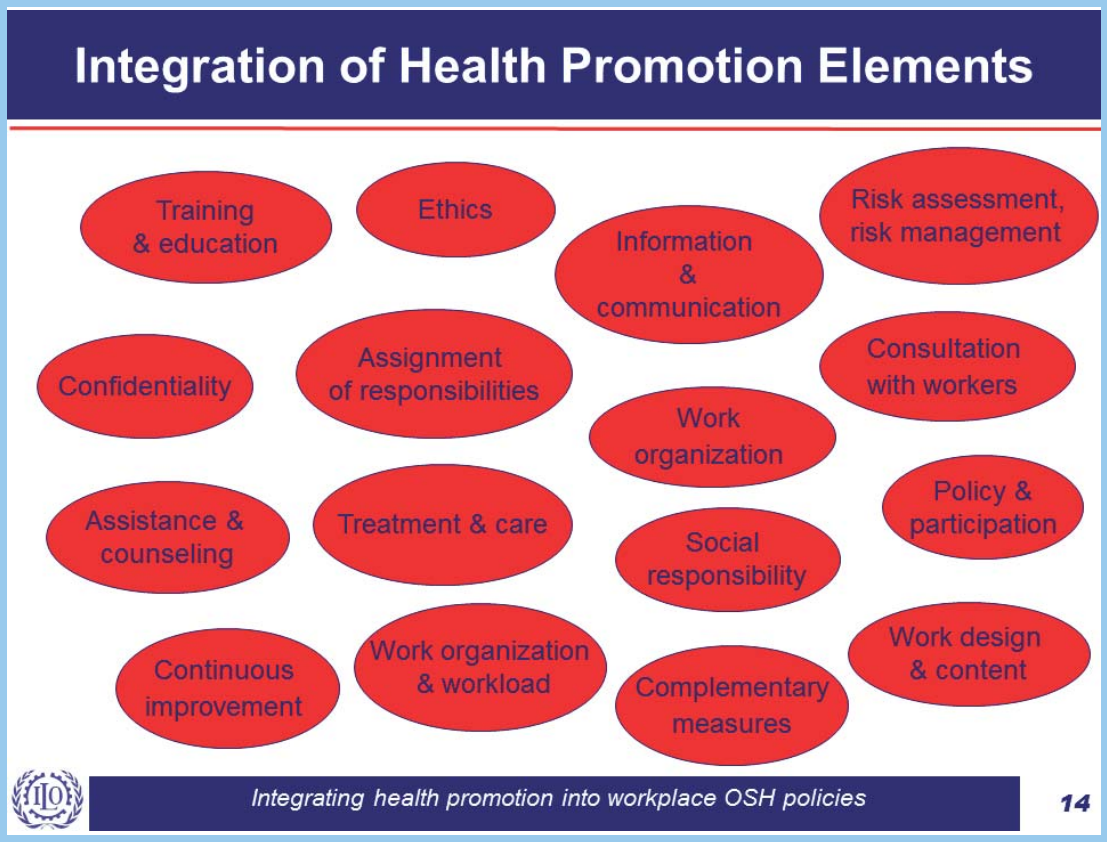
Exercise 4: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Nutrition at work*.

After that, use the checklist at the end of this module to choose the measures relevant to *Nutrition at work* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *Nutrition at work* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Nutrition at work* module has as headings the policy elements shown in the slide and includes a list of possible measures under each

policy element relevant to *Nutrition at work*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Nutrition at work* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their occupational health and safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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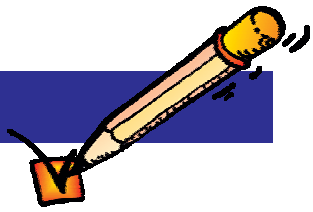
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist



Action–oriented checklist for addressing nutrition at work			
1.	**Policy and participation**		
1.1	Adopt a comprehensive approach to healthy nutrition at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of nutrition at work for workers' health, well-being and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and good nutrition in the health promotion programme, with a timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

2.	**Training, education, information and communication**		
2.1	Ensure that information, education, and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and good nutrition and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and plan through all means possible such as notice boards, mail, payslip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to good nutrition, including information on where support is available in-house and outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.	**Work organization, Workload, Design and Content**		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Encourage workers to discuss any conflicting demands between work and home, and food access at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Make sure working hours and eating breaks are of reasonable length.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Make sure that organization of shift/night work includes appropriate opportunities to eat.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or food preparation facilities appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Ensure that there is adequate ventilation and thermal control in the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Provide adequate and clean toilet facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.4	Provide medical examinations for all workers, including recommendations on how to improve their nutrition habits.	Is action needed?	☐ Yes ☐ No ☐ Comment

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Physical activity for health

9

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for improving workers' physical activity for health.

Introduction

A lack of physical activity as part of people's lifestyles is becoming increasingly common in most parts of the world, and in many places is rapidly increasing due to sedentary work or the motorization of transport. In countries experiencing rural to urban transition, as well as in industrialized societies, the problem is growing and is often connected with inappropriate diets and other factors, such as smoking or the excessive use of alcohol. Fortunately, there are ways of increasing physical activity in order to benefit all and the workplace can be a good place to start.

How is physical activity defined?

Physical activity can be defined as any bodily movement produced by the contraction of muscles that substantially increases both the heart rate and energy expenditure.

Where can physical activity be done?

- **Occupational physical activity:** done as part of a job. Many jobs today are largely sedentary, while others are physically too demanding and can lead to accidents and illness.
- **Lifestyle activities:** gardening, chores**,** walking, dancing.
- **Leisure physical activities:** exercise, training**,** sports.

Impact on health due to lack of physical activity

The lack of physical activity is a contributing factor to the seriousness of the following diseases:

- lower back pain and neck pain;
- obesity;
- coronary heart disease;
- stroke;
- cancer;
- type 2 diabetes;
- hypertension;
- arthritis;

- osteoarthritis;
- osteoporosis.

Impact of physical inactivity in the workplace:

- excessive health-care costs;
- reduced working capacity;
- reduced productivity.

Scientific evidence indicates that physical inactivity is a serious hazard to health, to working capacity, and to productivity, and it affects many people in most countries of the world. A large proportion of sufferers are persons of working age, and the losses in terms of productivity and health-care costs are extremely expensive. These adverse effects are increased by inadequate diet and other factors such as stress, smoking, and the excessive use of alcohol. Such factors are frequently connected to lifestyles in developed countries, and increasingly also in developing countries.

Nutrition and physical activity

The link between balanced nutrition and physical activity is very strong: they are both important for many functions of the body and for how the body processes carbohydrates and fats. The risk of chronic diseases is influenced by what people eat and how much physical activity they do.

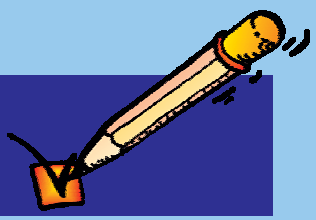
For muscles to develop and become strong they need both physical activity and sufficient protein, exercise alone, or just a high-protein diet will not be enough. The same is true for bone mass and strength: calcium and vitamin D are required from balanced nutrition, while physical activity makes the body incorporate them into bone tissue.

Carbohydrates and fats are processed by the body most effectively during physical activity. Without muscular activity, carbohydrates and fat are stored in the body, making the person gain weight. With increased weight, the risk of serious diseases, such as type 2 diabetes and cardio-vascular disease increases too.

Physical activity also helps to regulate appetite: the person is able to eat as much food as they need to function, rather than over-eating. Regular physical activity may make one conscious about diet, as someone who has made the effort to be physically active may not want to destroy the positive effects by eating an unhealthy diet, or vice versa.

Therefore, if an enterprise addresses nutrition as part of its health promotion activities, they must also incorporate physical activity for health in their strategy in order to have a good chance of success.

Exercise 1: Work and physical activity



You have 20 minutes to complete this exercise in groups. Each group will work on one case study chosen at random by the trainer.

Case Study 1: Luna

Luna is an office worker in a 25-storey building. Her favourite hobby is table tennis which she plays in a local club. She is one of the best players in the club league and she enjoys the club's social life as much as the game. However, she has recently not been able to play as often as she would like because she has had to do a lot of overtime at work.

Luna's home is a 15 minute walk from the nearest bus stop to get to her workplace. Her employer subsidises her bus ticket, so she prefers to take the bus than to use the car. The office is in town, so she can use the shops and restaurants in town on her lunch break.

She has recently started using the stairs more than the lifts to get to and from her 5 floor office because the lifts are over-used and don't always work. The stairs have been renovated and some office noticeboards relocated to the stairwells. It was there that she saw an offer for a reduced rate subscription to a nearby gym for company workers, including more flexible working hours for those who take up the subscription. The offer was a joint project by the management and staff union.

Case Study 2: Mark

Mark is a police officer who spends about 30 per cent of his working time at a desk but is otherwise out of the police station, either on foot, on a bicycle, or in a car. He has regular health checks at work with the medical officer and recently a colleague told him that as a result of a health check she'd been advised to improve her fitness and was given some information about opportunities in the local area.

Mark tries to swim at least once a week, which he can easily fit in around his working hours because his employer has an arrangement for priority access at certain times with the local pool. Mark is a community man and in his time off he does some volunteer gardening for social services at local hospitals, schools, and old people's homes. He lives alone in his parents' old 2-storey house which he looks after entirely himself, doing all the cleaning and maintenance, including renovations and repairs inside, and most of the work outside.

1. **Identify in the case studies 1 and 2 the examples of physical activity carried out by Luna or Mark.**

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2. **How many types of physical activity can you identify? Where do they perform physical activity? What kind of equipment do they need? Which parts of the body do they use and how hard do they work?**

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3. **How do Luna and Mark's workplaces contribute to how much physical activity they perform? Do they, in some ways, prevent them from performing physical activity?**

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4. **In some instances, the employer has taken measures to make it possible for the workers to be physically active. List all the reasons you can think of why they have done this.**

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Handout 9.1

Physical activity recommendations

Over the years various recommendations have been issued to guide people on the type, amount, frequency, and intensity of physical activity that is needed for different purposes. The table below is based on the Public Health Recommendation of Physical Activity issued by the Centers for Disease Control and Prevention (CDC) of the United States and by the American College of Sports Medicine in 1996.[1]

- All people over the age of 2 years should accumulate at least 30 minutes of endurance-type physical activity, of at least moderate intensity, on most – preferably all – days of the week.
- Additional health and functional benefits of physical activity can be achieved by adding length to moderate-intensity activity, or by performing more vigorous activity.
- Persons with cardiovascular disease (CVD), diabetes, or other chronic health problems who would like to increase their physical activity should be evaluated by a physician and provided an exercise programme appropriate for their clinical status.
- Previously inactive men over age 40, women over age 50, and people at high risk for CVD should consult a physician before embarking on a program of vigorous physical activity to which they are unaccustomed.
- Strength-developing activities (resistance training) should be performed at least twice per week. At least 8 – 10 strength-developing exercises that use the major muscle groups of the legs, trunk, arms, and shoulders should be performed at each session, with one or two sets of 8 – 10 repetitions of each exercise.

1 Centers for Disease Control, 1996.

Handout 9.2

Elements of a strategy for the promotion of physical activity for health	
Information	Can take the form of leaflets, posters, articles, websites, presentations; Can cover issues like the benefits of physical activity; different opportunities to be active, such as at the workplace, while commuting to work, during leisure time, or while doing household chores; advice on different exercise programmes, facilities, equipment, and clothing.
(Peer) Education	Provides more formal and thorough knowledge of the issues mentioned above through courses, lectures, articles, websites and discussion groups. Education and training are especially useful when provided by peers who assist workmates in becoming physically active.
Questionnaires	Collecting information on the health and physical activity habits of the workforce, and on the values, attitudes, preferences and obstacles related to physical activity can be used to design a programme and as an evaluation tool to measure its success.
Regular health examinations	Can measure a worker's need for physical activity and identify any health issues that could influence the choice of sport.
Fitness tests	Can measure the levels of various aspects of fitness; the need for physical activity for different purposes; can be used to follow-up the effects of exercise programmes.
Prompts and possibly incentives	Can encourage workers to use opportunities to be physically active during the working day, such as using the stairs instead of elevators and walking to communicate with workmates instead of using phone or email.
Counselling and guidance	Provides individual help on suitable physical activities; can be motivating.
Exercise groups	Groups of individuals with the same goals, motivation and level of skill provide much social support and sharing of experience that can encourage people to start and then continue exercising; Peers with some training in how to lead exercise groups have been shown to be a good way to provide the necessary leadership.
Exercise events	Either non-competitive and competitive; can provide opportunities to try a new sport, and can encourage more exercise by providing a goal to work towards; can increase social coherence at work. These events can be offered also to family members in order to widen the scope of the promotional efforts.
Facilities, equipment, clothing	Can be organized and paid for by the employer, either in part or in full.
Subsidies	Can be provided by the employer for the fees of a gym or other sport facilities outside work, either in part or in full.

Elements of a strategy for the promotion of physical activity for health	
Awards, prizes	Can be provided for either performance or participation.
Incentives to walk or cycle to work	Can include provision of facilities to change clothes and to wash; to park bicycles; improving road safety (in collaboration with the community), financial incentives.
Exercise breaks	Can be provided during the working day.
Monitoring	Of physical activity at work; timely feedback of the findings.

Who can do what?

Employers	• Include physical activity for health as an important part of the integrated worksite OSH policy; • contribute to the development the policy as a collaborative effort with other partners; • commit to support it financially and symbolically; • motivate, also by their own behaviour, others to adopt a physically active lifestyle.
Workers and their representatives	• participate in the development of the policy by expressing the views, needs, expectations and suggestions and implementing it; • promote acceptance of the policy among workers.
Occupational safety and health specialists	• provide their professional knowledge of the physical activity needs at the workplace; • provide information on effective ways of implementing the policy.
Community representatives and providers of sport and exercise services	• provide information of the possibilities for sports, exercise and other physical activities in the community; • supply information on the conditions for the use of sports facilities.

