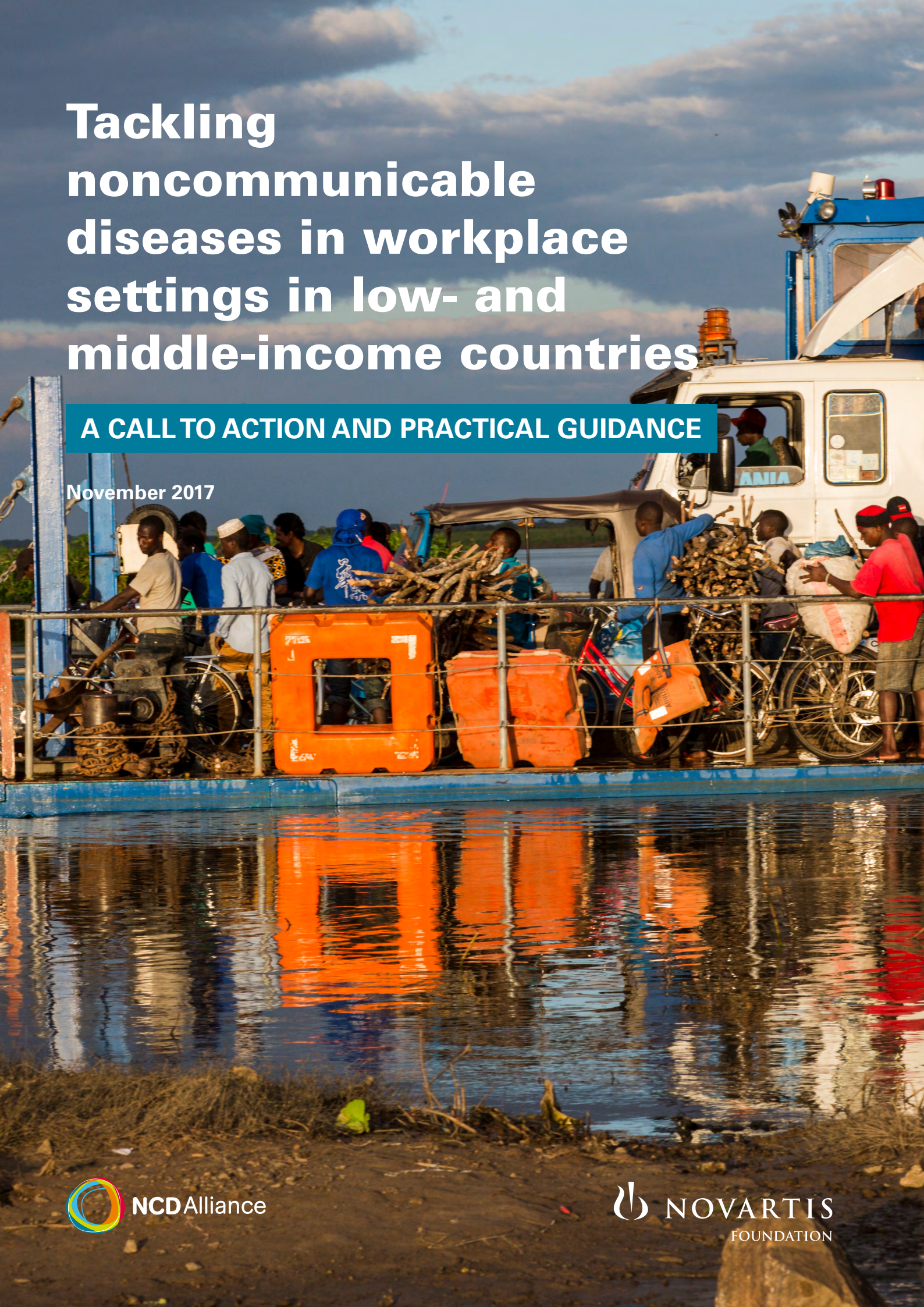
Tackling noncommunicable diseases in workplace settings in low- and middle-income countries

A CALL TO ACTION AND PRACTICAL GUIDANCE

November 2017



NCDAlliance

NOVARTIS FOUNDATION

Tackling noncommunicable diseases in workplace settings in low- and middle-income countries: a call to action and practical guidance

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Edited by NCD Alliance, November 2017

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Table of Contents

Introduction

Noncommunicable diseases (NCDs) are a growing crisis in low- and middle-income countries (LMICs). The workplace is recognised internationally as a crucial arena for tackling these health issues, but is often marginalised at national level. There is significant opportunity for civil society, governments and the private sector+ to work together in LMICs, taking shared responsibility for health and wellbeing through innovative partnerships, sharing expertise and knowledge, and mobilising resources.

This report provides an overview of the current realities of NCDs and progress made to date in workplace health, particularly in LMICs.# It sets out the challenges and opportunities to increase implementation in LMICs, offering recommendations for key stakeholders to create an environment within which workplace health can thrive, and a framework for action for employers.

Methodology

This report was developed from a recent *Situational Analysis: Workplace Health in Low-and Middle-income Countries*, which drew on:

a. extensive desk research of the grey / non-peer-reviewed literature in this area (including surveys setting out the drivers, challenges and extent of workplace health initiatives, globally and regionally);

b. a rapid review of the peer-reviewed literature on NCD workplace health initiatives in LMICs; and

c. key informant interviews with experts in NCDs and workplace health from countries and regions including Argentina, Brazil, the Caribbean, China, Ghana, India, Mexico and South Africa, drawn from companies, NGOs, intergovernmental organisations and academic institutions. Comments from these key informant interviews appear as quotes throughout this report.

This report has been developed with input from an Expert Advisory Group.*

+ Note, however, that the information in this report is relevant to employers in all sectors – public, private, the third sector and the informal sector – and should not be seen as referring only to those in the private sector.

For consistency, this report uses 'workplace health' rather than 'workplace wellness'.

* The key informants and Expert Advisory Group are listed in the Acknowledgements to this report.

Key messages

- Noncommunicable diseases (NCDs) kill 40 million people each year – 70 per cent of all deaths globally. 15 million of these deaths occur between the ages of 30 and 70 – a period which should be the prime productive years of employment. Over 80 per cent of these premature deaths occur in low- and middle-income countries (LMICs).[1].

- NCDs, primarily cardiovascular diseases, cancers, respiratory diseases, diabetes and mental health and neurological disorders share common causes. Tackling four risk factors – tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets – can lower the risk of these diseases.[1]

- NCDs have a profound economic impact beyond the personal suffering they cause. Nationally, NCDs place increased strain on health systems; while businesses are faced with economic losses due to absence from work (absenteeism), presence at work but not working at full capacity due to illness (presenteeism), and the loss of valued employees due to early retirement or death.

- Workplaces offer an excellent setting for NCD prevention and management, in particular in LMICs where the provisions of care for chronic diseases are still limited. In this context, workplace health programmes can benefit broader society and communities beyond employees.

- Despite growing awareness of the importance of the workplace in NCD prevention and management, active provision of workplace health programmes worldwide is inconsistent and patchy.

- Macro-level (national) challenges include the failure to prioritise workplace health in national NCD plans, lack of an holistic approach to health, and inadequate implementation of policy. Data on the risk, burden and impact of NCDs are often missing.

- Micro-level (organisational) challenges include lack of data to prepare a compelling business case, few incentives for employers or employees to take an active role in health in the workplace, absence of strong leadership, and a failure to fully engage employees.

- However, action by governments, employers, NGOs and workers' representative organisations can create a culture of health within workplaces, supported by the investment of sufficient resources, with significant impact on the health of the workforce.

- There are many links between the five groups of NCDs and other conditions – e.g. infectious diseases (such as HIV/AIDS and tuberculosis) and musculoskeletal disorders – and there are clear benefits for all in taking an holistic approach to workplace health.