Physical activity presentation

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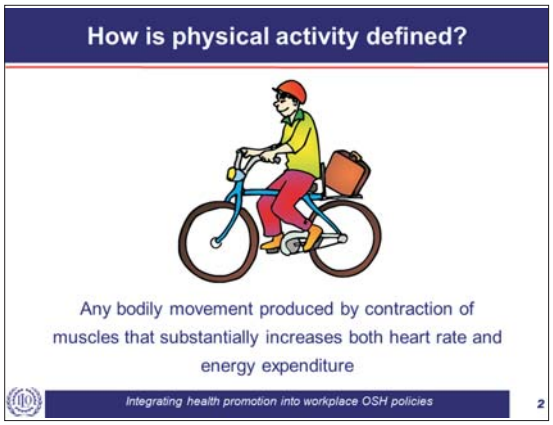

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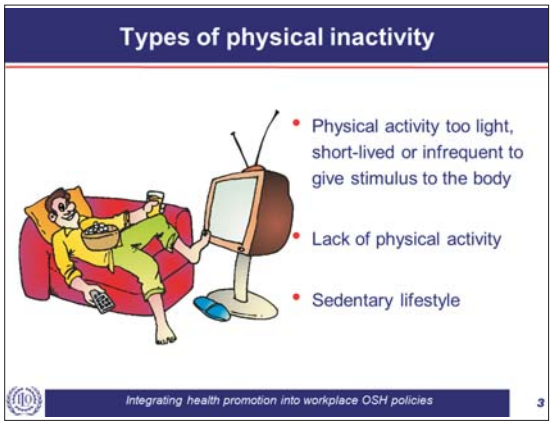

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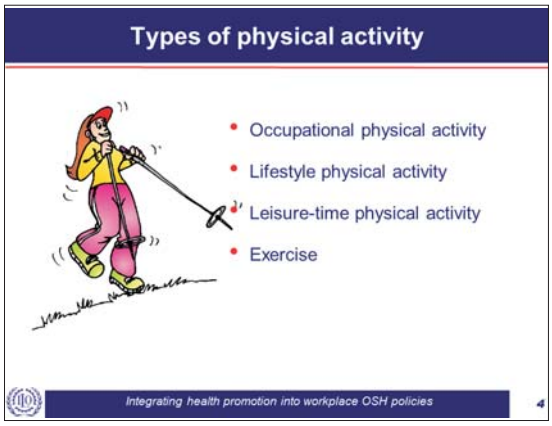

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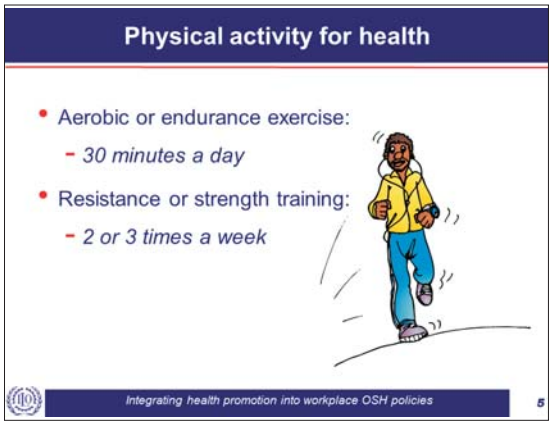

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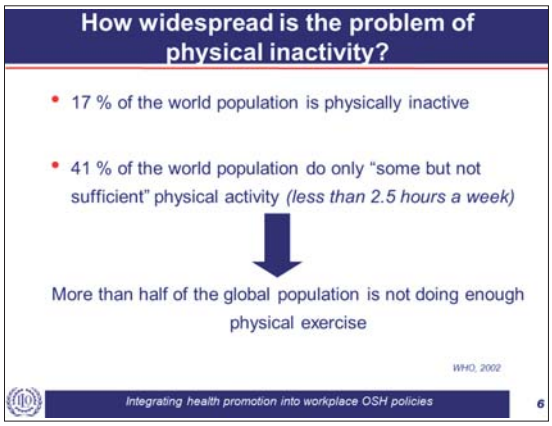

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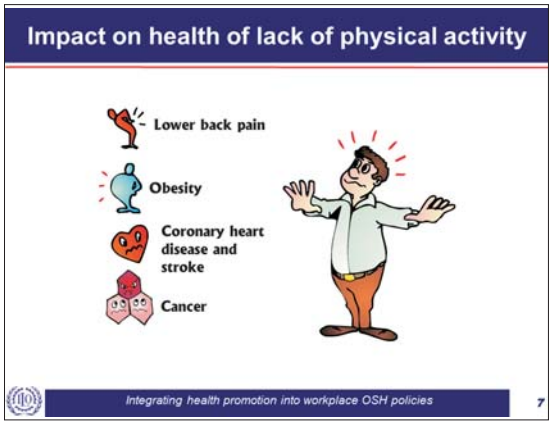

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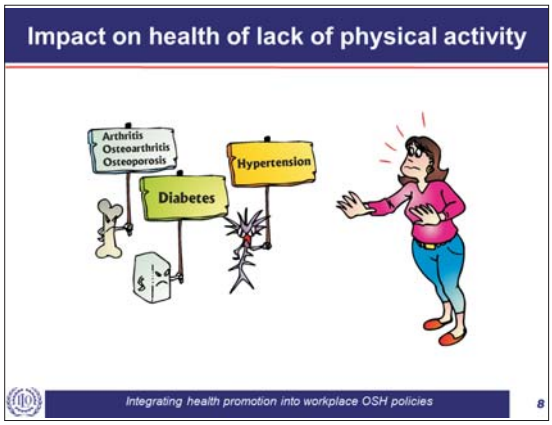

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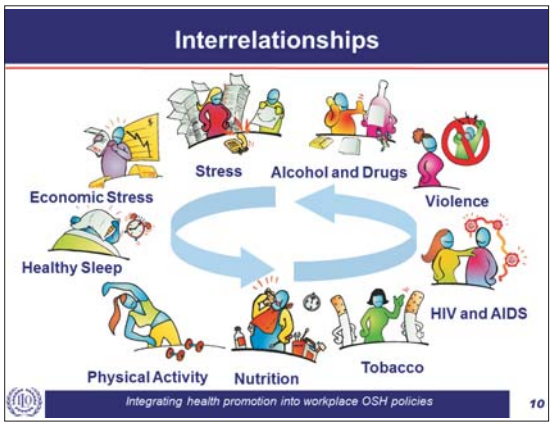

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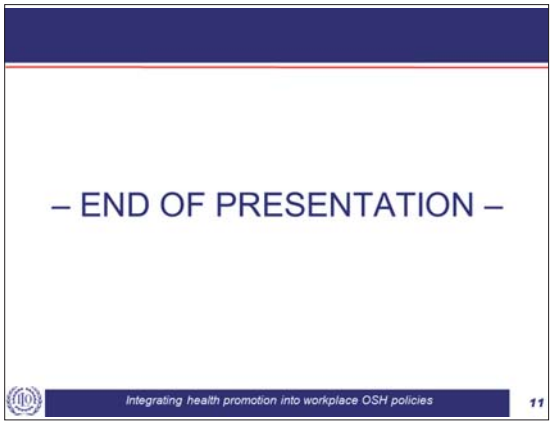

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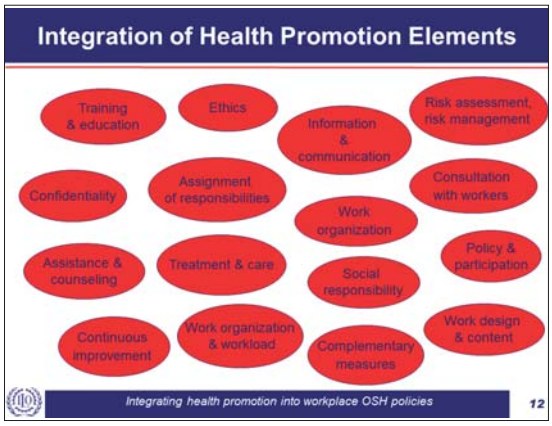

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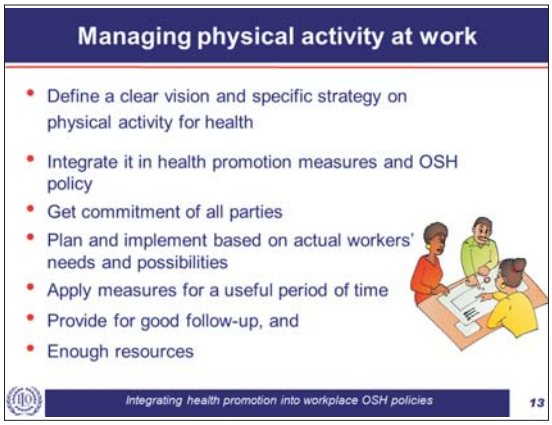

Slide 14

Slide 15

Slide 16

Who can do what?

OSH providers can:

- Provide information on effective ways of implementing the policy
- Make available their professional knowledge on physical activity for health at the workplace
- Contribute to work design for:
  a) less sedentary work
  b) work which does not cause physical strain on workers

Integrating health promotion into workplace OSH policies 16

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Slide 17

Who can do what?

Community representatives and sport facilities can:

- Provide information on possibilities for sports and exercise and the use of sports facilities
- Give priority access to sports groups from enterprises

Integrating health promotion into workplace OSH policies 17

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Slide 18

Elements for a strategy of promotion of physical activity

- Information
- (Peer) education
- Questionnaires
- Regular health examinations
- Fitness tests
- Subsidies and incentives
- Counselling and guidance
- Exercise events
- Facilities, equipment, clothing
- Awards, prizes
- Incentives to walk or cycle to work
- Exercise breaks
- Monitoring

Integrating health promotion into workplace OSH policies 18

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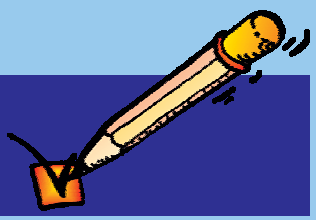
Exercise 2:
Simulation - Physical Activity



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* **module, in this simulation exercise, you and your management team will continue to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.**

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 4 November.

The economic situation seems to be slowly improving, although the exchange rates are not likely to recover any time soon. The sales manager has been instructed to focus on expanding domestic activities to try and make up for the shortfall in revenue. However there is little money available to fund extra production in advance, so time pressures on staff remain high.

In follow-up meetings which analysed the results of actions taken on nutrition in the enterprise, there has been some disappointment that a greater impact was not achieved. The executive director asks if something has been missed.

The director of human resources heard recently at a meeting of local business leaders about a government initiative to combat obesity by encouraging more physical activity for health in all spheres of life, including work, and suggests that this might help. At the meeting, there was also some discussion about how senior managers can function as role models (negative or positive) for the rest of the staff.

The executive director said that although the financial situation is tight, she is prepared to make some investment into measures which have been shown to improve health and productivity.

The management team should now review procedures within the plant to see if changes could be made to encourage more physical activity for health as part of work, without losing efficiency or putting strain on workers' health.

1. Decide what action should be taken.

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The action taken on nutrition should be reviewed and modified to coordinate with any action taken on increasing physical activity for health.

2. Decide what action should be taken.

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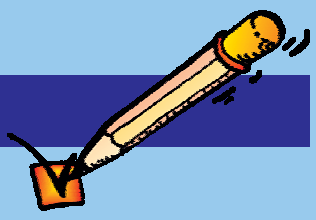
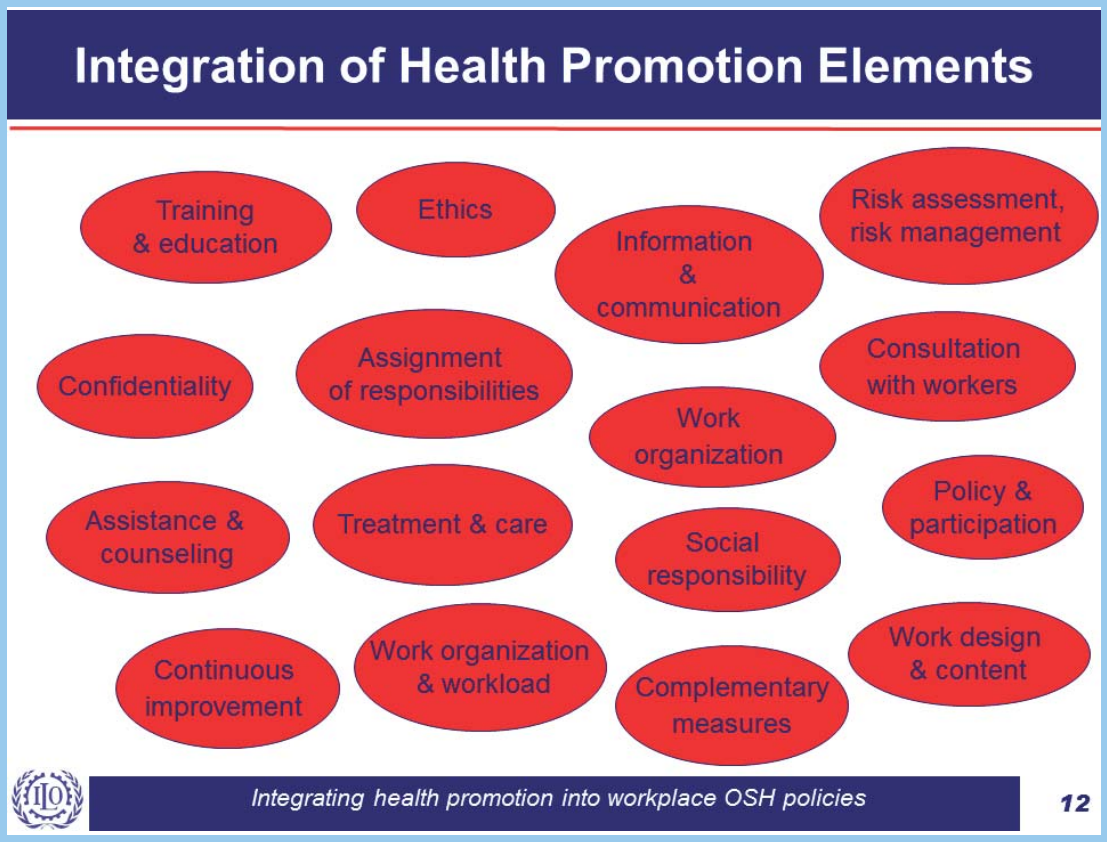
Exercise 3: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Physical activity for health*.

After that, use the checklist at the end of this module to choose the measures relevant to *Physical activity for health* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time:

Step 1: The instructor, together with the participants, selects the policy elements that are particularly relevant to *Physical activity for health* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Physical activity for health* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *Physical activity for health*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Physical activity for health* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their occupational health and safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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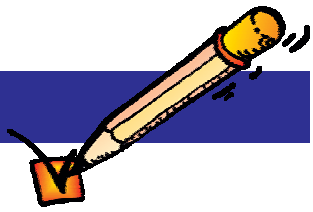
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist



Action–oriented checklist for addressing physical activity for health			
1.	**Policy and participation**		
1.1	Adopt a comprehensive approach to physical activity for health at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of physical activity for workers' health, well-being, and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of policy and preventive programmes.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and physical activity for health in the health promotion programme, with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly, in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.	**Training, Education, Information and Communication**		
2.1	Ensure that information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and physical activity for health and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment

2.2	Widely disseminate the policy and the plan of action through all means possible such as notice boards, mail, payslip inserts, special meetings, induction courses, and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to physical activity, including where support is available, both in-house and outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.	**Work organization, Workload, Design and Content**		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Make sure that working hours and the length of breaks are reasonable to allow proper rest.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Ensure that there is adequate ventilation and thermal control in the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Make provisions to encourage walking or cycling to work where appropriate.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.4	Provide adequate and clean toilets, as well as changing and showering facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.5	Provide medical examinations for all workers, including recommendations on how to improve their health through physical activity.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.6	Assist in the provision or access to appropriate equipment for physical activity and exercise in the workplace or elsewhere.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.7	Make arrangements for storage facilities at work for sporting equipment and gear, when appropriate.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.8	Develop or improve recreational and/or sport facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment

International
Labour
Office
Geneva

Healthy sleep

Objective

The participant will be able to identify the elements of a health promotion strategy which provides the basis for improving the quality of sleep.

Introduction

Sleep is both a personal and a workplace issue

Working and sleeping habits have changed dramatically in modern times. Sleep is now commonly sacrificed for work, recreation, and other activities.

Medical research is revealing the importance of adequate sleep and bringing greater awareness of the negative impact on health, productivity, and safety of extreme sleep deprivation, chronic insufficient sleep, and sleep disorders.

Increased risk of depression, obesity, hypertension, type 2 diabetes, heart attacks and strokes are some of the deleterious consequences of the cumulative effects of sleep loss and sleep disorders when combined with other psychosocial factors.

Key facts about sleep

- Sleep is a basic need.
- Sleeping needs change with age.
- An average adult needs between seven and nine hours of sleep in every 24-hour period, while children and adolescents require more.
- Sleep deprivation increases irritability and impairs performance.
- Sleeping for five hours or less per night routinely is associated with a 39 per cent increased risk for heart disease.
- The lack of sleep is especially dangerous in some jobs, e.g. transportation, nuclear and chemical plant operators, surgeons, etc.
- People can do more to improve their sleep than is commonly known.