- In practical terms, there is no one single route to workplace health, but case studies and reports analysed for this publication indicate that there are key elements that can guide employers when establishing a workplace health programme:

1 Noncommunicable diseases: a crisis for low- and middle-income countries

The way we live our lives is changing. Worldwide, the ways in which we learn, work, travel and play are becoming more sedentary. What we eat is shifting away from traditional diets and towards meals, snacks and drinks that are high in fat, salt and sugar and low in nutrients. The environments in which we live are polluted, indoors (due to fumes from cooking and heating) especially in low- and middle-income counties (LMICs), and outdoors (due to industrial processes and motor vehicles). Demographic changes including urbanisation and ageing are occurring most rapidly in LMICs. Half of the world's population now live in cities – a proportion that will increase to 66 per cent by 2030, and at the fastest rates in Africa and Asia.[2] With regard to ageing, it took more than 100 years for the share of France's population aged 65 or older to double from 7 to 14 per cent, while the equivalent increase in Brazil and China will take less than 25 years.[3]

Poor health follows in the wake of these transitions. The burden of obesity has risen rapidly – more than twice as many people in the world are overweight (1.9 billion)[4] than are undernourished (0.8 billion).[5] An estimated one in five adults (and a higher proportion in many LMICs: up to 30 per cent in Africa) have raised blood pressure (hypertension), a condition that causes around half of all deaths from stroke and heart disease.[6] Noncommunicable diseases (NCDs) claimed 40 million lives in 2015 (70 per cent of all deaths),[1] a figure that is set to increase to 52 million by 2030.[7]

NCDs are *not diseases of affluence*. They are a fast-increasing burden: 15 million deaths from NCDs occur annually among people between aged 30 to 70 – a period that should be the prime productive years of employment – and *80 per cent of these premature deaths occur in LMICs.*[1] NCDs are a clear threat to the health of working-age adults in LMICs, and therefore to workplace productivity and to the health of economies.

The increase in deaths from NCDs reflects the great progress made in tackling infectious diseases and malnutrition. However, *too often people die prematurely* – cardiovascular disease (heart disease and stroke), cancer, chronic lung disease and type 2 diabetes together account for 80 per cent of all premature NCD deaths (deaths of those aged 30–69 years).[1] And deaths often follow protracted periods of illness; NCDs account for the majority of illness in

NCDs and sustainable development

NCDs were not included in the Millennium Development Goals in 2000 – but by 2015 they were acknowledged as essential for achieving sustainable development.

The 2030 Agenda for Sustainable Development, to which all governments have committed, includes a specific NCD target: 'By 2030, reduce by one-third premature mortality from NCDs through prevention and treatment, and promote mental health and wellbeing' (target 3.4).

Other sustainable development goals (SDGs) – notably SDG 8 on decent work and economic growth and SDG 11 on sustainable communities – will be impacted by efforts to tackle NCDs.

all regions of the world other than sub-Saharan Africa (and even there the burden of NCDs is expected to overtake that of infectious diseases by 2030).[8] The amount of donor assistance for NCDs is currently far from proportionate to their impact: just 1.71 per cent of global health financing expenditure was allocated to NCDs in 2016.[9]

For an economy to thrive, people need to be in work and productive – and, particularly in ageing populations, remain in work for longer. ***NCDs have a profound economic impact*** beyond the personal suffering they cause. From 2011–2025, cumulative economic losses due to NCDs in LMICs have been estimated at USD 7 trillion.[10] This financial burden is observed at all levels, as follows:

Nationally, NCDs increase strain on health systems, and lower taxes from people not at work impact on services such as health and defence – and economic growth is dependent on a healthy workforce.

Families of people living with NCDs endure serious or catastrophic out-of-pocket spending on health where there is no social protection scheme.

Intergenerationally, when young people are removed from school to care for family members with an NCD, this impacts on their education and potentially long-term health (educational attainment is a known social determinant of health).

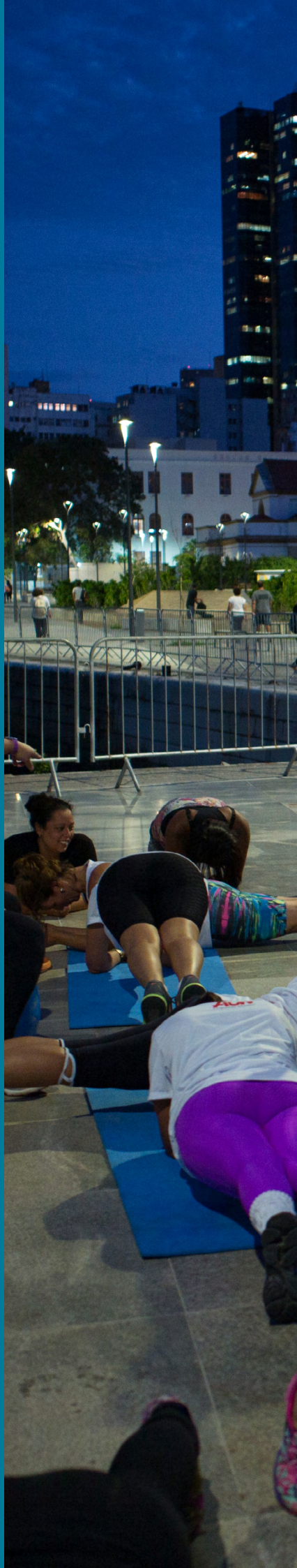
People living with NCDs may find it harder to find work due to discrimination, and productivity may be lower (a study in Latin America found that people affected by NCDs work 3–6 per cent fewer hours per week than the average[11]).

Businesses lose the time and skills of valued employees. In Brazil, China, India and the Philippines, absenteeism and presenteeism alone cost over 2 per cent of each country's GDP. The cost of early retirement exceeds this, ranging from 3.4 per cent to 5.1 per cent in the same countries. In Brazil, these costs are set to rise to a total of 8 per cent in 2030.[12]

Local communities are impacted, since people in work tend to spend their wages in their locality – unemployment therefore affects the neighbourhood economy.

The good news is that ***many cases of NCDs can be delayed or prevented*** through addressing poor diet, tobacco use, physical inactivity and the harmful use of alcohol. In addition, many NCDs can be treated and managed, bringing them under control and enabling people to live fulfilling lives.

Addressing NCDs and their risk factors – extending the time that we live in good health – is the responsibility not just of individuals and their families, but also of government, communities and employers. It requires a ***whole-of-society, partnership approach.***



Why focus on NCDs?

The most effective workplaces are those that foster a culture of health throughout the organisation, covering a range of conditions, including the major NCDs: cardiovascular diseases, cancers, respiratory diseases, diabetes, and mental health and neurological disorders. These diseases have shared risk factors – including tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol – and addressing any given risk factor the workplace will effectively reduce the burden from multiple diseases. Reducing exposure to these risk factors is also beneficial for other conditions, including obesity, some infectious diseases, and musculoskeletal disorders. Conversely, the fact that multiple diseases have roots in or are exacerbated by the same risk factors leads to many individuals living not only with one disease, but two or more – referred to as 'co-morbidities' – which necessitates a fully comprehensive and tailored approach to workplace health.

For example, obesity is a risk factor for cancer, diabetes, cardiovascular disease and for musculoskeletal disorders – and can increase the likelihood of accident or injury at work.[13] Creating an environment within which everyone is supported to adopt healthy lifestyles will empower employees to take control of their weight without stigma or discrimination, potentially reducing accidents and injuries as well as lowering individuals' risk of disease.

2
NCDs and the workplace

Employees spend a significant proportion of their waking hours at work, over days, weeks and years – and there are numerous opportunities in a workplace setting both to prompt and facilitate healthy choices, to provide treatment for those with health conditions, and tackle stigma and discrimination, with positive impacts throughout working life and beyond. Workplaces are often a microcosm of the local community, with the systems in place to deliver improvements to health behaviours, disease management and cultural change.

This combination of time and opportunity makes the workplace an important – and potentially life-changing – venue in which to address NCDs.

The role of the workplace was acknowledged by the United Nations High-level Meeting on NCDs in 2011, which called for a 'whole-of-government, whole-of-society' approach, including the promotion and creation of an 'enabling environment for health behaviours among workers'.[14] This has since been reiterated in the World Health Organization's Global Action Plan for the Prevention and Control of NCDs.[15]

Despite this international acknowledgement, this link may not be explicitly made at national level: *the workplace as an arena for NCD prevention and management is often marginalised in national NCD plans and in policy and implementation*.[16] Legislation such as smoke-free regulation has been shown to have an immediate and profound impact on the actions of employers, but even in high-income countries government support for workplace health (such as incentives or provision of accreditation schemes) is often very limited.