The impact of lack of adequate sleep on work productivity and safety:

- work errors;
- reduced concentration and memory;
- slower reaction time;
- poor work performance;
- accidents;
- impaired thinking and learning;
- reduced attention;
- impaired decision making.

Healthy sleep and work organization

- Working time schedules may conflict with optimal sleep.
- Extended shifts, frequently rotating shifts, and night shifts without adequate sleep have all been shown to reduce productivity, increase error rates, and increase the risks of accidents.
- "Jetlag" is suffered by international business travellers as they rapidly cross time-zones; it leads to sleepiness during scheduled waking hours and difficulty sleeping during scheduled sleeping hours, together with stomach problems, irritability, and other chronic problems.
- Workers on rapidly rotating shifts driven by their work schedule can suffer similar symptoms to jetlag where the body's internal sleeping and waking activities do not match the person's sleep and wake patterns.

Managing work organization for healthy sleep

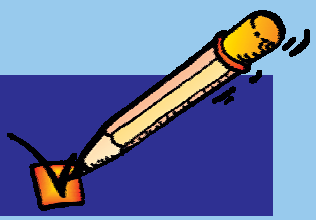
Tips for non-shift work:

- do not encourage working long hours and overtime;
- establish a non-intrusive way of registering hours worked;
- provide supervisors with necessary training;
- have flexible working hours, where possible;
- set up an assistance program;
- incorporate cultural practices and norms into workplace policies and practices.

Tips for shift work:

- no "one-size-fits-all" strategy;
- focus on a practical and realistic approach;
- guidelines on the use of double shifts;
- identify ways to meet extra staffing needs as an alternative;
- offer commuting assistance after late or long shifts;
- ensure optimal conditions of sleeping facilities on site;
- manage the use of financial incentives;
- allow for the fact that individuals have different levels of tolerance for extended wakefulness (long shifts).

Exercise 1: What went wrong at Greentree Tech Support?



Greentree Tech Support is a telephone-based computer support company that recently became a 24-hour operation. There are now three shifts: the day, evening, and night shifts. There is no law regulating night shift scheduling, and Greentree Tech Support had no specific strategy regarding the scheduling of night work.

Joseph was offered a position as manager of the night shift, but there were difficulties from the beginning. He was sleepy for much of his shift and spent extra time double-checking his work and the work of others for mistakes. Several times, without meaning to, he found himself becoming irritable and curt with phone customers. As a manager, Joseph was required to work double shifts when there were absences on the evening or the night shift. He had no workplace policies to help him manage the additional demands in an orderly way, some of which were related to the religious traditions of some of his co-workers. To keep different groups from coming into conflict, he ended up taking even more shifts himself.

It took months to get used to leaving for work in the dark, and on the way home in the mornings he was nervous about falling asleep while driving. He never felt like he slept very deeply during the day, even with darkening curtains. His neighbours were active and noisy during the day and his children were excited to see him when they came home from school in the afternoon. As months went on, Joseph found that he was gaining weight. He was hungrier than before, and it was relaxing to eat when he got home.

One morning, while Joseph was driving home from work after a stressful shift, he nodded off behind the wheel and his truck was hit by a van. Joseph was not hurt badly, but in the hospital he was given a neck brace for his injuries and his doctor commented on his recent weight gain.

Joseph believed his difficulties began when he went to work at night. He then spoke with his boss and asked for help educating the other workers about coping with the risks of shift work, but she said she couldn't see the difference between working during the day and working at night and that it was the person's own responsibility to get enough rest to do a good job. Joseph's co-workers were reluctant to speak up about similar problems they were having.

Eventually Joseph brought the issue to the trade union. There was a meeting but no one from senior management showed up. Joseph gained some support for his requests for educational programmes informing the workers about the risks of extended shift work. Others thought that regulating shift work was a management decision and they could do nothing to change it.

Nothing happened after the meeting. The trade union representative said that little could be done unless there is a strong support from the workers and senior management. Although several workers supported Joseph's view, other colleagues started to ignore him, and he suspected they were talking about him behind his back. Joseph found it increasingly difficult to be productive at work and brought his stress and frustration home to the family. He had more difficulty sleeping, and his wife and children felt distressed at seeing him so unhappy. He asked for an appointment with the company physician, but the doctor told Joseph to call a psychologist if he was having nervous problems. From being a dedicated and skilled worker, Joseph has become unhappy, unhealthy, and socially more isolated.

You have 15 minutes to complete this exercise individually.

Analysis: What went wrong at Greentree Tech Support?

Management commitment:

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Workplace policy:

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Workers' involvement:

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Information and education:

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Cost-benefits analysis:

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Impact on family and community:

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Cultural traditions, practices, and norms:

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Measures to be taken:

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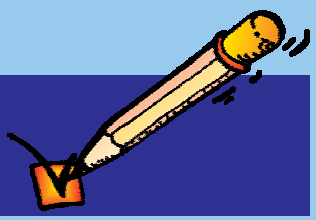
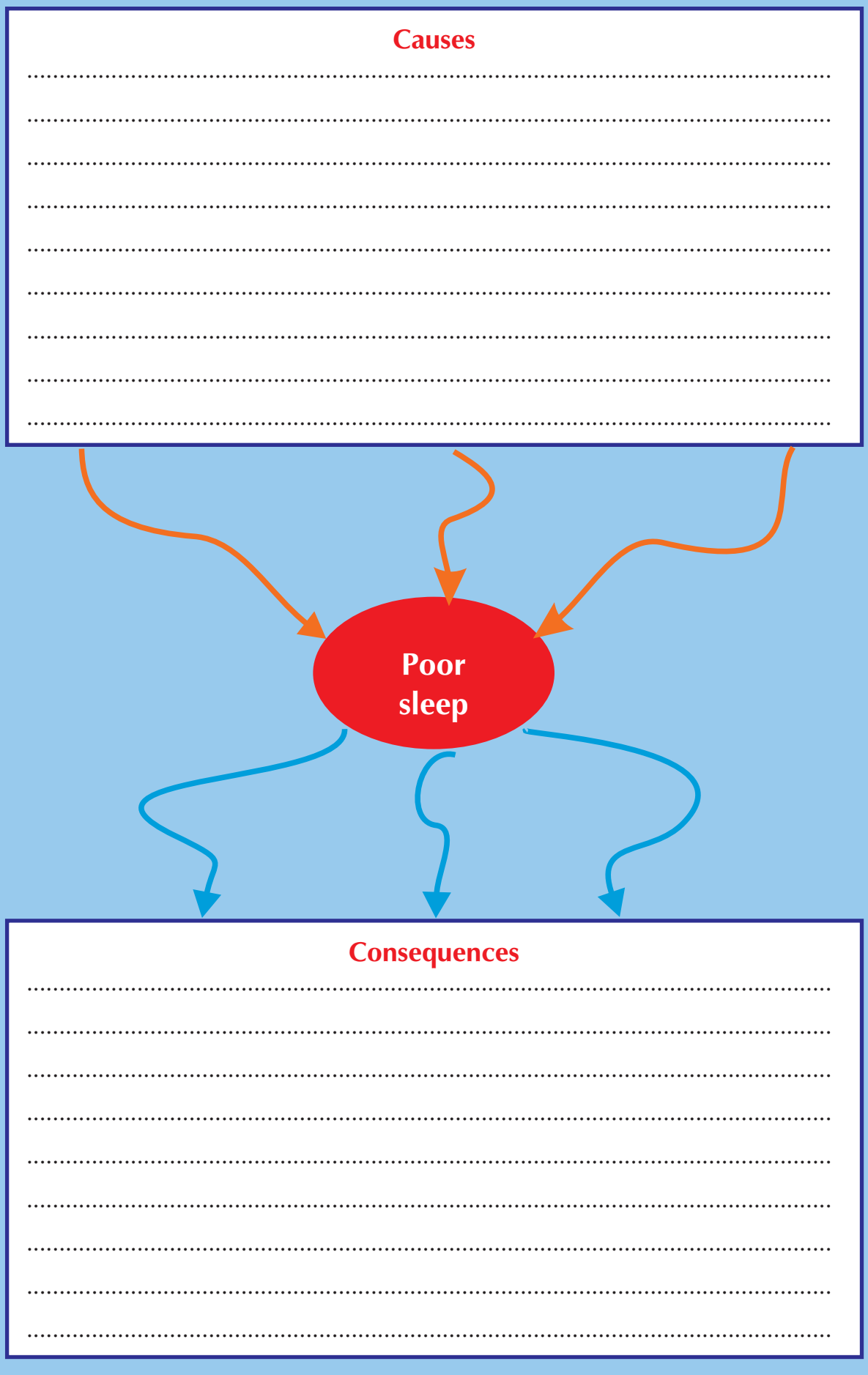
Exercise 2: Causes and consequences of poor sleep

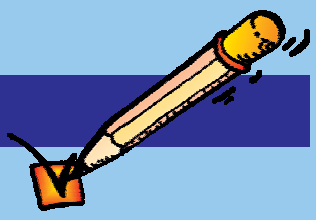


Fill in the diagram on the following page with as many details as possible about the causes of poor sleep and its consequences. Also consider aspects related to work, health and private life; remember to include any aspects which may be different for women and men. Are there any relevant connections with the other topics covered in SOLVE?

You have 5 minutes to complete this exercise individually.


Causes
Poor sleep
Consequences

Exercise 3: Sleepy on the job



Look at this list of effects of poor or insufficient sleep. Write in each box how this impacts specifically on your own work and on your workplace in general. Are some jobs more affected than others? Are any jobs not affected at all?

You have 10 minutes to complete this exercise individually.

Decreased alertness:

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Lower concentration:

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Reduced efficiency of actions and mental processes:

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Difficulty paying attention:

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Slow reaction time:

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Poor decision-making:

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Poor memory:

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Loss of situational awareness:

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Reduced ability to learn:

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Handout 10.1

Sleep and work

Short-term measures to increase productivity using night or shift work can have a negative impact on health and often result in an overall productivity decline and an increased risk of accidents. This is because sleep restores brain functions and regulates the body's metabolism. Decreasing hours of sleep in a desperate attempt to get more done is counterproductive both in terms of work performance and health.

In children, lack of sufficient sleep contributes to shortened attention spans and overactive behaviour. Sleep-deprived adults have shown to have less alertness and ability to cope emotionally, greater irritability, fatigue, increased obesity, and higher risk of cardiovascular diseases.

Mental alertness, accuracy, and ability to learn

Studies show that the degree to which chronic sleep deprivation lowers efficiency is often underestimated. A single sleepless night can impair performance as much as a blood alcohol level of 0.08–0.1 per cent (the legal limit for driving in many places).[1]

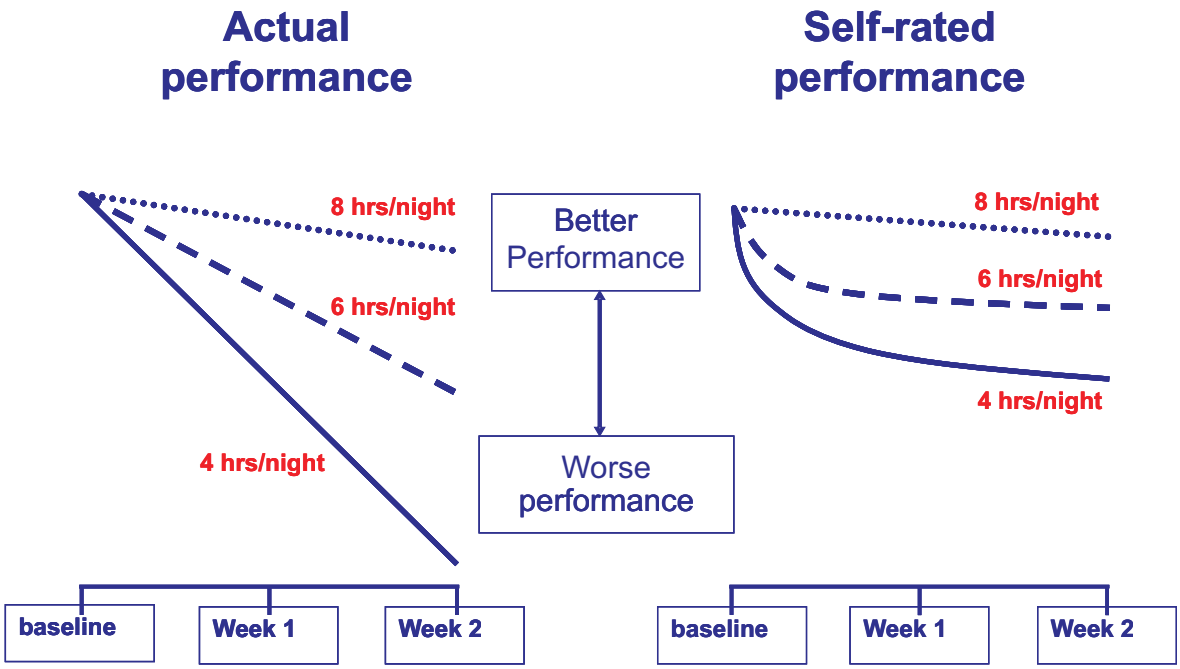

Figure 10.1: Chronic Sleep Restriction and Performance

[1] ILO: *Quality Sleep*, http://www.ilo.org/safework/areasofwork/lang—en/WCMS_118392/index.htm

The cumulative effects of insufficient sleep are worse than many people think. A number of studies have shown that participants performed gradually worse as they slept too little each night. However, in their own subjective perception of their ability, they overestimated how well they were performing as they grew sleepier (Gillberg et al., 2003).

Quality and quantity of sleep

There are many factors that determine how much and how well a person can sleep at any given time.

1. *Individual factors*. They relate to individual characteristics and habits. Avoiding a sleep "debt", sleeping at the right times of day or avoiding harmful effects of drugs and medications are individual habits that together with sleep disorders - such as sleep apnoea or insomnia - can lead to non-restorative sleep and many chronic illnesses.
2. *The physical environment*. Factors such as noise, temperature and humidity, light, and safety have to do with the physical environment around the sleeper. Sleeping in a quiet, dark, and secure environment with a comfortable room temperature and humidity can be key factors in ensuring a deep and restful sleep.
3. *Interpersonal factors*. Meaning the family and the social environment. Sleeping at home, for instance, requires the cooperation of the people with whom we live. Parental duties and sharing a home with individuals who have different biological sleep needs, sleep capabilities, and life demands can be major obstacles to getting a healthy amount of sleep.

Larger social groups also have cultural practices that affect the environment in which a person can attempt to sleep.

Recommendations from an expert group on working time and safety and health

Intervention measures include various options for:

1) creating more appropriate work schedules (working time arrangements and shift work);
2) modifying the working environment;
3) involving of workers' representatives in the design of work schedules; and
4) introducing health training and counselling where appropriate.

Some specific measures include:

- Night work should be avoided or limited where possible.

- Unpredictable, irregular hours, particularly where these are beyond the worker's control, should be avoided or limited.
- Overtime should be limited, distributed between workers, and should not become routine.
- Shift work:
  - Where shifts rotate, forward rotation (clockwise) is preferable.
  - Weekly shift rotation is undesirable.
  - Slow rotation (2-3 weeks) is likely to produce an adjustment in the sleep cycle (e.g. an adjustment to working at night and sleeping during the day).
  - Fast rotation (1-2 days) maintains workers on a normal circadian (daily sleep) cycle.
  - Adjustment of the sleep cycle is preferred for workers whose jobs are routine and therefore particularly susceptible to fatigue effects.
  - Jobs which are mentally stimulating are less susceptible to fatigue effects and probably more suited to schedules where sleep cycle adjustment does not occur.
  - Traditional starting times for shifts, notably 6 a.m. for the morning shifts, may not be optimal. Later starts (7-8 a.m.) should be considered.
  - Shift changes and overtimes are vulnerable points as errors and accidents are most likely to occur.
  - Evidence relating to 12-hour shifts is largely positive, given certain conditions.
  - Where work is extended beyond an 8-hour period, a re-assessment of other occupational risks (e.g. chemical, ergonomic, etc.) should be carried out.

Source: Working time, its impact on safety and health
A. Spurgeon, ILO, 2003.

Healthy sleep presentation

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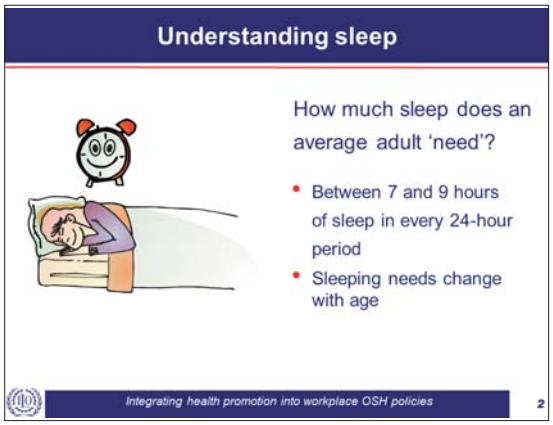

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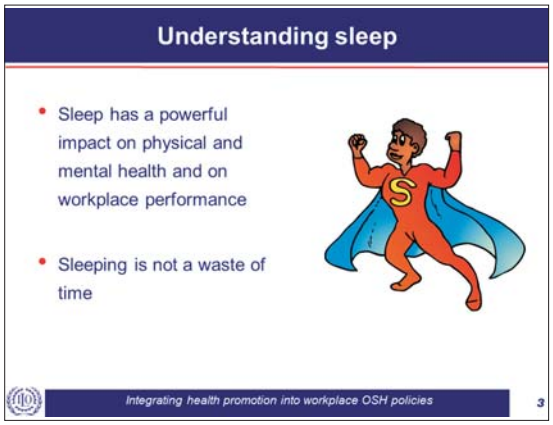

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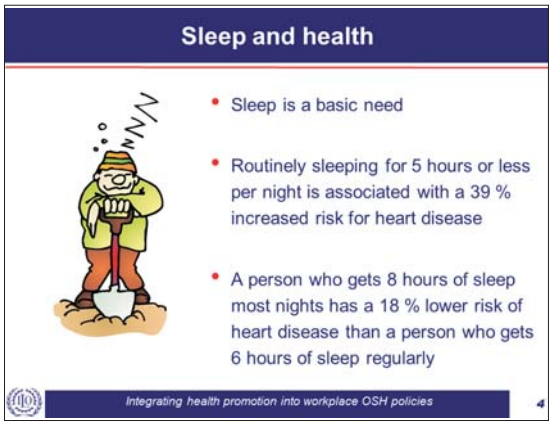

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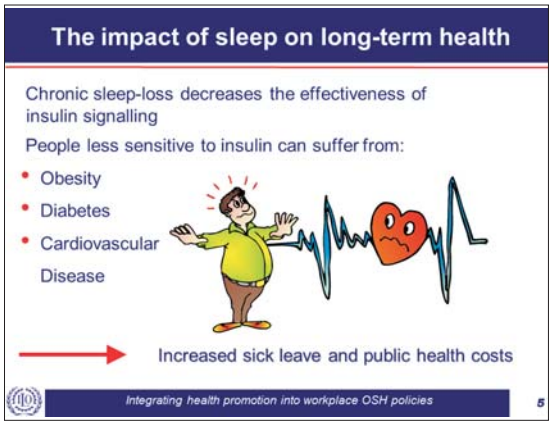

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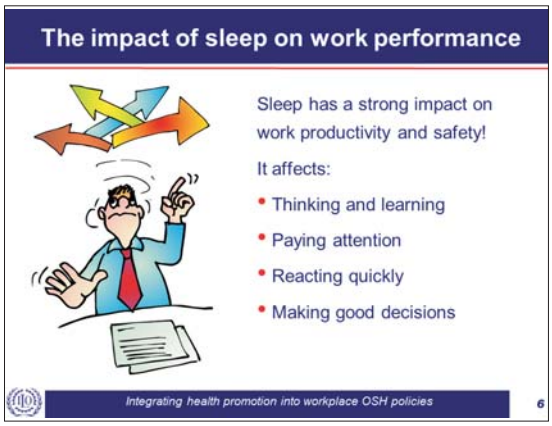

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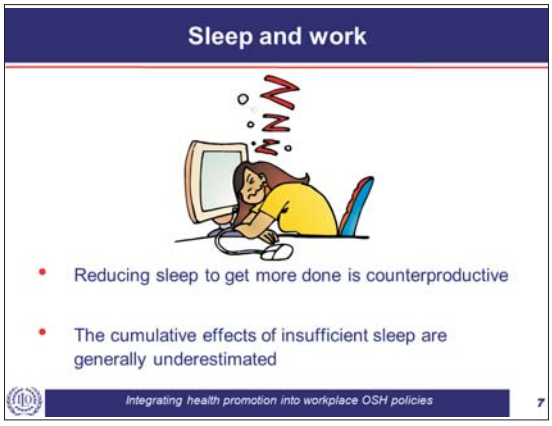

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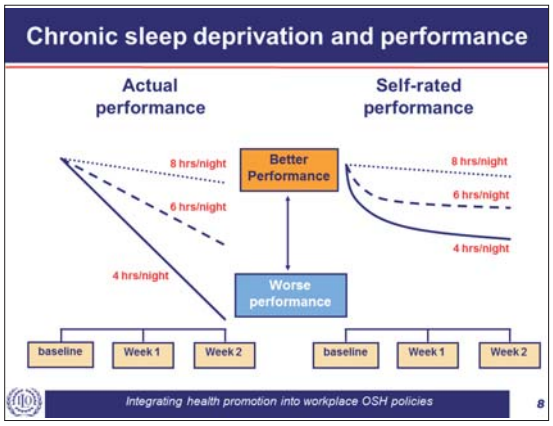

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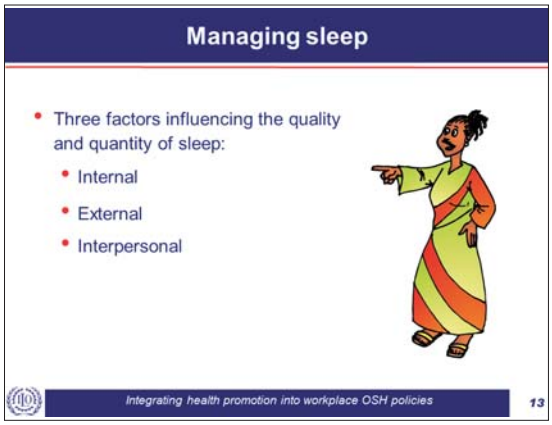

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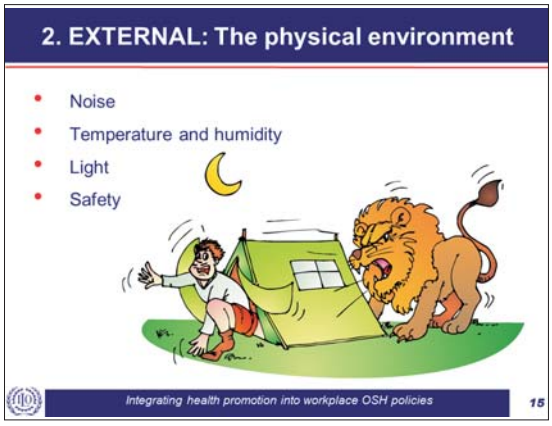

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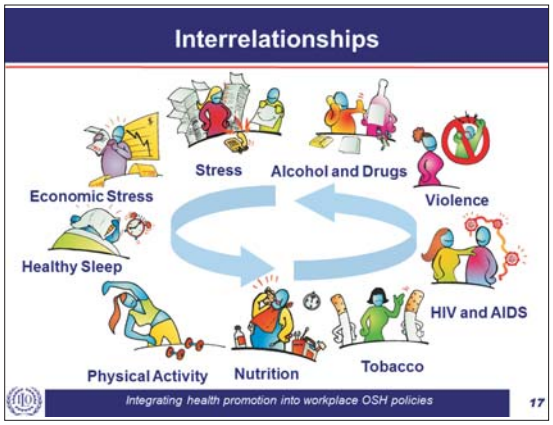

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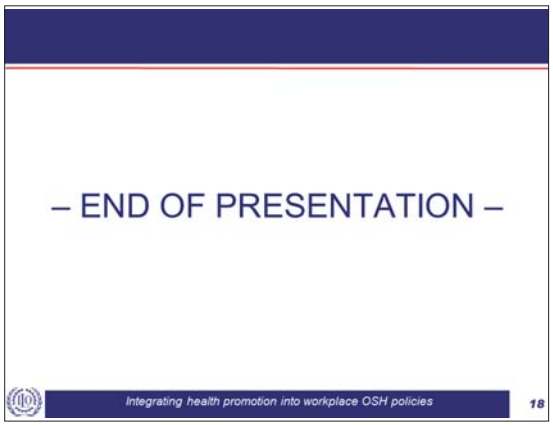

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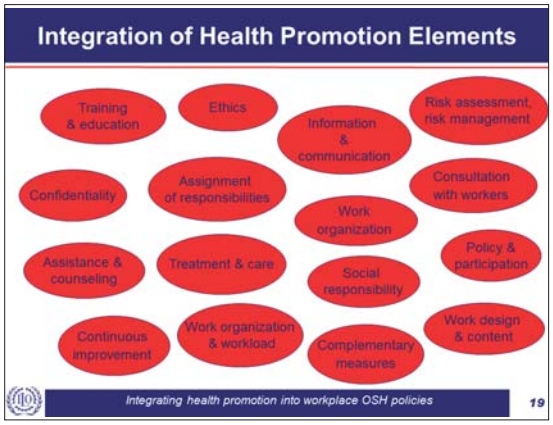

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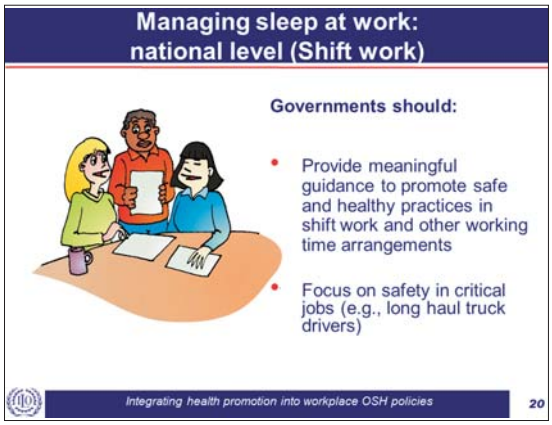

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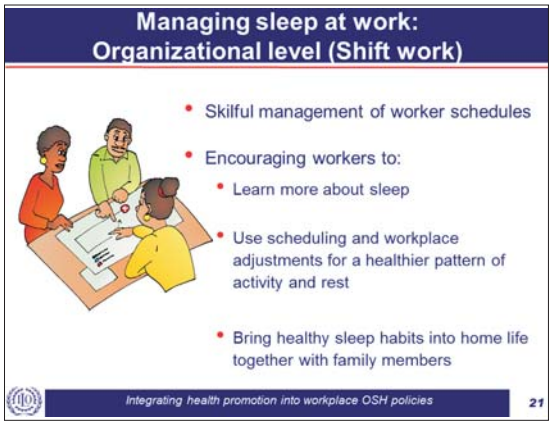

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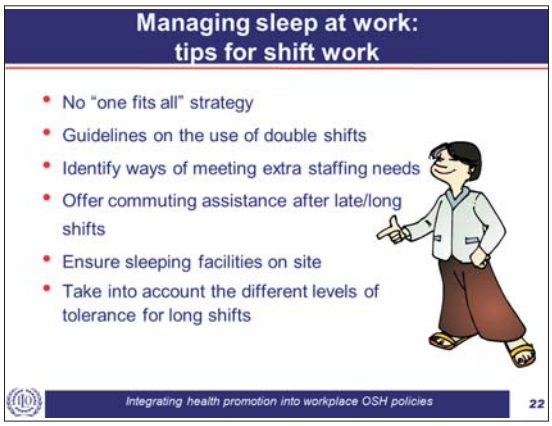

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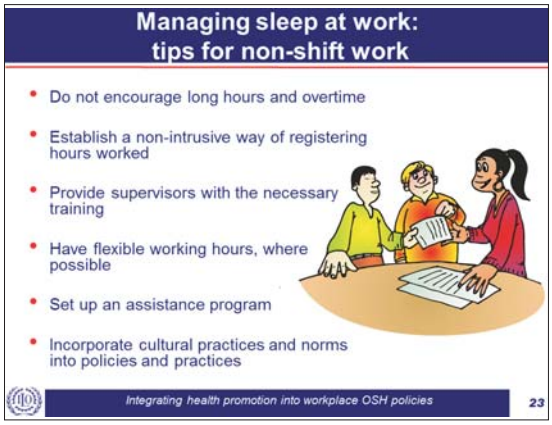
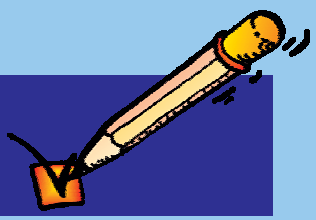


Exercise 4: Simulation - Healthy Sleep



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* module, in this simulation exercise, you and your management team will continue to make operational decisions to solve problems related to health promotion in your "virtual" enterprise.

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 26 February.

The executive director calls a routine management meeting.

She reports that thanks to the efforts of the sales manager and team, domestic sales are showing a positive development, with significant increases in new orders. This is good news for the company's financial health, but increases productivity pressure on workers. The production manager reports large amounts of overtime being worked, including unpredictable schedule changes in order to meet demand.

The director of safety, health, and environment has already registered a steady rise in the number of minor accidents that are often associated with fatigue, and the production manager has anecdotal evidence of several near-miss incidents in recent weeks.

The executive director asks for quality control data to be submitted to the management team as soon as possible. She is concerned not to sacrifice safety, workers' health, and the quality of the company's products in the drive to maintain the production recovery generated by the success of the sales team.