As section 3 sets out, it is often large businesses that take the lead, recognising the significant benefits for business of tackling NCDs. Investing in workplace health is a form of risk mitigation, and the returns include higher productivity, lower recruitment costs (turnover is reduced, as employees with NCDs are enabled to stay in work, or to return after a period of illness) and lower insurance. And where workplace-based programmes are extended to include employees' families and the local community, they can have wider impacts for local and national economies. However, while workplace health programmes are becoming increasingly common in high-income countries, the gaps in LMICs, especially in small organisations, need to be addressed.

Table 1: Case studies

Throughout this Guide, case studies illustrate practical ways in which organisations in LMICs are addressing NCDs within workplaces. They cover a wide range of approaches and diseases, and many focus on the need to take an holistic approach, partnering across a variety of sectors.

Page	Organisation	Location	Programme summary
15	International Labour Organization WISE (Work Improvement in Small Enterprises) initiative	Asia, Latin America, Middle East	Training and support in workplace **health and safety**, aimed at **micro and small enterprises** and intended to improve productivity
18	China Tobacco Control Partnership Tobacco-free Cities Smoke-free Business Initiative	China	**City-level** support for businesses to tackle **tobacco** use among employees
19	Healthy Caribbean Coalition Private-sector response to NCDs	Caribbean	Regional NGO alliance establishing NCDs as a **priority** within workplace health, and creating a **network** of businesses to share best practice
21	Ghana Revenue Authority Employee Wellbeing Programme	Ghana	**Public–private** partnership delivering an Employee Wellbeing Programme covering all aspects of **health and social security**
22	Swedish Workplace HIV/AIDS Programme (SWHAP) Value-chain Programme	Sub-Saharan Africa	**Co-funded** model of support for Swedish-related companies in Africa, integrating NCDs into **HIV** workplace health programmes.
24	Virgin Pulse Global Challenge	Global	Team-based **physical-activity** challenge over 100 days, delivered **online** and using wearable technology
28	Arogya World Healthy Workplace Programme	India	A Healthy Workplace **Award** scheme addressing **tobacco, healthy eating, physical activity,** work–life balance, and changing mindsets
29	Technica International Healthy Workplace Programme	Lebanon	Programme addressing **physical** and **psychosocial** aspects of health within an SME using a '**servant leadership**' model

3
Workplace health worldwide

3.1 Provision of programmes

Active provision of workplace health programmes is, at best, inconsistent and patchy in LMICs and across small- and medium-sized enterprises (SMEs) worldwide. A global survey in 2016 estimated that a total of 69 per cent of multinational organisations offer some form of health programme (81 per cent of organisations in North America to 57 per cent in Europe, 45 per cent in Asia, 40 per cent in Latin America, and 26 per cent in Africa).[17]

However, beyond these large companies, the proportion of the global working population with access to a workplace health programme is much lower: estimated at 9 per cent of the global population, with just 5 per cent in Latin America and Asia, and 1 per cent in Africa. Throughout this report, case studies of successful programmes illustrate a wide range of initiatives, summarised in Table 1.

SMEs, in particular, may not have the resource or impetus to prioritise workplace health, but the impact of the loss of a single employee can be devastating – and they are a vital group to engage, because they employ two-thirds of the global workforce.[18]

There are an estimated 365–445 million micro- and SMEs in LMICs,[19] contributing to a high percentage of countries' GDP. Many are in the informal sector, and there are examples of the successful introduction of workplace health into this sector, such as the ILO's Work Improvement in Small Enterprises initiative (**case study – WISE**).

> “
>
> There has been enormous change over the last 10 years or so – it is hard to find a [large] company that isn't doing something about it.
>
> **Latin America**

> “
>
> Other than pioneering companies, they don't get it.
>
> **India**

International Labour Organization
WISE (Work Improvement in Small Enterprises)

In brief	Training and support in workplace health and safety, aimed at micro and small enterprises and intended to improve productivity
Partners	International Labour Organization (ILO), owners and managers of SMEs, local facilitators
Established	1988
Reach	Over 20 countries

THE PROGRAMME

WISE – Work Improvement in Small Enterprises – is a low-cost, scalable programme established by the ILO to help owners and managers of micro-, small- and medium-sized enterprises in the formal and informal sector to improve working conditions and productivity. It takes a participatory and action-oriented approach, building on local practice, using learning-by-doing and problem solving, encouraging sharing of experience and focusing on achievement, and promoting active involvement of employees.

A network of facilitators (e.g. local government, unions and inspectors) are given 'participatory action-oriented training' by ILO on the WISE methodology. They then convene small groups of SME owners or managers in short training sessions, building up confidence to identify needs and implement changes.

WISE addresses both the physical work environment (e.g. machine safety) and the social work environment (e.g. positive working environment and work–life balance). Employers can use the WISE-R Checklist to baseline their activities and establish priorities across a range of areas (including managing, motivating and retaining staff), and an Action Manual provides practical suggestions on improvement, helping employers to formalise processes and encourage health and safety. The network that provided the initial training is embedded within the community and can provide ongoing support.

IMPACT

WISE has demonstrated that it can catalyse low-cost interventions that make real improvements to health and safety. The approach has been used in over 20 countries (Asia, South America and, more recently, in the Middle East and Africa), and has been adopted as national policy in countries including the Philippines and Vietnam.

While WISE is not aimed at preventing specific diseases and does not address provision of treatment, it is an important gateway to workplace health in SMEs: it impacts on healthy lifestyles (e.g. nutrition and encouraging breaks from working) and is the beginning of a more comprehensive approach including NCDs.

KEY LEARNING

What began as a pilot project has been successful enough to be adopted as national policy for SMEs (including in the informal economy) in workplace health and safety.

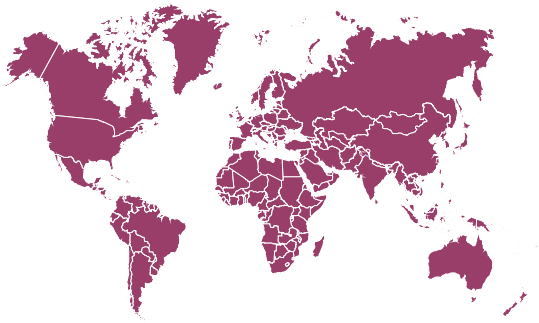
3.2 Priorities and trends in workplace health

3.2.1 NCDs as a global workplace health priority

Occupational health and safety management has traditionally dealt with injuries at work and diseases associated with industrialisation. In some cases, globalisation has resulted in companies taking advantage of lower labour standards in LMICs than in high-income countries.[20] However, there is increasing recognition among employers that health concerns, including NCDs, can be successfully tackled in the workplace[21] – this is an opportunity to extend occupational health and promote a culture of prevention throughout the organisation[22] (**case study – Healthy Caribbean Coalition**).

A 2016 global survey found that the ***top three issues*** *driving wellbeing programmes are all related to NCDs and their risk factors*: physical inactivity, unhealthy diets and stress (Figure 1).

Ensuring tobacco-free workplaces is also a high priority worldwide (**case study – Tobacco Free Cities**). The survey found that the main objectives of employers in addressing workplace health are to increase workforce productivity and engagement – and also to improve the health of the general population, from which many of their employees are drawn (a particular concern where there is little health coverage provided by the government).