Decide what action should be taken:

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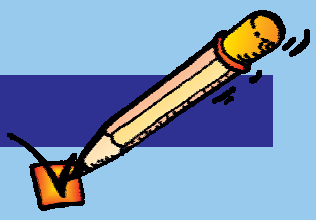
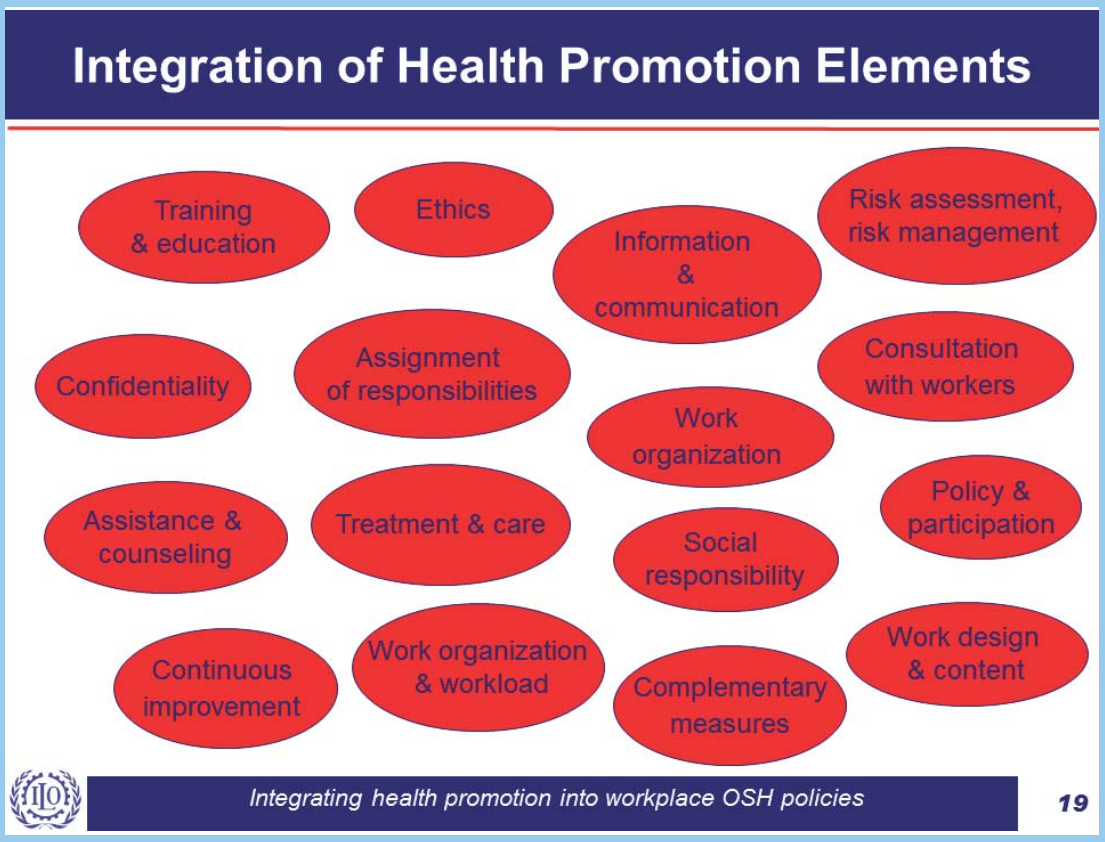
Exercise 5: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Healthy sleep*.

After that, use the checklist at the end of this module to choose the measures relevant to *Healthy sleep* to be incorporated in your workplace health promotion (WHP) programme.

The policy integration exercise will consist of two steps each time:

Step 1: The whole group, together with the instructor, selects the policy elements that are particularly relevant to *Healthy sleep* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Healthy sleep* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy

element relevant to *Healthy sleep*. You and your team should take into account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Healthy sleep* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This exercise will continue from one module to the next, until the *Action* module where each management team will finalize their occupational health and safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist

Action–oriented checklist for addressing healthy sleep at work			
1. Policy and participation			
1.1	Adopt a comprehensive approach to working time arrangements at work and healthy sleep.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of healthy sleep for workers' health, well-being and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate working time arrangements at work and healthy sleep in the health promotion programme with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.11	Ensure that organizational changes are clearly and timely communicated to the workers.	Is action needed?	☐ Yes ☐ No ☐ Comment

2.	**Training, Education, Information and Communication**		
2.1	Ensure that the enterprise or the organization provides information, education and training to increase awareness, knowledge and understanding of healthy sleep and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and the plan of action through all means possible such as notice boards, mail, payslip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on issues related to healthy sleep, including where support is available outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.5	Inform and guide workers about occupational risks associated with lack of sleep, fatigue and tiredness, including interaction with drugs and alcohol.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.	**Work organization, workload, design and content**		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Assign tasks according to experience and competence.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Encourage workers to discuss any conflicting demands between work and home.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Make sure working hours are reasonable.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	Make sure that designation of shift/night work is fair and reasonable.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.6	Rotate staff on particularly demanding jobs.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.7	Ensure appropriate gaps between shifts.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.8	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.9	Regularly assess time requirements and assign reasonable deadlines.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.10	Ensure that working hours are predictable and reasonable.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.11	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Ensure that there is adequate ventilation and thermal control at the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.3	Provide adequate and clean toilet facilities.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.4	Provide medical examinations for all workers, including recommendations on how to improve their sleeping habits.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.5	Where necessary, provide appropriate rest facilities on the worksite.	Is action needed?	☐ Yes ☐ No ☐ Comment

International
Labour
Office
Geneva

Economic stress

Psychosocial risks in times of change

Objective

The participant will be able to identify the elements of a health promotion strategy that provides the basis for a response to economic stress at work.

Introduction

What is economic stress?

In Module 3 – *Work-related stress* – we saw that people experience stress at work when they perceive that there is an imbalance between the work demands made on them and the resources they have available to cope with those demands.

We also pointed out that stress becomes a risk to safety and health when work exceeding the person's capacity and ability to cope is prolonged.

Economic stress refers specifically to stress that is associated with psychosocial risks related to uncertainty regarding one's income and financial situation in relation to employment security or one's unemployment. In the workplace, economic stress can result from doing several jobs in order to make ends meet. Workers may experience economic stress in times of change, if their company is downsizing, restructuring, or merging with another company. In the worst case, workers may suffer from economic stress if they become unemployed. Economic stress can affect a person's psychological and physical health.

Types of economic stressors

Three of the most important economic stressors are: unemployment, underemployment, and job insecurity.

1. Unemployment: loss (or lack of) employment and loss of income.
2. Underemployment: the extent to which one's current employment situation falls short of one's idea of "satisfactory employment", when workers are underpaid for their work, or when they are asked to work fewer hours than they would like.
3. Job insecurity: When the employment situation is perceived as unstable or at risk.

What causes economic stress?

Many different factors can lead to workers experiencing economic stress, either by being laid off, by being underemployed, or by perceiving that their employment situation is insecure. These factors can be summarized into four categories: economic factors, organizational change characteristics, worker characteristics, and employment characteristics. Any one of these factors can cause workers to experience economic stress.

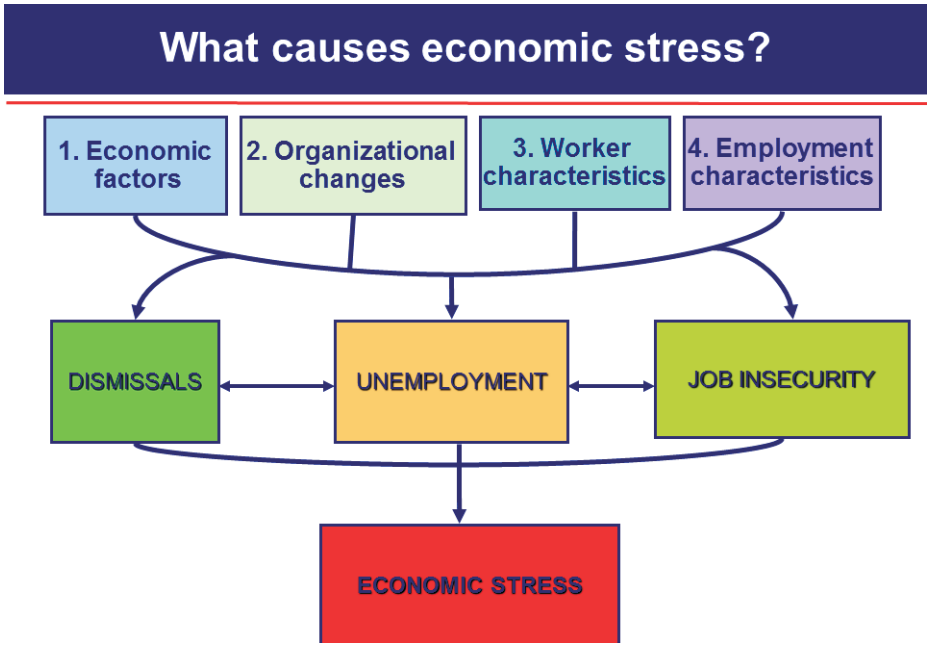


Fig. 11.1 Factors causing economic stress.

Warr's "Vitamin Model"

According to Warr's "vitamin model" of work and unemployment, individuals require nine environmental "vitamins" in order to stay psychologically healthy:

- Two of these "vitamins" are the very basic needs of money and physical security.
- In addition, workers need a number of "vitamins" related to what they do in their work: variety, opportunities to use the skills they have, a degree of control over what they do, externally generated goals to pursue, and environmental clarity which means knowing what their role is in their job and how it will develop in the future.
- Finally there are social "vitamins", such as opportunities for contact with other people, or having a valued social position.

When individuals are deficient or malnourished in these vitamins, poor psychological health can result.

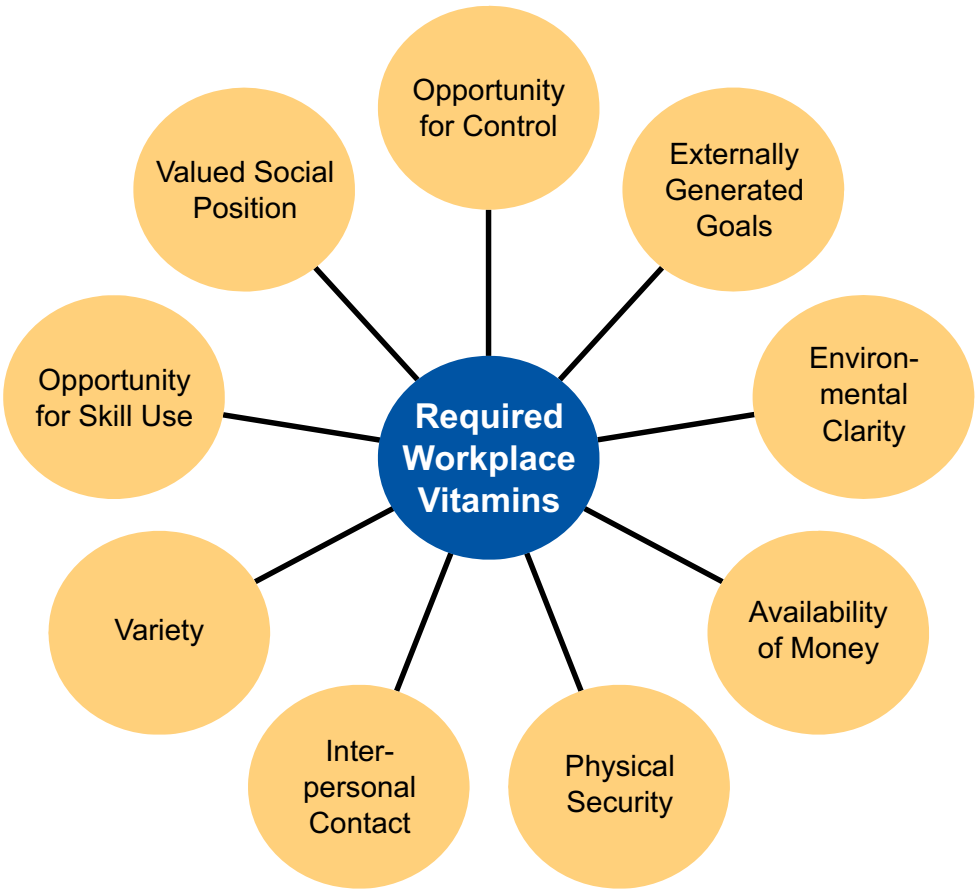


Figure 11.2: Warr's Vitamins model of work and unemployment, 1994.

Consequences of economic stressors

Stress related to unemployment, underemployment, and job insecurity can have very negative effects on the psychological and physical health of the affected individual. The following table shows the possible physical and psychological effects of stress due to being unemployed.

PSYCHOLOGICAL EFFECTS	PHYSICAL EFFECTS
• Worrying; • strain; • stress; • hostility; • depression; • anxiety; • alcohol abuse; • violent behaviour; • anger; • fear; • paranoia; • loneliness; • pessimism; • despair; • social isolation; • psychiatric illness; • suicide attempts; • low self-esteem; • fewer positive feelings; • lower life satisfaction; • not feeling competent; • fewer feelings of mastery; • lower aspirations; • loss of social identity.	• Headaches; • stomach aches; • trouble getting to sleep; • lack of energy; • ulcers; • high cholesterol levels; • high blood pressure; • contributing or aggravating factors of strokes; • contributing or aggravating factors of heart disease; • contributing or aggravating factors of kidney disease.

In addition, workers do not experience the effects of economic stress in isolation from other people. Co-workers, family members, and society at large can be affected. Economic stress can lead to increased marital stress, divorce and domestic violence. Moreover, children whose parents are experiencing economic stress are also negatively affected: child abuse or children having to move in order for the parents to take up a new job are the most common consequences.

Finally, women tend to experience higher levels of underemployment than men. In addition, if they do become unemployed, they tend to remain unemployed for longer periods of time.

Impact on work:

- lower performance;
- less creativity;
- more quitting;
- more accidents and injuries;
- less loyalty to the enterprise;
- less job satisfaction;
- career frustration;
- lower involvement at work;
- less trust in management.

How can economic stress be managed at work?

- Increasing worker's control over their work.
- Improving organizational communication.
- Allowing workers' participation in decision-making.
- Enhancing the value placed on safety and health within the organization.

Measures to avoid layoffs

Many alternatives to layoffs exist and involve re-organizing staff, development of labour management policies by companies, and assistance from the State.

The following are some examples of on-going measures to deal with the crisis and the recession:

Lending workers to other workplaces

In times of crisis some enterprises have explored lending workers to another factory that had more orders than they could fulfil for a short period and as an alternative to dismissal. The manufacturer continues to pay its staff's wages, but invoices the amount to the other factory.

Cross-training

Training staff to carry out a variety of tasks, so they could be employed where they are most needed is another alternative. For example, in a hotel, administrative staff such as secretaries can be trained to take on serving work at banquets when they are not needed in the office.

Unpaid leave

Some big firms are offering their workers one month of unpaid leave to be taken at some time during the first six months of the year. In one case, about 90 per cent of staff agreed to the deal, which cut payroll costs by 17 per cent.

In some countries, there have been agreements between governments and national companies to reduce workers' hours and pay, but the local government pays the shortfall to workers out of its unemployment benefit scheme. Participating companies appreciated not having to fire staff with key skills.

Cut wages

Some companies simply reduce wages to cut costs. To make this more equitable, two international companies reduced pay by only 5 per cent for salaried workers but by up to 20 per cent for senior executives.

The role of trade unions

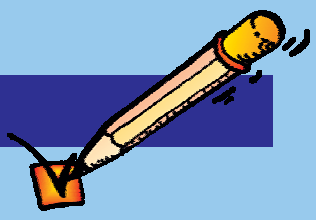
Many trade unions provide advice and guidance to members on how to encourage employers to find alternatives to layoffs during the crisis. For example by using their web site or an electronic newsletter to suggest options like voluntary layoffs, job sharing, and shorter working hours; information on how to negotiate alternatives to layoffs through collective bargaining; or other possible measures for avoiding cuts such as changing working conditions, redesigning work, and training in new skills.

Measures to avoid layoffs: reducing non-staff related costs

Potential avenues for saving:

- energy bills: this has the additional advantage of being environmentally friendly;
- stationary supplies: a telecom firm decided to buy only the most essential office equipment;
- catering: one company stopped providing free lunches on Fridays; another replaced the yearly office party in a top hotel with a family-friendly self-catered barbeque;
- training: an advertising agency still provides training but at a lower cost, using fewer outside consultants and utilizing in-house skills instead;
- *quid pro quo* arrangements: a marketing company was able to offer marketing services to the owners of the office they leased in return for reduced rent.