Global

9%

of employees with access to a workplace health programme[23]

Top issues driving programme priorities*[17]

- Nutrition and healthy eating
- Physical activity
- Access to healthcare services
- Use of preventive health screening
- Stress

Top wellbeing objectives
('extremely' / 'very important')*[17]

- Improving productivity and performance
- Improving employee engagement/morale
- Attracting and maintaining employees

Figure 1: Access to workplace health, top priorities and objectives

* No information was provided for Africa in this survey

Latin America

5%

of employees with access to a workplace health programme[23]

Top issues driving programme priorities*[17]

- Nutrition and healthy eating
- Physical activity
- Access to healthcare services
- Workplace environment and safety
- Obesity

Top wellbeing objectives
('extremely' / 'very important')*[17]

- Improving performance and productivity
- Furthering organisational values / mission
- Improving workplace safety

Asia

5%

of employees with access to a workplace health programme[23]

Top issues driving programme priorities*[17]

- Physical activity
- Use of preventive health screening
- Workplace environment and safety
- Compliance with recommended care for health conditions

Top wellbeing objectives
('extremely' / 'very important')*[17]

- Attracting and retaining employees
- Improving performance and productivity
- Maintaining work ability

China Tobacco Control Partnership

Tobacco-Free Cities Smoke-Free Business Initiative

In brief	City-level support for businesses to tackle tobacco use among employees
Partners	City health authorities, local businesses and media, the Think Tank Research Center for Health Development (China), academia (the Emory Global Health Institute, Georgia State University and the National Cancer Institute), and the Gates Foundation
Established	2014 (one-year)
Reach	240 companies (400,000 employees)

THE PROGRAMME

Since 2008, the China Tobacco Control Partnership has developed a network of 22 Tobacco-Free Cities across China. There is no national legislation on smoke-free workplaces so, in 2014, six of the most forward-thinking cities were chosen to form the Smoke-Free Business Initiative.

The Partnership team in each city recruited local businesses (ranging in size from 37,000 to just 15 employees, and from sectors including manufacturing, transportation, energy and IT), used local media for advocacy, built strategic partnerships with the local business community, provided materials and training, and evaluated the companies' programmes (through a combination of employee surveys and on-site visits to assess the smoking environment). Participating businesses' initiatives include workplace signage, inspections of public areas, financial rewards for employees who quit, on-site smoking cessation and a mobile tobacco-control classroom that visits the local community. An award ceremony (for which there were 80 applications) was held in Beijing at the end of the year, to recognise the companies that had made the most progress.

Many of the Smoke-free Business Initiative participating companies are now leaders in China in tobacco control, and are continuing to source funding from external partners, which makes programmes sustainable over the longer term.

IMPACT

Zhejiang Grandma's Home is a restaurant chain employing 1,600 people in Hangzhou. Its director was initially sceptical of the benefits of going smoke-free, but the local Tobacco-free Partnership project manager – a personal friend – persuaded him to take part, prohibiting smoking among employees and discouraging diners from smoking. Customers and staff report being happy that they are no longer exposed to smoke, and business has improved: tables turn over more rapidly because customers no longer spend time smoking after their meal.

KEY LEARNING

It is the businesses with high-level support (e.g. directors who quit smoking; leaders who promote and enforce the policy) that are the strongest champions.

Healthy Caribbean Coalition

Civil society supporting private-sector response to NCDs

In brief	Regional NGO alliance establishing NCDs as a priority within workplace health, and creating a network of businesses to share best practice
Partners	HCC and its member organisations, Pan American Health Organization, Caribbean Public Health Agency (CARPHA), Commonwealth Secretariat and CIBC/ FirstCaribbean Bank
Established	HCC 2008 (workplace health programme 2015)
Reach	Several businesses have been engaged to date with a recently established case-study hub anticipated to have a much wider reach throughout the Caribbean region

THE PROGRAMME

The Healthy Caribbean Coalition (HCC) is the Caribbean regional NCD alliance, giving a strong coordinated voice to over 100 civil society organisations, including 60 Caribbean-based health NGOs in NCD prevention and management.

In 2015, the HCC undertook the region's first Healthy Workplace Survey among 35 businesses, ranging from fewer than 100 employees to over 1,000, 65 per cent of whom responded, to assess workplace health priorities and the extent of their existing workplace health programmes.

The survey was followed up with an HCC-led regional Private Sector Forum, attended by businesses of the Caribbean Region, the public sector and CSOs, resulting in the development of a Framework for Action, and a subsequent report, The Caribbean Private Sector Response to NCDs: A Situational Analysis and Framework for Action, summarising processes and ideas on workplace health, applicable for organisations of all sizes. The process clearly showed that businesses were keen to bring NCDs into occupational health, but were unsure as to how best to achieve this.

IMPACT

HCC's efforts to establish healthy workplaces as a priority led to the identification of CIBC/First Caribbean Bank (a regional private-sector business) as a regional Workplace Wellness Champion, and the establishment of a collaboration including provision of dedicated funding. HCC is currently planning a range of programmes, including a regional meeting of workplaces and a volunteer programme to encourage staff from private-sector companies to be champions of health in the workplace. Sharing best practice will be facilitated through an online 'hub', to be hosted on the HCC website.

KEY LEARNING

An NCD alliance model can take a strong lead in consulting with, being a technical resource and facilitating the development of a network of private-sector businesses to advance workplace health, with emphasis on NCD prevention and control.

3.2.2 NCDs as a workplace health priority in LMICs

> “Workplace health is beginning to trickle through to LMICs through supply chains.
>
> **Global**

There is increasing recognition among employers of the burden of NCDs in lower-income countries, and the value of workplace health programmes. In 2013 the diseases of most concern among employers surveyed in LMICs were HIV/AIDS and tuberculosis – but *mental health, diabetes, cancer and cardiovascular disease were all among the top seven priorities*. This survey also suggested that NCDs are more likely to be targeted in upper-middle-income countries, and found that diabetes was not addressed by any of the programmes in low-income countries.[24] This correlates with national priorities in workplace health: a 2008 survey by the World Health Organization found that 65 per cent of national workplace health policies cover NCDs globally; however, in Africa where communicable diseases remain the priority, only 30 per cent include NCDs.[25]

Some companies also recognise the impact of addressing NCDs in the context of *a more holistic strategy and programme* (**case study – Ghana Revenue Authority**). Within this, education on health issues, better coordination with local health systems (such as referral to local health facilities, if screening at work shows that employees have an NCD), and a people-centred approach that empowers individual employees to take control of their own health (see 3.3.2 below) are some of the most prominent aspects of workplace health programmes.

Two-thirds of workplace health programmes in the LMIC survey noted above took the form of education and training.[24] This should be presented in a form appropriate for the level of literacy of employees), and complemented with interventions to improve physical and social environments in the workplace itself.

In some LMICs, the role of employers reaches beyond employees to their families and the local community. Through extending health support, employers can play a valuable role in improving social protection across communities and in supply chains, from which their workforce is drawn and where their families live (**case study – SWHAP**).

> “Making a difference to workplace health requires employers, government and health-care professionals to operate in harmony with each other.
>
> **Global**

Ghana Revenue Authority
Employee Wellbeing Programme (EWP)

In brief	Public–private partnership delivering an Employee Wellbeing Programme covering all aspects of health and social security
Partners	Ghana Revenue Authority, Ghana Community Network Services Limited (GCNet), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and local health services and health insurers, local and overseas universities
Established	2010
Reach	Over 7,300 employees

THE PROGRAMME

Since 2006, the German agency for International Cooperation (GIZ) has worked with partners in Ghana to establish what was initially an HIV programme in workplaces; this has now been extended into a wider Employee Wellbeing Programme (EWP), incorporating preventive health programmes (including NCDs), comprehensive disease control and social protection. This reflects health priorities in Ghana: malaria, hypertension and its complications, and obesity are all in the top five causes of productivity loss. The EWP approach links companies that are seeking ways to shape long-term corporate investment with existing systems and services locally, and has created a network of organisations that lead by example.

IMPACT

One successful case study is the Ghana Revenue Authority (GRA), which has partnered with GIZ and GCNet (a local company providing comprehensive IT services to GRA and the Ghanaian Government) to provide services to all employees, integrating this Employee Wellbeing Programme within its Strategic Plan. There is a strong focus on screening and early diagnosis (including education on lifestyle factors, such as nutrition and stress management), wellbeing fairs (also open to local communities), support for employees with chronic conditions (all employees have access to an employee assistance programme) and preparation for retirement (additionally encouraging good personal financial management).

Monitoring and evaluation has been built in from the start, with periodic surveys of staff also carried out, indicating areas where more effort would be beneficial – such as cancer and hypertension awareness, and tackling stigma. GCNet has developed an electronic Health Management Information System to enable the GRA to track employee health and evaluate the impact of services. Programme performance scores improved by 32 per cent within four years and the proportion with normal blood pressure increased by 18 per cent.