Exercise 1: A hospital merger



PART I

You have 5 minutes to read the text individually and jot down some answers.

Then you will have 10 minutes to answer the questions in groups.

At the end of part III the answers will be discussed in plenary.

Micah was a happy-go-lucky soul for whom most things in life had gone well. He liked his job as a nurse in a local hospital, because he had some responsibility, but also contact with people and the ability to help them. His salary allowed him to take on some financial commitments which made his life a little better, such as a nice place to live, and even allowed him to save a little for the future. His wife was expecting their first baby, so this financial security had become more important to him recently. Micah liked to do sport in his spare time, and his income allowed him to buy the equipment he needed to go out and socialise with his teammates.

About six months ago there began to be rumours of a merger between the clinic where Micah worked and a bigger hospital further away in the next big town. There was much speculation about job losses and about which wards would stay and which ones would be transferred away. The information provided by the management was different to what the unions were saying, and workers in each institution were hearing different things. Micah was particularly worried. He could neither afford to lose his job, as there was no other alternative employer in the town, nor could he move because he was the only member of the family left in the town to look after his elderly mother who was too frail to move away.

1. What effects could this situation have on Micah's job performance?

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2. What effects could this situation have on Micah's health?

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3. What effects could this situation have on Micah's family and social life?

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4. What demands are being placed on Micah?

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5. What does he have control over in this situation?

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PART II

You have 5 minutes to read the text individually and 10 minutes to complete this exercise in groups.

With time Micah noticed changes at work. He and his colleagues were more irritable because they felt they were competing with each other for disappearing jobs. The maintenance and upkeep of the building changed too, as nobody was certain whether it was worth the effort to keep it clean and tidy. No clear messages came from management, whether slackness was not acceptable, or about the future of the different wards and jobs.

One day Micah slipped on something on the floor while he was lifting a patient. Although not seriously hurt by the incident, the patient became very angry and verbally abused Micah in front of his supervisor. Later that day Micah noticed his back beginning to hurt and it got worse towards evening. Micah's supervisor grudgingly accepted his sick note from the doctor for two weeks off work. Micah was extremely worried about how this affected his chance of staying in his job.

6. What effects could this situation have on Micah's job performance, once he is back at work?

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7. What effects could this situation have on Micah's self-esteem?

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8. What effects could this situation have on Micah's health? What could the impact be on his diet and exercise habits, his drinking, smoking, and sleeping habits?

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9. What effects could this situation have on Micah's family and social life?

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PART III

You have 5 minutes to read the text individually and 10 minutes to complete this exercise in group.

When Micah got back to work he found a message from management that his ward was to be closed down and that selected workers would be offered the chance to join the merged ward in the bigger hospital 50 kms away. Others would be able to compete for remaining jobs in Micah's clinic, but at a general service and cleaning level rather than as a nurse.

With his back only just back to normal and advice from his doctor to be careful when lifting for the next few weeks, Micah was not even sure he would be a good candidate for the lower level jobs left in his clinic. With the baby due soon, he needed to maintain his health insurance. There may well be some big medical bills to pay if they were to have the best medical care. His wife will get a small income during her maternity leave, and Micah is very unhappy at the thought of her having to take on any of the family's financial burden before she is really able to.

10. What effects could this situation have on Micah's job performance and his attitude towards his employer?

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11. What effects could this situation have on Micah's self-esteem?

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12. What effects could this situation have on Micah's home life?

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13. What effects could this situation have on Micah's health? What could the impact be on his diet and exercise habits, his drinking, smoking, and eating habits?

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Handout 11.1

Global economic crisis

Does the current global financial crisis affect safety and health at work?

With globalization the greater flexibility to respond to production demands has also determined changes in employment patterns and labour relations. As a result, we are witnessing:

- an increase in precarious contracts, in temporary, and in subcontract work;
- downsizing and outsourcing of enterprises;
- an increase in telework and working from home;
- changes in working time arrangements and in working hours;
- changes in the composition of the workforce with:
  - a higher percentage of older workers and women workers;
  - a large proportion of the working population in developing countries engaged in the informal economy;
  - increased mobility of the workforce and migration for work, resulting in cultural and ethnic diversity;
- a decreased rate of unionization and of collective agreements with workers negotiating on an individual basis their conditions of employment.

Companies around the world are:

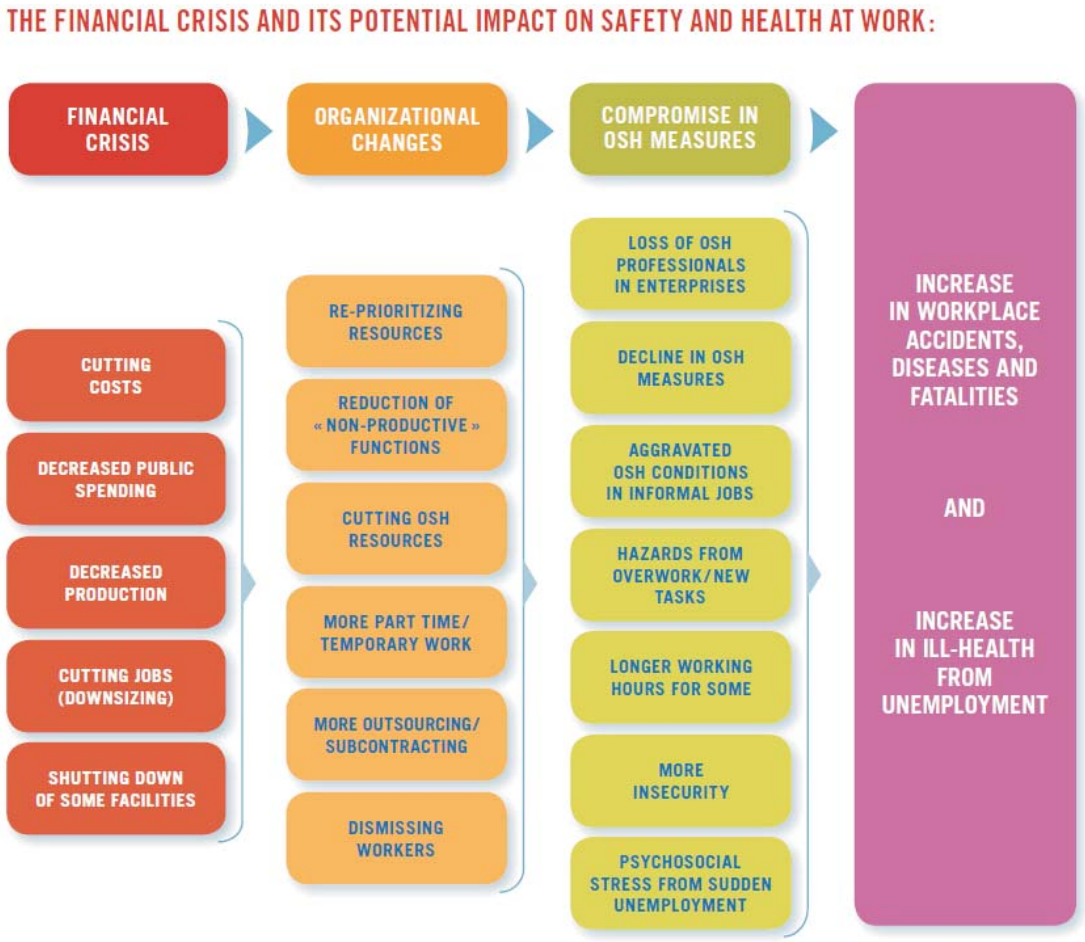
- decreasing production;
- cutting jobs;
- closing factories;
- laying off workers in large numbers;
- increasing part-time and temporary work;
- outsourcing and subcontracting.

These occupational changes affect the type and nature of occupational risks and their management. Changes in the socioeconomic balance are also affecting the workplace. The global financial crisis had undoubtedly an impact on safety and health, and we have to respond to it. As safety and health at work is an essential part of labour relations, it is affected by the same forces of change that prevail in the national and global socioeconomic context.

Reduced production may have reversed the tight schedules and peaks of intensive work in production or services which were prevalent before the crisis; but these may also have increased for certain industries where there has been severe reduction in personnel. Some workers have to work extra hours with heavier workloads to compensate for the lack of human and financial resources, leading to an increase in physical and mental workload and fatigue.

Organizational changes in this period may lead to a decrease in the investment on the management of occupational risks, under the argument of a necessary reduction in costs. This will often be the case in small-scale enterprises which traditionally lack the resources and the know-how to manage occupational safety and health and may consider it a cost rather than an investment.

All the trends mentioned above are expected to continue and be aggravated by this crisis. The outcome being inadequate working conditions, poor safety and health and an increase in accidents, diseases and fatalities for millions of women and men, particularly those employed in precarious and informal work, including younger and older workers, migrants and low-skilled workers.

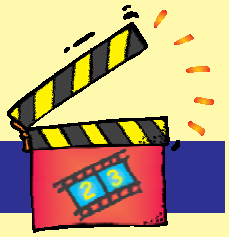


The prevention of stress at work is an important aspect of the ILO's primary goal, on health promotion at the workplace. A comprehensive approach to psychosocial risks related to the changes in the organization of work, working conditions and the working environment would allow for effective programmes, policies and strategies for new models of prevention of stress and other psychosocial hazards at work, particularly in times of crisis and economic recession.

Initiatives to address psychosocial risks at the workplace, such as offering counselling, fostering supportive exit strategies, induction and mentoring of new staff, supportive exit strategies, on-going support during redundancy and addressing major life events by building links with local unemployed people contribute to a safer and healthier working environment, to healthy working practices and to the health and social development of communities.[1]

[1] Adapted from: ILO, *Safeday report 2009*.
Available at:
http://www.ilo.org/legacy/english/protection/safework/worldday/products09/booklet_09-en.pdf.

Economic stress presentation



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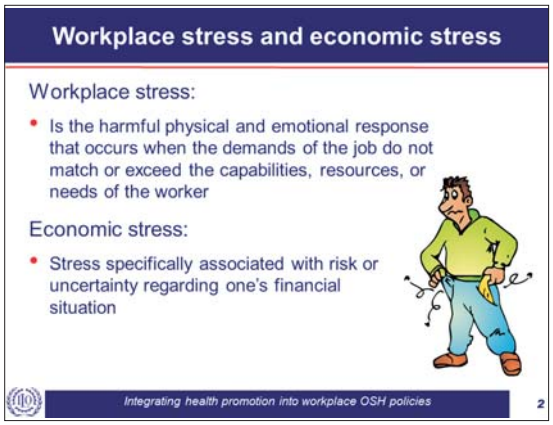

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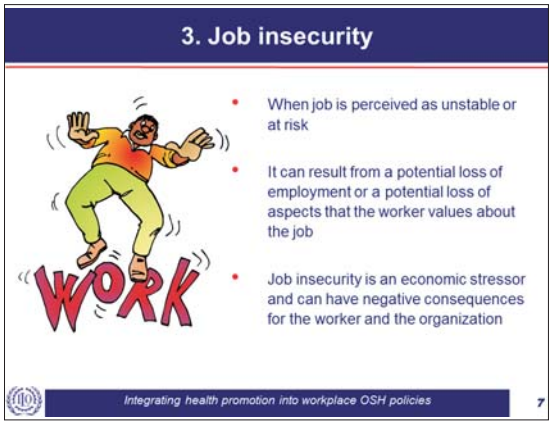

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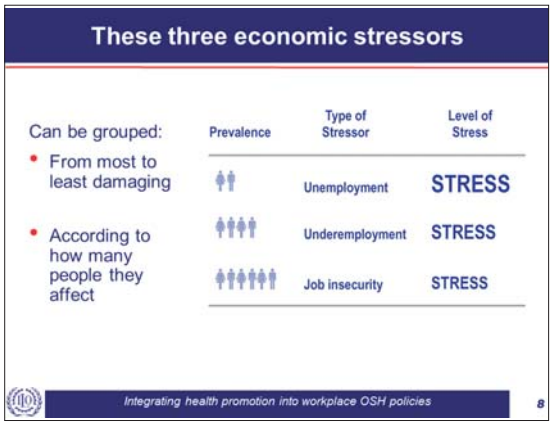

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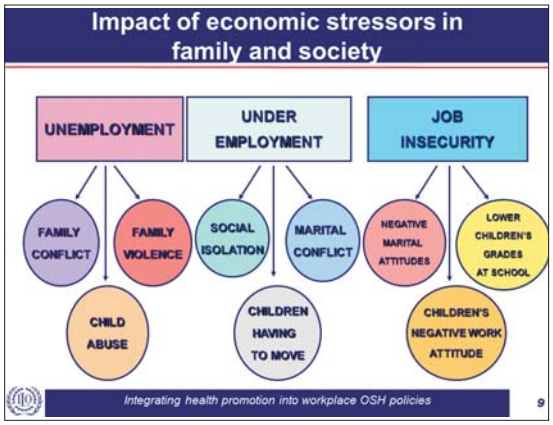

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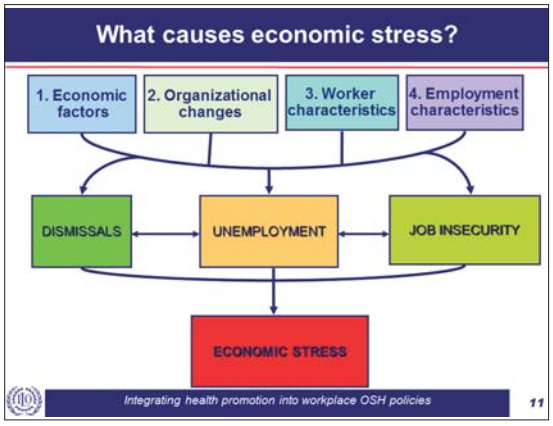

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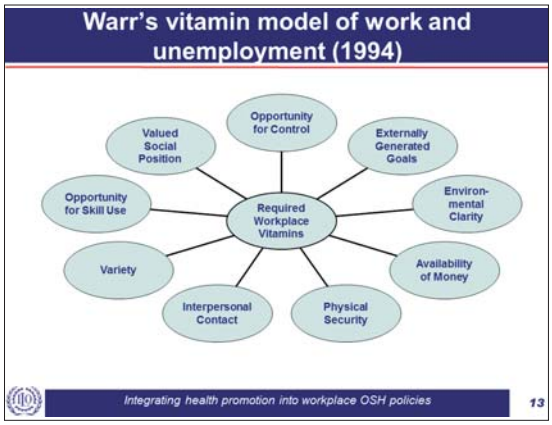

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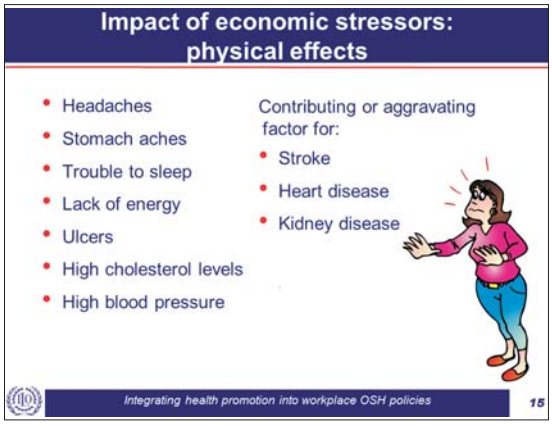

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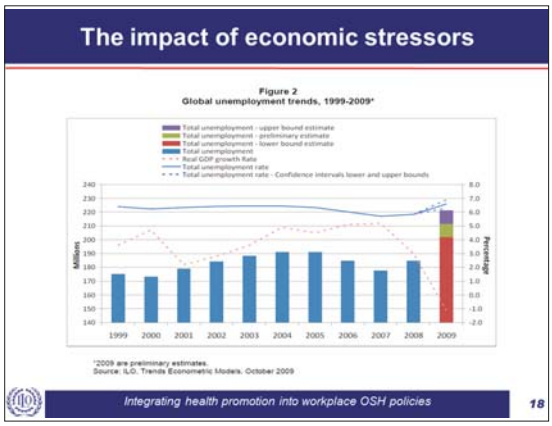

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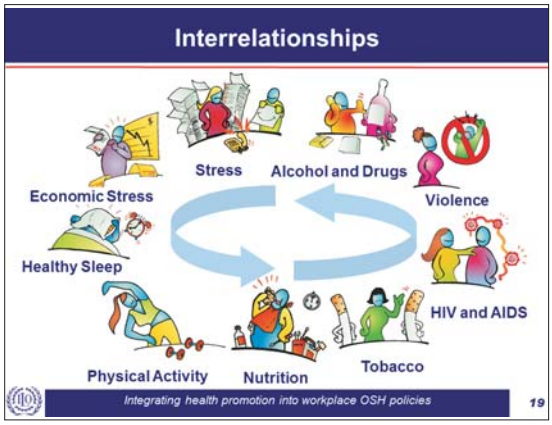

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Slide 20

– END OF PRESENTATION –

Integrating health promotion into workplace OSH policies 20

Slide 21

Integration of Health Promotion Elements

Training & education
Ethics
Information & communication
Risk assessment, risk management
Confidentiality
Assignment of responsibilities
Consultation with workers
Work organization
Assistance & counseling
Treatment & care
Social responsibility
Policy & participation
Continuous improvement
Work organization & workload
Complementary measures
Work design & content

Integrating health promotion into workplace OSH policies 21

Slide 22

Managing economic stress

- Increasing workers' control
- Improving organizational communication
- Allowing workers' participation in decision making
- Enhancing the value placed on safety and health within the organization

Integrating health promotion into workplace OSH policies 22

Slide 23

Possible alternative strategies to layoffs: organizational measures (staff)

In consultation with trade unions, by:

- Lending workers to other workplaces
- Cross-training
- Unpaid leave
- Cutting wages
- Work-share
- Shorter working week and training

Integrating health promotion into workplace OSH policies 23

Slide 24


Possible alternative strategies to layoffs: reducing non-staff related costs
Reduce costs in other areas of the business, such as:
Energy bills
Stationary supplies
Catering
Training
Quid pro quo arrangements
Integrating health promotion into workplace OSH policies
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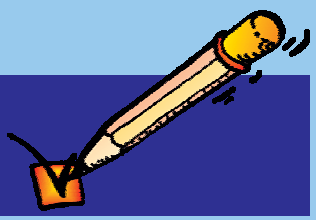
Exercise 2: Simulation - Economic stress



You have 40 minutes to complete this exercise in groups.

Nominate a spokesperson who will have 10 minutes to present the results in plenary.

After having designed your occupational safety and health policy statement in the *Managing workplace health promotion* **module, in this simulation exercise, you and your management team will now make the final operational decisions to solve problems related to health promotion in your "virtual" enterprise.**

This simulation exercise takes place before the exercise on policy integration at the end of each module and runs from one module to the next to deal with each of the topics of SOLVE.

Each management team will have to make decisions in this exercise that will later help them in identifying the policy elements for the design of their workplace health promotion (WHP) programme. See explanation on the integration exercise below.

Your course instructor will give you more details about this at the appropriate time.

The date is 15 May.

The economy is still experiencing difficulties, and while the recent improvements in domestic sales have held off the worst consequences for the company, they are not out of the woods yet. In fact, their success has made them a target for a takeover bid from a larger rival company which has not done so well in the recession.

The executive director calls a meeting of the management team to discuss the potential takeover. She is keen to have a swift and coordinated response, in order to prevent unhelpful rumours from developing.

All of the management team agree that there have been significant improvements in the integrated management of the business, in its occupational health, safety and health promotion aims, and that it would be a shame to lose these benefits in times of economic difficulties. Any takeover or merger would have to be very carefully managed to maintain the progress made so far, especially as the first signs of economic stress can already be seen in the company: tension on the shop-floor seems to be higher than usual, there have been a couple of violent incidents which have been referred to the tribunal, and the medical doctor has seen more cases of depression in the last 12 months than in the last five years.

How may the company respond to a takeover bid?

1. In terms of communication with workers:

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2. In business terms (you may want to develop several alternative strategies depending on the circumstances):

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3. In terms of occupational safety and health and incorporating health promotion measures:

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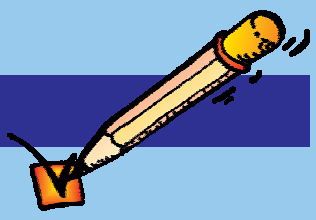
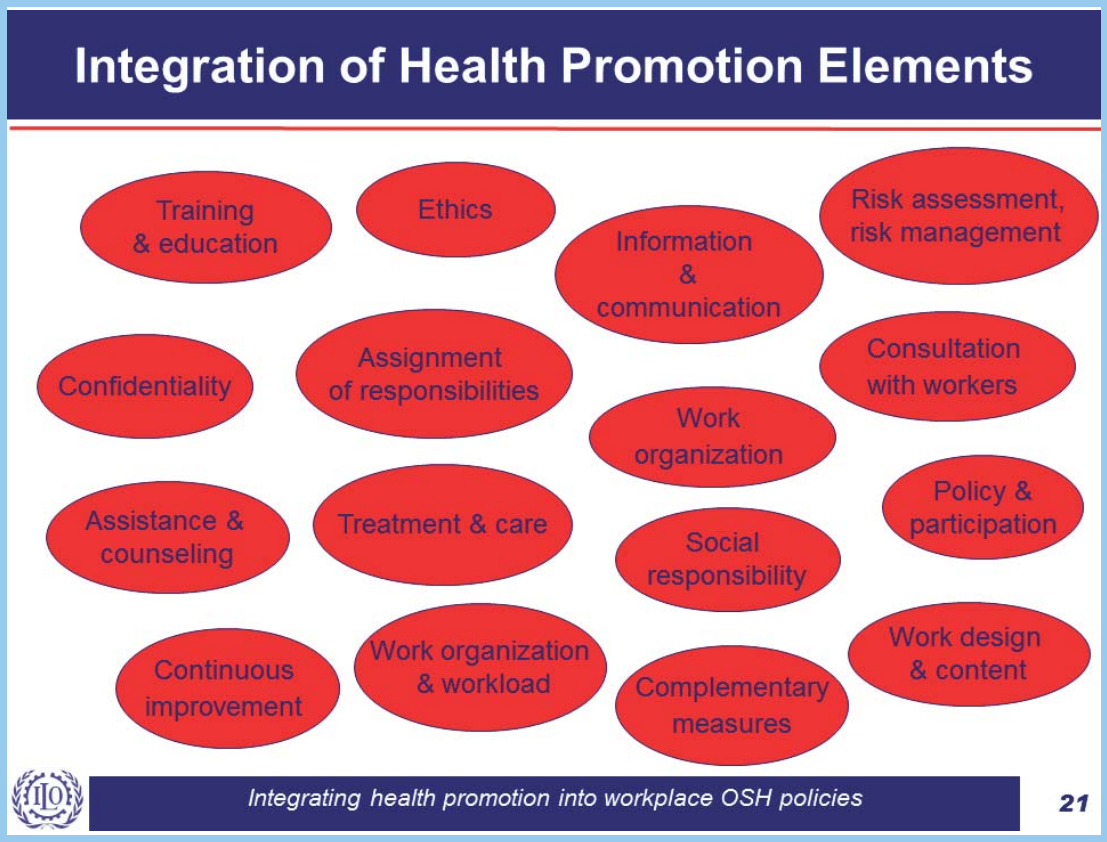
Exercise 3: Policy integration



You have 15 minutes to complete this exercise.



Integrating health promotion elements into your health and safety policy, workplace health promotion (WHP) programme and action plan

In this exercise you will be selecting from the PowerPoint slide on policy integration above, the policy elements which are particularly relevant to *Economic stress*.

After that, use the checklist at the end of this module to choose the actions relevant to *Economic stress* to be incorporated in your workplace health promotion programme.

The policy integration exercise will consist of two steps each time:

Step 1: The whole group, together with the instructor, selects the policy elements that are more relevant to *Economic stress* from the PowerPoint slide shown to you. You can already note down the elements chosen in your workbook and continue completing the WHP programme matrix located in Annex 1 at the end of the *Action* module (12) of your workbook.

Step 2: The checklist at the end of the *Economic stress* module has as headings the policy elements shown in the slide and includes a list of possible measures under each policy element relevant to *Economic stress*. You and your team should take into

account the outcomes of the simulation exercise and use the checklist to select the relevant measures under each heading (policy element) to be included in your draft WHP programme.

The nine areas of SOLVE are highly interrelated and policy action in one area could lead to positive changes in others. Bear this in mind when designing your WHP programme.

The drafting of the WHP programme may require creating or rearranging sentences taken from the checklist or adding new concepts. The new or adapted phrases should fit the focus of the measures necessary to deal with *Economic stress* in the context of the outcomes of the simulation exercise. The draft WHP programme will not be collected after each exercise. This is the last exercise. In the *Action* module each management team will finalize their occupational health and safety policy, WHP programme and an action plan and present its work to the whole group.

The policy elements chosen for this module are:

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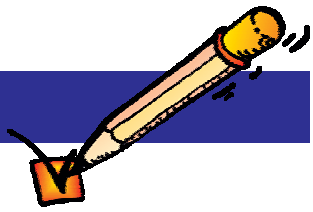
NOTE: If you realize after finalizing this exercise that you need to revise your draft policy statement created in the first module, please do so. You can update your information during each exercise until the *Action* module of the SOLVE Policy Course.

Checklist



Action–oriented checklist for addressing economic stress at work			
1.	**Policy and participation**		
1.1	Adopt a comprehensive approach to work-related stress and economic stress at work.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.2	Establish a committee to deal with the integration of health promotion into a safety and health policy. It should include representatives of top management, supervisors, workers, trade unions, the human resources department, the occupational safety unit, and the occupational health unit.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.3	At the policy level, develop a clear statement of intent recognizing the importance of preventing economic stress at work for workers' health, well-being and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.4	Ensure that existing legal or regulatory requirements are taken into consideration.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.5	Examine successful policies and practices in similar workplaces for guidance.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.6	Involve all parties concerned (including workers and managers) in the development of the policy and preventive programme.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.7	Establish a plan of action to incorporate the risk assessment and management of psychosocial hazards and economic stress-related issues in the health promotion programme, with timetable and lines of responsibility.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.8	Ensure that there is two-way communication and people-orientated leadership.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.9	Ensure that all medical information is absolutely confidential.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.10	Ensure that all programmes are gender-specific as well as sensitive to ethnic diversity and sexual orientation. This includes targeting both women and men explicitly, in recognition of the different types of risks for men and women.	Is action needed?	☐ Yes ☐ No ☐ Comment

1.11	Ensure that the policy of the organization enables workers to recognize the value of their work and to see the connection between their good performance and the positive outcomes of the organization.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.12	Ensure that organizational changes are clearly and timely communicated to the workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.13	Ensure that information related to layoffs, remains confidential and remaining workers are treated with due respect in relation to their employment prospects.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.14	Set clear objectives and ensure that all workers are aware of their role in achieving them.	Is action needed?	☐ Yes ☐ No ☐ Comment
1.15	Provide for an environment conducive to problem solving.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.	**Training, Education, Information and Communication**		
2.1	Ensure that information, education and training is provided to increase awareness, knowledge and understanding of psychosocial hazards and economic stress and its impact on health and productivity.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.2	Widely disseminate the policy and the plan of action through all means possible such as notice boards, mail, payslip inserts, special meetings, induction courses and training sessions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.3	Circulate information and guidance on the management of work-related stress and economic stress, including information on where support is available in-house and outside the workplace.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.4	Ensure transparency and fairness in procedures dealing with complaints.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.5	Ensure an efficient communication level between the management and the workers in order to avoid rumours and misleading information.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.6	Implement measures (periodical questionnaire, interviews, etc.) to assess and monitor the workers' perception of their working and economic conditions.	Is action needed?	☐ Yes ☐ No ☐ Comment
2.7	Provide adequate training and updating opportunities for knowledge and skills.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.	Work organization, Workload, Design and Content		
3.1	Provide for adequate resources and staffing.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.2	Assign tasks according to experience and competence.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.3	Ensure career development opportunities for all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.4	Ensure that there are supportive relationships between supervisors and managers and all workers.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.5	Reinforce motivation by emphasizing the positive and useful aspects of the work.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.6	Provide job security to the extent that is possible.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.7	Assign clear roles, avoiding role conflict and ambiguity.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.8	Ensure the proper utilization of skills.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.9	Ensure that targets and appraisal schemes are clear and fair.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.10	Provide adequate recognition and feedback about work.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.11	Provide adequate pay for the work performed.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.12	Allow workers a say in how their work is to be carried out.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.13	Incorporate a specific risk assessment of psychosocial hazards and management of the economic stress in the broader workplace's risk management procedures.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.14	Consider measures such as cross-training, reducing working time temporarily, or unpaid leave in order to reduce costs without firing staff.	Is action needed?	☐ Yes ☐ No ☐ Comment

3.15	Encourage workers to discuss any conflicting demands between work and home and find solutions collectively with management.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.16	Consider reducing non-staff related costs, such as energy bills and stationary supplies in order to avoid staff lay-offs.	Is action needed?	☐ Yes ☐ No ☐ Comment
3.17	Provide a safe and healthy working environment (safety, hygiene, health surveillance and ergonomic measures).	Is action needed?	☐ Yes ☐ No ☐ Comment
4.	**Complementary measures**		
4.1	Provide adequate facilities for eating or for food preparation, appropriate to workers' needs.	Is action needed?	☐ Yes ☐ No ☐ Comment
4.2	Provide adequate support, counselling and referral for treatment, as appropriate, for people showing either physical or psychological symptoms of stress.	Is action needed?	☐ Yes ☐ No ☐ Comment

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From concept to action

Objectives

At the end of this module the participant will be able to design a workplace health promotion (WHP) programme and an action plan on the basis of the knowledge gained during the course.

Introduction

In Module 2: *Managing workplace health promotion* you were asked to draft a health promotion policy statement (see page 45) and to integrate it into an occupational safety and health policy as the first step to start a process that aims at incorporating policy elements of workplace health promotion into the Occupational Safety and Health (OSH) enterprise policy.

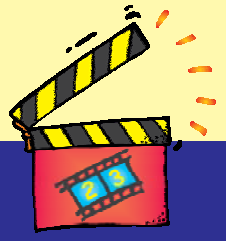
As a second step, in the simulation exercises of each module, you and your team acted as management teams of a "virtual" enterprise to make operational decisions on health promotion.

As a third step, the decisions made during the simulation exercises and the incorporation of the measures from each checklist in each module, allowed you to draft your workplace health promotion (WHP) programme.

The final step of the process is drafting your action plan. Once finalized, the WHP programme and the action plan will be presented by your team for discussion in plenary with the other teams.

Remember that although the exercises in the training package concern a "virtual" enterprise, the training allows you to consolidate the knowledge gained to design a WHP programme and action plan for your enterprise once you have finished the training.