KEY LEARNING

Evidence on the benefits of the EWP has led to ongoing commitment from management to invest resources in the programme.

GCNet electronic Health Management Information System:
https://www.youtube.com/watch?v=WDU2tXAYO9g

Swedish Workplace HIV/AIDS Programme (SWHAP)
Value-chain programme

In brief	Co-funded model of support for Swedish-related companies in Africa, integrating NCDs into HIV workplace health programmes
Partners	International Council of Swedish Industry, Swedish Industrial and Metalworkers' Union, Swedish International Development Agency, employers, unions and local service providers
Established	2004 (value-chain programme since 2008)
Reach	360+ worksites in 11 African countries (66 through the value-chain programme)

THE PROGRAMME

SWHAP provides support and three years of co-funding for workplace health programmes. Initially established to extend access to prevention and treatment for HIV, NCDs are now included; 'taking HIV out of isolation' makes workplace health more accessible and acceptable to all.

SWHAP is now also extending workplace health to smaller organisations (such as suppliers) within larger companies' value chains (usually between 25 and 300 employees). Each larger company mentors 3–5 organisations, beginning with awareness-raising for senior management. The mentee companies put together a Steering Committee (management and employee representatives) and choose workplace champions, trained to drive/lead the programme and peer-educate colleagues. A service provider, contracted by SWHAP, monitors and supports the Committee during site visits. The company is mentored to develop a policy, a KABP (baseline survey on knowledge, attitudes, beliefs and practices) is taken and a concept programme developed, based on employee needs.

The 15-week programme is funded by SWHAP, with mentees and mentor companies providing logistics and covering the cost of their own time. The culmination of the mentoring initiative is the launch of the workplace programme and policy, with employees tested during a wellness day event. To support sustainability and establish a peer-learning channel, mentees are encouraged to attend all SWHAP network workshops and conferences, and the mentor companies to include them in their own in-company events.

IMPACT

As part of a partnership between a Swedish company supplying high-tech tools to the mining industry and a mine in Zimbabwe, a 'know your numbers' campaign screened 90 per cent of the 1,000 employees (including for blood pressure, BMI and blood sugar), and those who needed it were given treatment and monitored monthly. High BMI – a particular concern – is now regularly monitored as part of the programme, and employees are encouraged to take part in a fitness programme (including Zumba) and provided with information on healthy diets.

KEY LEARNING

The sustainability of the value-chain programme is enhanced through an ongoing mentorship relationship and inclusion of mentee companies into the wellness activities of the mentor company, and through linkages to HIV and wellness networks.

3.2.3 Trends in workplace health action

Action by government – particularly legislation – can have a significant impact on health in the workplace, such as the *adoption of smoke-free laws* in many parts of the world, as well as safety legislation. However, compliance may only be superficial and enforcement inadequate.

Incentive schemes – such as co-funding or tax breaks for workplace health programmes from governments or incentives for employees – can encourage adoption of initiatives. These are more common in higher-income countries – there are tax benefits for businesses in the United States,[26] and 77 per cent of large companies use incentives in the US/Canada – but are more rare in LMICs (23 per cent in Asia and 22 per cent in Latin America in large companies).[17] However, a study from Brazil found that subsidising healthier meal options at work led to increased consumption of fruit and vegetables.[27] There are also challenges around the design of such initiatives, and if used they should be part of a more comprehensive programme.[28]

There is also increasing use of m-health – *mobile technology* – as a highly efficient and scalable way to reach individuals and increase awareness and engagement in health issues, including in the workplace. There are over 5 billion users of mobile phones globally who can be reached by phone through text messaging and apps. Mobile technology can be used in smoking cessation, weight-management, diabetes and chronic respiratory disease. And, while technology is not a panacea (and the evidence on the use of apps is very mixed), it can be a useful support for health initiatives (**case study – Virgin Pulse Corporate Challenge**).

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> Government action, especially policy change, can have a tremendous and rapid effect
>
> Latin America

Virgin Pulse
Global Challenge

In brief	Team-based physical activity challenge over 100 days, delivered online and using wearable technology
Partners	Virgin Pulse, clients and employees, Science Advisory Board members and research partners
Established	2004 as Global Corporate Challenge
Reach	223,000 participants worldwide in 2017

THE PROGRAMME

The Virgin Pulse Global Challenge is an annual, three-month physical activity-based challenge for employees, first launched in 2004 in Australia and now reaching 190 countries. Workplaces enter teams of seven people, with participants issued with a smart accelerometer or they can use their own wearable tech. Everyone is encouraged to take at least 10,000 steps daily, with conversion to equivalent 'steps' for people who prefer to cycle or swim. A website tracks progress of individuals and teams (which encourages competition and team-building), provides information about nutrition and sleep, and includes health tools such as a 'Heart Age' calculator. The aim is to build new physical-activity habits that will be continued beyond the end of the formal challenge – and the website allows participants to continue to track their progress once the Challenge has ended.

There are many entrants from organisations in middle-income countries: in 2017, there were around 4,400 participants in Brazil and nearly 17,000 in China. The male:female ratio of participants is much higher in most lower-income countries (e.g. 3:1 in India) than in high-income countries (where the gender balance is nearly equal). The cost of participating is around $89–99 (USD) per person.

IMPACT

The average office worker is estimated to walk only 4,500–5,500 steps per day, but Global Challenge participants averaged 13,027 steps a day in 2017. Before the Challenge, only 19 per cent reported reaching 10,000 steps a day – but 69 per cent achieved it over the three months. In most countries, step-count improved during the Challenge – in India rising from 13,219 to 14,970 steps a day among the 7,400 participants.

An end survey was completed by 37 per cent of participants, suggesting that 68 per cent felt their stress levels at home or at work had decreased and 55 per cent that their productivity/concentration had improved. There is also self-reported weight loss – an average of 0.62kg globally, with 0.93kg in Pakistan, 0.52kg in China and 0.22kg in India.

KEY LEARNING

A physical-activity challenge not only impacts on behaviour for the duration of the challenge; it can also support formation and reinforcement of positive/healthy habits over the longer term.

3.3 Challenges to establishing workplace health

3.3.1 Macro-level (national) challenges

Low- and middle-income countries are enormously diverse, and are home to 80 per cent of the world's population. In Africa, 95 per cent of the population is under age 60. In both Asia and Latin America, the figure is 88 per cent. This offers a clear demographic dividend, with particular potential for employment.[29] Many face major challenges such as high unemployment, a dual burden of infectious and noncommunicable disease, and significant inequalities (of wealth and health) within the population. The majority of people in LMICs work for SMEs or in the informal (micro-enterprise) sector. This provides a particular challenge for workplace health and a very different backdrop for implementation to that for which workplace health programmes in high-income countries are tailored. There may be no social safety net or adequately functioning health system to protect workers when they become ill. Safety concerns and infectious diseases are often prevalent and pressing issues. Economic crises can add strain to already overburdened health systems. Too often, addressing NCDs are not a political imperative.

- Addressing workplace health can offer *opportunities for synergies* with other important policy areas: addressing workplace health can have benefits elsewhere. For example, tackling climate change through encouraging active travel (walking and cycling), including to and from work, also has health benefits.

There is also great *cultural diversity* that might prevent employers from engaging in employee health or addressing specific risk factors – in some countries for example, obesity is seen as a sign of wealth and health (i.e. free from infectious disease such as TB or HIV). In individualist cultures, responsibility for health may be seen as primarily on employees themselves, with employers' interest seen as unwelcome interference or as having the potential for discrimination.

- Fully *understanding and engaging with the workforce*, in conjunction with local communities and health services, identifies and contextualises the needs of employees – and can begin to build a culture of health [30] both at country and organisational level, in which workplace health is a new social norm.

In many LMICs, a lack of health data means that the burden of NCDs on the population and on the national economy cannot be fully assessed, and therefore the business case for action is not clearly articulated for the government and employers.

3.3.2 Micro-level (organisational) challenges

Where there are workplace health initiatives in place, these often fail to *take baseline measurements or assess the impact* on employees,[31] indicating that programmes offered may not be based on actual priorities and needs. In a survey of companies that already offer workplace health programmes in the Caribbean, for example, only 37 per cent had conducted a health risk appraisal of employees.[32] Identifying appropriate key performance indicators is a challenge (going beyond reducing absenteeism to include productivity, engagement etc.), which makes initiatives hard to assess – and evaluation can be expensive, complex (particularly separating out the impact of specific programmes), and with many returns on investments and health impacts of behaviour change not seen for some time. Lack of a business case is a barrier to high-level buy-in, whatever the size of the organisation; difficulty in ensuring ongoing support of senior management was one of the main barriers to programme implementation in a survey of LMIC initiatives.[24]

- However, *lack of hard data should not be a reason for failing to address workplace health* (**case study – Arogya World**).
- *Sharing what works* among organisations can help to overcome this inertia, and stories about the impact of programmes on individuals can also be a powerful motivating factor. There are also free resources – online tools or local community assets – that employers can use, and there are a variety of international, national or local health initiatives or campaigns (e.g. car-free days or World Heart Day) that are low-cost and can engage the informal sector.
- *Local networks and peer-to-peer learning* can also facilitate sharing of information and processes (**case study – Technica International**). This can be an important route to reaching the informal sector (**case study – WISE**).

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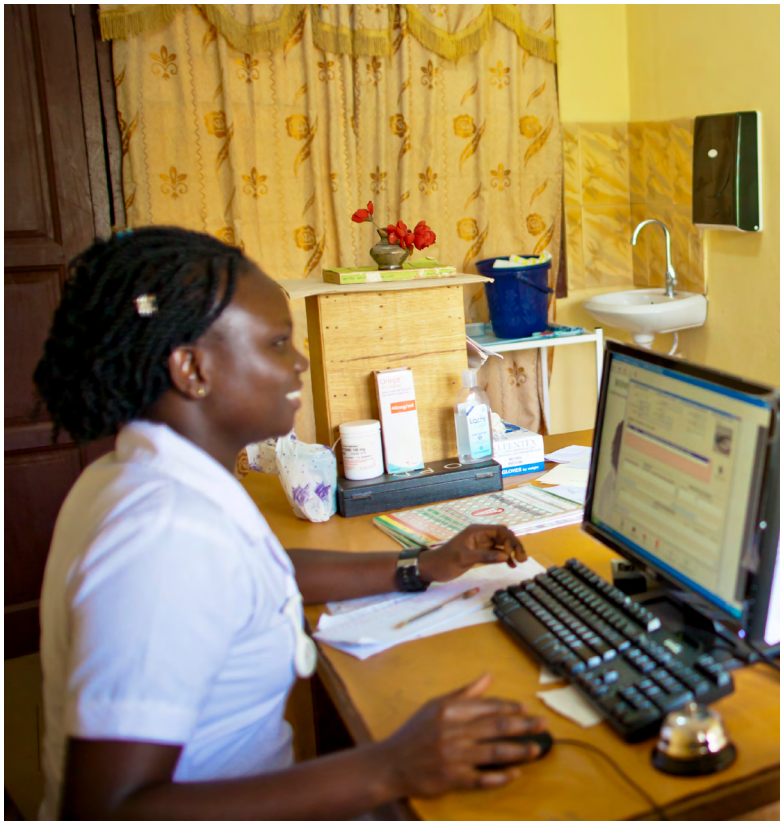
> In rough economic times when employees don’t trust management, they will trust the unions.
>
> **Sub-Saharan Africa**



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>
> In general, workplace health is more lacking than it is adequate.
>
> **China**

Failure to *engage employees* themselves is also a barrier to successful workplace health – clear, ongoing communication is required. When the work environment is one in which all feel supported in healthy decisions then employees are less likely to feel stigmatised and are more likely to take part.

- The establishment of a *Workplace Health Committee* empowers employees to have their voices heard, and *involvement of other workers’ groups/organisations* builds trust between employee and employer, ensuring that workplace health remains a priority even if management changes. In communities in which literacy is low, it may be more appropriate to deliver information through a wide range of media (such as pictures or by word of mouth from other employees) rather than written

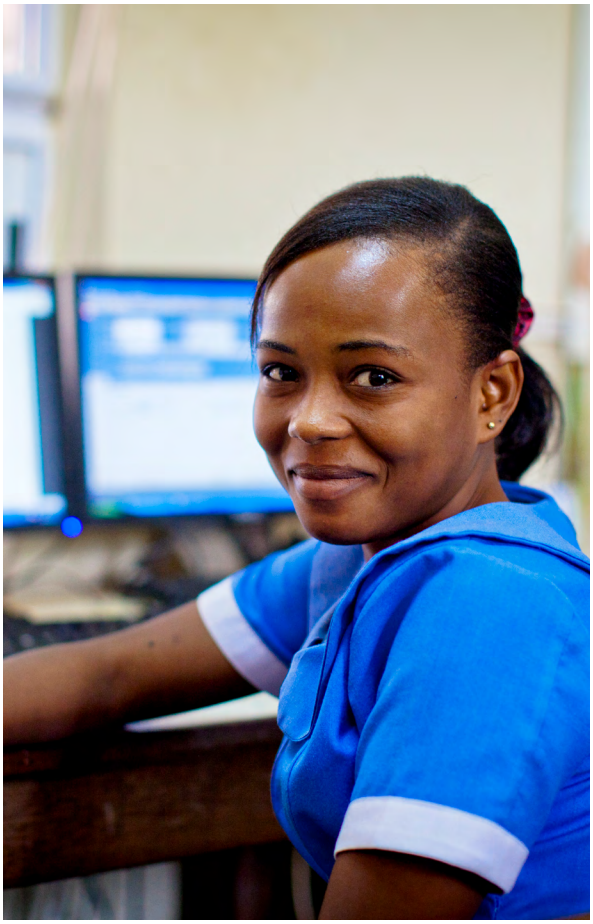
communication. In particular, people living with NCDs should always be consulted, as they have valuable insights into ways to address their needs in the workplace.

Feeling *unable to take time out from work* is the single biggest barrier to participation in workplace health initiatives, according to a 2016 survey.[17, 33]

- However, initiatives *need not be time consuming.* One study in Mexico trialled short 10-minute exercise breaks during (paid) work time, combined with prompts to take the stairs and other encouragement – and found a significant decrease in BMI and weight for men, and waist circumference for both genders.[34]

Resourcing workplace health is a common challenge – and not all organisations can be expected to undertake a full range of actions. There are minimum actions that all companies should take (such as becoming smoke-free), with additional action and measurement taken that is appropriate to the resource and size of companies, and the cultural context. There is, however, scope for taking a *consistent approach to workplace health* – working to overcome the challenges that this report highlights. This approach is set out in section 5.

Initiatives need not be time consuming



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This doesn’t take money – this takes ingenuity, organisation and a bit of motivation.

Global

To be sustainable, health in the workplace must be fully integrated into individual organisations’ vision, policies and practice – in both high- and low-income settings.

Arogya World
Healthy Workplace Programme

In brief	A Healthy Workplace Award scheme addressing tobacco, healthy eating, physical activity, work–life balance, and changing mindsets
Partners	Arogya World, employers and employees, wellness service providers, health experts
Established	2012
Reach	Over 100 companies (2.3 million employees)

THE PROGRAMME

Arogya World is a global health NGO that tackles NCDs through health education and lifestyle change. In 2012, in close consultation with industry representatives and health experts, Arogya World drew up a checklist of criteria defining what it means to be a 'healthy workplace' in an Indian context, across five areas – tobacco, healthy eating, physical activity, work–life balance and 'changing mindsets' (creating a culture of health). This forms the basis of the Healthy Workplace Awards.

An Arogya World representative, a clinician and someone with industry experience visit each applicant company. They begin by assessing the work that is already being done, which is both an informal benchmark and a way to encourage and enthuse the workforce. The workplaces are awarded Bronze, Silver or Gold status – and a Platinum Award has recently been added, with requirements to track data on employee health and to begin measuring the impact of programmes (an important step, but initially beyond the capacity of some organisations). Arogya World also provides additional services, such as a mobile app designed to prevent chronic disease in working Indians, behaviour-change training led by lifestyle coaches, a new nutritional icon called myThali that tells people what they should eat and in what quantities, and a Tobacco-free Worksite Challenge.