From concept to action presentation



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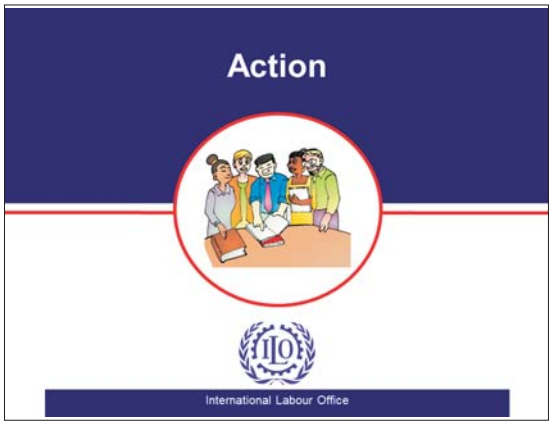

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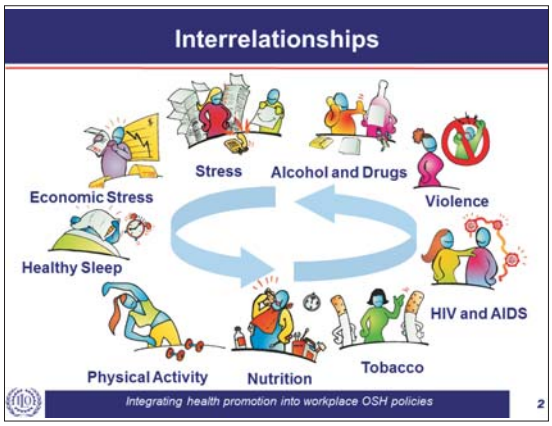

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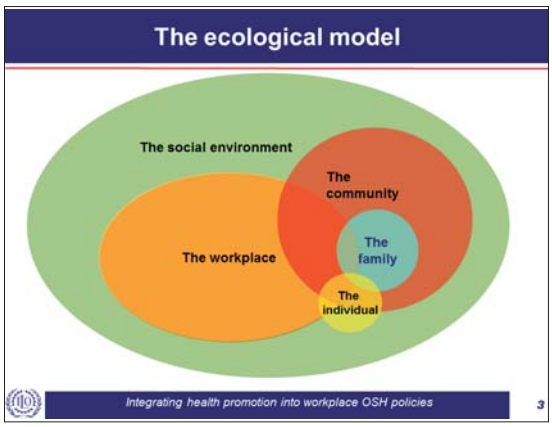

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Slide 4

1st step: Policy Statement on Health and Safety at Work

- Workers are this company's most important resource. We will foster a safe and healthy environment for all employees, contract workers, clients and visitors
- We will commit to make all premises and equipment safe as reasonably practicable to ensure a healthy, injury-free working environment
- Health and safety considerations will be incorporated into all phases of business, including product design and development, facility design, operation, maintenance and product delivery
- Emergency procedures including emergency evacuation measures will be developed, reviewed with local competent authorities and implemented
- We will regularly assess, implement and verify compliance with health and safety measures
- *We will ensure that health promotion measures be put in place and that workers' representatives will actively participate in the design and implementation of the OSH policy*
- This policy will be reviewed at regular intervals

Integrating health promotion into workplace OSH policies 4

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Slide 5

2nd step: the Workplace Health Promotion (WHP) Programme

- During the SOLVE policy course you have been using specific checklists to incorporate the relevant actions for each module
- The actions detected as "needed" in the checklists have been incorporated into the matrix of your WHP Programme
- You will now finalize your WHP Programme taking into account the work carried out so far

Integrating health promotion into workplace OSH policies 5

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Slide 6

2nd step: the Workplace Health Promotion (WHP) Programme

WORKPLACE HEALTH PROMOTION MATRIX	1 Preparation	2 Planning	3 Implementation	4 Evaluation	5 Ongoing implementation
Policy and participation					
Training, Education, Information and Communication					
Work organization, Workload, Design and Content					
Complementary measures					

Integrating health promotion into workplace OSH policies 6

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Slide 7

3rd step: WHP Action Plan

Define:

- What are the expected results
- Which are the resources you are going to allocate
- Who will be responsible for the implementation
- By when you expect to obtain the results

Integrating health promotion into workplace OSH policies 7

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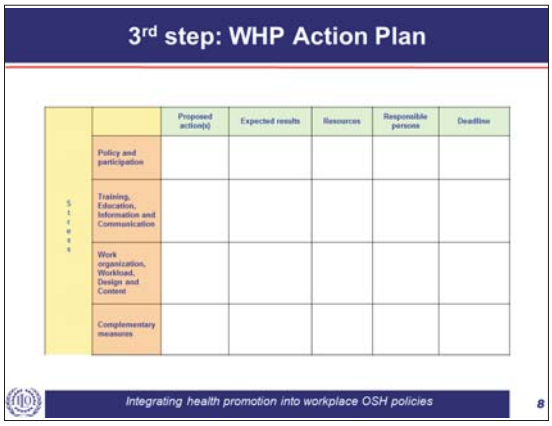
Slide 8



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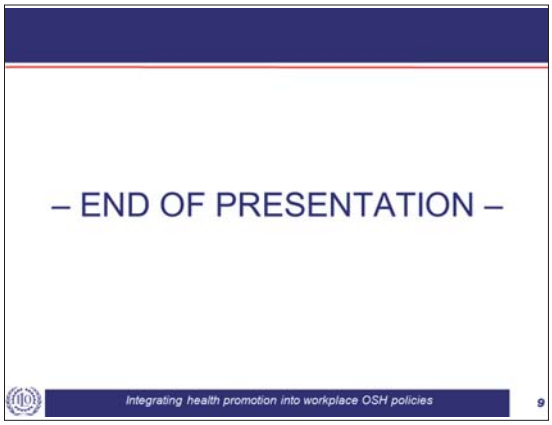

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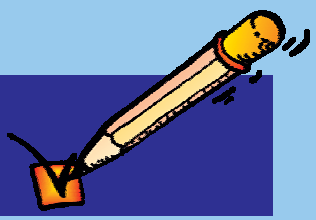
Exercise 1: Workplace Health Promotion (WHP) Programme



This exercise will allow you to create an integrated tool with a continuos improvement approach in which all the SOLVE areas are tackled and the five phases of health promotion management are taken into account. It will also be used as the basis for the development of your action plan.

You have 45 minutes to complete this exercise in groups.

At the end of the exercise, each group will briefly present its Workplace Health Promotion (WHP) Programme.

Your course instructor will select the topic or topics to be presented by each group, but all the groups will comment on the work of the others.

The matrix in Annex I, at the end of this module, has been used as a basis to design your WHP programme.

During the SOLVE policy course you have been using specific checklists for each module to incorporate the relevant measures for each topic.

Those checklists helped you to identify the specific measures that needed to be undertaken for each of the topics in your WHP programme in the following four different areas:

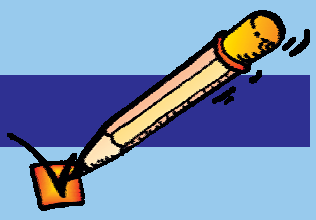
1. Policy and participation.
2. Training, education, information and communication.
3. Work organization, workload, design and content.
4. Complementary measures.

At this point, the measures detected as "needed" in the checklists have been incorporated into the matrix for your WHP programme, identifying also the correct phase of the health promotion programme in which they should be implemented (Preparation, Planning, Implementation, Evaluation and On-going implementation).

Please remember that the five phases of the health promotion programme are explained in the Managing workplace health promotion workbook and correspond to the above.

Please revise the work carried out until now and consolidate your WHP programme; add to, or rearrange whatever you consider necessary for your presentation.

Exercise 2: Action plan



The matrix in Annex II, at the end of this module, will help you to plan "WHAT" needs to be done, and "IN WHICH" phase of the implementation of your workplace health promotion (WHP) programme.

You have 1 hour to complete this exercise in groups.

Using the action plan matrix, choose 3 of the topics and draft an action plan for each on the basis of the WHP programme.

In the previous exercises, you selected policy elements from the PowerPoint and measures from the checklist and incorporated them in the matrix of your WHP programme under the following areas:

1. Policy and participation.
2. Training, education, information and communication.
3. Work organization, workload, design and content.
4. Complementary measures

Describe specific actions needed to complete these measures. Propose at least 2 specific actions.

For each measure and action(s) that you want to implement, you should specify:

- what are the expected results;
- which resources you are going to allocate;
- who will be responsible for the implementation;
- by when you expect to obtain the results.

Please note that the action plan should cover a minimum of three months and the proposed actions should lead to the implementation of the WHP programme to reflect the integration of health promotion measures in the Occupational Safety and Health (OSH) strategy and policy.

The action plan represents the last step of a process which started with the definition of an OSH policy, continued with the development of a WHP programme and it will end with the design and implementation of your action plan.

This exercise will also allow you to apply the knowledge and skills gained during the SOLVE course when you return to work. Use them to design your own workplace policy, programme and action plan.

Post - test

NAME: _____

For each item below, please circle the response that you think best answers the question. Please only circle ONE response for each item.

You have 30 minutes to complete this exercise.

1. Policy and actions addressing emerging health-related problems need to take into account:
   a. The worker's social support network
   b. The affected workers
   c. The worker's job tasks and organizational environment
   d. All of the above
2. The combination of low psychological demands and high decision latitude at work is related to:
   a. High stress
   b. Low stress
   c. A strong need for social support
   d. A strong need for control
3. Unhealthy stress at work can be caused by:
   a. Proper utilization of skills
   b. Well-defined roles and job tasks
   c. Social isolation
   d. Clearly defined job security
4. The areas of health promotion covered in SOLVE (stress, alcohol and drugs, violence, HIV and AIDS, tobacco, nutrition, physical activity, healthy sleep and economic stress):
   a. Are isolated
   b. Are interrelated
   c. Should be managed individually
   d. Are unrelated to each other

5. From the list below, identify which form of violence is not considered physical violence:

   a. Beating

   b. Sexual assault

   c. Pushing

   d. Threat of physical force

6. The majority of HIV positive people get infected through:

   a. Unprotected sex

   b. HIV positive mothers to babies

   c. Homosexual activities

   d. Organ transplants

7. When someone has AIDS:

   a. There is damage to the nervous system

   b. There is damage to the immune system

   c. There is damage to the blood and circulatory system

   d. All of the above

8. Examples of high decision latitude include:

   a. Allowing workers to set their own work pace

   b. Setting up a strict chain of supervision

   c. Implementing a strict working hours/breaks schedule

   d. Demanding frequent reports to supervisors

9. Smoking increases the risk of occupational diseases in:

   a. Coal mining

   b. Jobs involving the handling pesticides

   c. Working with cotton and wood dust

   d. All of the above

10. Individual risk factors for perpetrating workplace violence include:

   a. Difficulties in personal relationships

   b. Mental health problems

   c. Alcohol/drug use

   d. All of the above

11. Which of the following statements is false regarding violence?

    a. An efficient job design can prevent violence

    b. Work organization and the working environment can be part of the cause of violence at work

    c. Mobbing is a form of physical violence

    d. The risk of violence at work can be significantly reduced by good design of the physical environment

12. When decision latitude decreases and psychological demand increases:

    a. Stress will increase

    b. Stress will decrease

    c. There is no impact on stress

    d. There is a high level of motivation

13. Which of the following statements is true regarding HIV?

    a. It cannot be transmitted via blood transfusion

    b. One can become infected by sharing a drinking fountain

    c. It can be transmitted through mosquitoes

    d. HIV does not live long outside the body

14. The following situation may increase the risk of a worker's alcohol dependency:

    a. Flexible work schedule

    b. Travel away from home

    c. Social support

    d. Lack of job stress

15. Use of alcohol and drugs in the workplace can cause all of the following except:

    a. Higher health-care costs

    b. Increased absenteeism

    c. Higher number of accidents

    d. Increased productivity

16. Which of the following substances can negatively affect one's mind and body?

    a. Alcohol

    b. Inhalants

    c. Non-prescription medications

    d. All of the above

17. The occupations with the lowest risks of psychological strain and physical illnesses are the ones with_____ decision latitude, and _____ psychological demands.

    a. high; low

    b. low; low

    c. low; high

    d. high; high

18. The majority of people infected with HIV:

    a. Are currently working

    b. Are homosexuals

    c. Should not be allowed to work

    d. All of the above

19. Micronutrients:

    a. Occur in larger proportions in food compared to macronutrients

    b. Should be eaten in smaller proportions than macronutrients

    c. Are vitamins, minerals and trace elements

    d. Are carbohydrates, proteins, fats and oils, and water

20. Which of the following statements on fats and oils is not true?

    a. Consuming some fats and oils helps to regulate blood pressure

    b. Saturated fats should be limited because they raise cholesterol levels

    c. Unsaturated fats are healthy if eaten in small quantities

    d. Unsaturated fats lower the levels of "good" cholesterol

21. Complex carbohydrates are found in

    a. Rice, cereals and pulses

    b. Sugar and honey

    c. Fish

    d. None of the above

22. In countries experiencing the so called "nutritional transition":

    a. The population is under-nourished

    b. Parts of the population have made a rapid switch from traditional diets to high-energy high-fat diets while other parts may suffer from malnutrition

    c. Parts of the population have made a rapid switch from high-energy high-fat diets to traditional diets

    d. The risk of nutrition-related diseases is lower

23. Individuals suffering from sleep loss and sleep disorders:

    a. Have a decreased likelihood of injury

    b. Are easy to diagnose

    c. Have an increased health-care utilization

    d. None of the above

24. Which of the following statements regarding sleep is NOT true?

    a. Sleep has a powerful impact on physical and mental health and on workplace performance

    b. Sleeping for 5 hours or less per night is routinely associated with an increased risk for heart disease

    c. Reducing sleep to get more done improves productivity

    d. People generally underestimate the cumulative effects of insufficient sleep

25. Which of the following health consequences have not been associated with chronic sleep loss?

    a. Increased risk of hypertension

    b. Depression

    c. Lung cancer

    d. Heart attack and stroke

26. Which of the following is not an internal factor influencing sleep?

    a. Maintaining a schedule

    b. Noise

    c. Avoiding harmful effects of drugs and medications

    d. Insomnia

27. Which of the following statements is not true?

    a. The risk of getting many chronic diseases is influenced by what people eat and how much they exercise

    b. People who are physically active tend to smoke less than inactive people

    c. Physical activity helps to regulate appetite

    d. Physical activity does not influence well-being and work capacity at the worksite

28. Lack of physical activity can lead to:

    a. Obesity

    b. Cancer

    c. Type 2 diabetes

    d. All of the above

29. Doing household chores, walking or cycling to work and using the stairs instead of the elevator are considered:

    a. Leisure-time physical activities

    b. Lifestyle activities

    c. Sports

    d. Occupational physical activities

30. Scientific evidence indicates convincingly that physical inactivity is:

    a. A serious hazard to health, to working capacity, and productivity

    b. A serious hazard to working capacity

    c. A serious hazard to productivity

    d. A serious hazard to health and productivity

31. Three of the most important economic stressors are:

    a. Unemployment, underemployment, and job security

    b. Job insecurity, unemployment, and underemployment

    c. Employment, underemployment, and job security

    d. Employment, underemployment, and job insecurity

32. Among the economic stressors, which one would you rate as the most damaging?

    a. Job insecurity

    b. Unemployment

    c. Underemployment

    d. All the economic stressors are equally harmful

33. Among the economic stressors, which one you would rate as the most widespread?

    a. Job insecurity

    b. Unemployment

    c. Underemployment

    d. All the economic stressors roughly affect the same number of people

34. Which of the following statements is false?

    a. Job insecurity is a very subjective notion

    b. Government programmes are often targeted toward the more visible economic stressors

    c. It is relatively easy to say when someone is unemployed

    d. It is relatively easy to say when someone is underemployed

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