The main challenges are: limited resources to scale up the accreditation, and little support from government and business organisations (which would drive demand for the programme).

IMPACT

101 companies have received awards to date, of which 22 have Platinum status; organisations are encouraged to reapply for higher status in subsequent years. More companies may use the checklist to self-assess – it is freely available online – but may not want to apply until they are confident of achieving Gold! Award recipients become part of a network of 2.3 million employees; they receive a newsletter and are invited to attend an annual conference at which progress is celebrated and shared.

KEY LEARNING

A big checklist of to-dos can be a deterrent for initiating action. In this case, a focus on starting with what the company is already doing for employee health (rather than immediately prioritising additional programmes or measurement) contributed to more companies willing to be involved.

Technica International
Healthy Workplace Programme

In brief	Programme addressing physical and psychosocial aspects of health within an SME using a 'servant leadership' model
Partners	Local NGOs and health organisations (e.g. physiotherapist and a smoking-cessation provider)
Established	2010
Reach	210 employees in Lebanon (one factory and local offices)

THE PROGRAMME

A principle of Technica International's culture is servant leadership ('managers are servants first, leaders second'), which includes a strong focus on health. Employees have an important guiding role, including in the Healthy Workplace Program Committee that reports directly to the general manager (whose job description includes implementation of healthy workplace requirements). Feedback is also gathered through focus-group discussions and an Employee Satisfaction Questionnaire.

Both the physical work environment (e.g. ergonomics assessments and safety buddies) and psychosocial work environment (e.g. flexible working hours for mothers and a music club) are addressed. All employees and their families are offered health screening (employees receive an employee health record sheet from the company doctor), and health insurance is available at discounted rates.

Active lifestyles are encouraged, including sports teams and local gym membership, and in 2018 a competition is planned that will encourage employees to stay fit and will gather health metrics. A healthy eating habits programme is led by an external dietician, who has one-on-one nutrition sessions with all employees. The company has also set up an HR Club that shares its surveys and systems with 15 other local businesses. The programme also provides services in the local community, such as repairing 5km of road between the factory and a neighbouring village. The biggest challenge is funding: there is no government support for the programme, so all resources are found internally.

IMPACT

The impact of the programme is analysed and communicated to employees. Accident rates have fallen by 20 per cent, employee satisfaction and engagement has increased, and some employees quit smoking (with others receiving ongoing support to quit). The sizes of new uniforms are monitored – and this has stayed the same or decreased for most staff. The success of the programme has been acknowledged by the Global Healthy Workplace Awards, as Technica International has twice been a finalist in the SME category.

KEY LEARNING

"Creating the right environment for our team is an investment with high returns. It impacts positively on employee engagement and productivity".

4

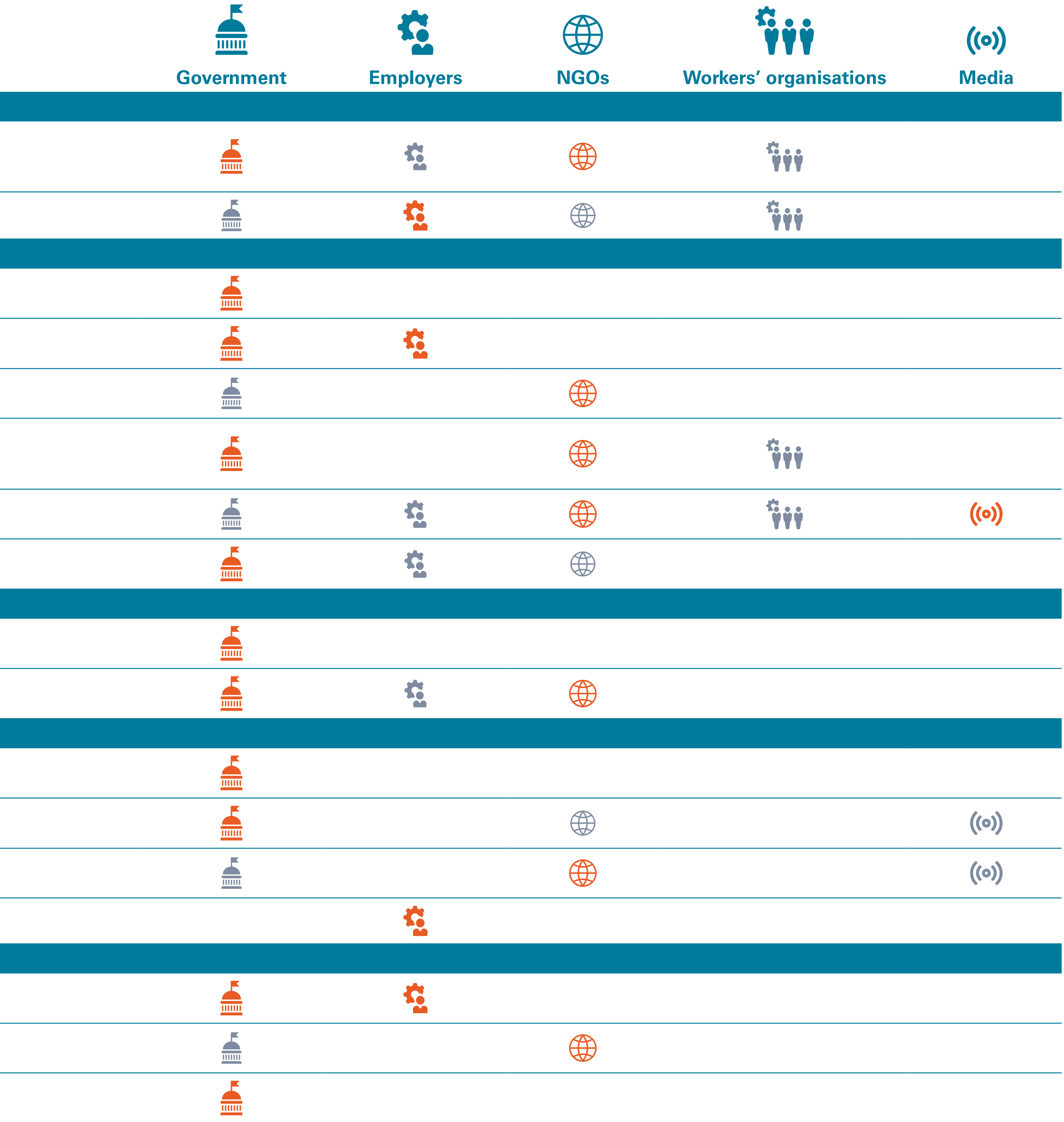
Recommendations for the way forward: coordinated action

Coordinated, consistent and concerted action is required from a range of stakeholders if workplace health is to become a political and social priority for LMICs, and a reality for all. Governments, employers, NGOs, workers' organisations/unions and the media play an important role in creating a culture within which workplace health

RECOMMENDATION
Align vision and focus among stakeholders
Identify key in-country partners, convene them on workplace health and NCDs to ascertain what 'healthy' means in national context and ways to work in partnership and keep channels of communication open to ensure that guidance on workplace health is as relevant as possible
Identify and develop local (e.g. city-level) networks and programmes to pool resources and assets
Develop data-informed and culturally appropriate messages and business case
Analyse the health of the working-age population at community level to assist employers in understanding local health needs
Ensure that any health-screening requirements for employees include a range of NCD-relevant indicators (BMI, blood pressure, etc.), and that this (anonymised) information can be accessed and used by employers
Build a 'national business case' for tackling NCDs in the workplace, using national statistics on the economic cost of reduced productivity from NCDs
Develop standardised tools for measurement and assessment of need, ways to engage employees, and how to use metrics to build the business case for continuing (or increasing) investment and measurement of impact, relevant for all sizes of organisations
Ensure that employers are aware of their role in making international, national or local health initiatives or campaigns a success by encouraging employees to take part – e.g. car-free days or World Heart Day
Consider using and developing digital health tools to deliver appropriate initiatives
Resource and incentivise workplace health
Consider incentivising workplaces as a major arena for tackling NCDs e.g. by providing tax incentives for healthy workplaces by making it a requirement for procurement of government contracts
Consider co-funding new workplace health programmes, to overcome initial resourcing barriers
Share learning and celebrate success
Instigate workplace health programmes within public bodies, to be exemplars of workplace health programmes and share resources
Consider providing accreditation for businesses – and publicise this where it exists
Disseminate examples of best practice, including NCD prevention and management, which employers can access for inspiration
Consider a model in which large businesses share expertise and resources with their supply chain or local community
Ensure follow-up and policy implementation
Implement smoke-free legislation
Develop and publicise materials and tools to help plan, implement and support initiatives: bringing NCDs into existing programmes including for SMEs, translating tools from other countries and adapting them to national realities
Consider requiring public reporting on workplace health for larger organisations

can thrive as a part of the local community, embedded within national NCD policies and individual companies' strategies, aligned with employees' needs and culture, and with sufficient resources invested.

The recommendations in this table suggest actions for key stakeholder groups, and are broad enough to be applied in many LMICs. A ***red icon*** *indicates where one actor is particularly well placed to initiate change in partnership with others, but not is the only actor able to or responsible for doing so.*



5
LEADERS: an employers' framework for effective NCD workplace health programmes

Successful workplace health programmes can deliver health benefits for individual employees and improve the economic bottom line for businesses.

In practical terms, even when all the stakeholders are aligned behind a common vision, the business case is clear and national policies are in place to incentivise and catalyse action, there is no one single route to workplace health, because organisational diversity is so great. However, learnings from the case studies and research analysed for this report point to some key elements to guide employers in establishing a workplace health programme:

LEADERS: Lead, Engage, Assess, Do, Evaluate, Rethink, Share*

These components are as applicable to diabetes and cardiovascular disease as they are to HIV or musculoskeletal disorders, and tackle NCD prevention, treatment and care, and stigma and discrimination.

LEAD

Lead from the top: a prerequisite for effective, sustainable workplace health.

High-level commitment (including support from senior management, where relevant, support from the Board) drives the vision and resourcing for a healthy working environment. This can be a *signed policy, pledge or statement*, including NCD prevention and management as a key component within wider workplace health initiatives. Where managers act as *role models* themselves, this demonstrates that the company-level commitment is genuine.

Example ***Technica International – Healthy Workplace Programme***

ENGAGE

Engage the cooperation, support and participation of employees, and the active involvement of appropriate external partners.

A Workplace Health Committee (or coordinator, in a small organisation) formalises the ongoing engagement with employees, provides feedback, and holds the programmes to account. *Health champions* are enthusiastic, engaging and active individuals who can take part and encourage others to do so, reducing stigma around participation and building relationships between employees and employer.

External partners from other sectors can help to steer and deliver health in the workplace: government, non-governmental organisations (including national NCD alliances) and health-care professionals and providers of health services based in the local community.

Example ***Technica International – Healthy Workplace Programme***
Arogya World – Healthy Workplace Programme
ILO – WISE initiative

*The LEADERS structure draws on a number of different models from the WHO,[35,36] US CDC,[37] GBCHealth,[24] the Global Centre for Healthy Workplaces,[38] and the Healthy Caribbean Coalition.[32]

ASSESS

Assess the needs of employees to establish workplace health priorities and plan the design of effective ways to tackle NCDs.

An *assessment of the health needs of employees* will demonstrate where there is the greatest need and can prioritise action both on lifestyle factors and on management of NCDs. This also provides a baseline from which to set targets and show impact of initiatives.

A plan of action sets out where and when programmes will take place, participants (e.g. employees / families / wider community), resourcing (an essential aspect of budget planning), and delivery partners (e.g. external vendors or NGOs).

Example ***SWHAP – Value-chain programme***

DO

Do programmes that are based on the needs of employees with (or at high risk of) NCDs and that foster a broader health-promoting working environment.

The first step is ensuring that all *relevant legislation* (e.g. safety risks, health screening of employees, smoke-free regulations) is implemented throughout the organisation.

Next, implement the plan of action, *prioritising what is most needed*. Organisations of all sizes can take steps to support health (large organisations might consider pilots at individual sites before rolling out more widely). Employees will only take part if initiatives are relevant, effective and attractive, and if medical confidentiality is assured.

Where a business operates across several sites, *programmes may already be in place elsewhere in the company* that can be adapted and extended, appropriate to local priorities (e.g. incorporating NCDs within existing infectious disease programmes).

Sustainability depends just as much on motivation and enthusiasm as on monetary resources.

Example ***Virgin Pulse – Global Challenge***
China Tobacco Control Partnership – Tobacco-Free Cities Smoke-Free Business Initiative

EVALUATE

Evaluate the impact of programmes on the health of employees and the health of the business; this justifies future investment, although it can be challenging.

Even *small organisations can gather information to guide programme development* – e.g. asking health champions and employees (particularly those with an NCD) about barriers to participation, and whether people with health conditions feel that they are discriminated against or stigmatised.

Impact metrics include: resources dedicated to workplace health (e.g. budget / personnel / physical assets); activities and number of participants; outcomes (e.g. the number of people who have quit smoking or brought their blood pressure under control); and the wider impact on the business (e.g. decrease in absenteeism).

Capturing stories – real-life experiences of employees – can be just as valuable as cost-effectiveness data in making the case for continuing investment.

Example ***SWHAP – Value-chain programme***
Ghana Revenue Authority – EWP

RETHINK

Rethink and adapt programmes and health priorities in response to evaluation, to ensure continuous quality improvement.

Continuous improvement and sustainability depends on regular adjustment of health programmes and strategy – including minimising any unexpected adverse consequences that are revealed by evaluation.

However, *programmes should not be immediately rejected* as ineffective if there is no clear financial return. Employees' experiences are invaluable in making this decision – if those with (or at most risk of) NCDs are feeling the benefit, the programme may need more time to embed.

Example ***Ghana Revenue Authority – EWP***

SHARE

Share successes and challenges to encourage a culture of health within and beyond the organisation.

Celebrating workplace health achievements with employees encourages a more supportive environment. Sharing success stories with the Board demonstrates the impact of programmes on the real lives of employees – and shareholders and investors can be informed of progress in annual reporting.

Health initiatives can be *extended into the wider community* – e.g. partnering with supply chains to reach smaller organisations that would otherwise not have access to NCD management and prevention.

Relating experiences to peers – through networking opportunities, awards or certification schemes, and conferences – can identify replicable, scalable examples, and avoid repetition of mistakes.

Example ***Healthy Caribbean Coalition – Private-sector response to NCDs***
SWHAP – Value-chain programme

6
Conclusion – a call to action

The workplace is an immensely influential arena in which to foster good health – an opportunity that is greatest in LMICs where 80 per cent of the 15 million deaths from NCDs among people aged 30–70 occur each year.[1] Among this age group, the workplace environment has a significant impact on health – but currently just 5 per cent of employees in Latin America / Asia and 1 per cent in Africa are estimated to have access to a workplace health programme.[23]

This is a call to action to take advantage of this largely untapped opportunity: workplace health benefits individuals, their families, employers, local communities and national economies.

Action is most effective when done in partnership (section 4):

- *aligning vision and focus* among stakeholders – governments, employers, NGOs, workers' organisations and the media – both nationally and city/community-wide;
- using data and stories to develop a *business case for action* including clear, culturally appropriate NCD messages for employers, enabling them to embed workplace health into business strategies and plans;
- *resourcing and incentivising* workplace health to bring successful examples to scale, identifying ways to overcome resource challenges;
- *sharing and celebrating* what has worked in NCD prevention and management – e.g. through peer-to-peer learning or accreditation; and
- ensuring *policy implementation and ongoing support* for employers through legislation and tools that assist in planning and implementing workplace health programmes.

Employers, working alongside health professionals and government, can take a lead in creating a culture of health that includes NCD prevention, health education and management (section 5):

- although different organisations have different priorities and needs, there is scope for a *consistent approach*, including strong leadership and harnessing the enthusiasm and knowledge of employees themselves;
- existing programmes, such as *HIV/AIDS initiatives and occupational health and safety,* can be leveraged to introduce lifestyle risk factors and management of NCDs; and
- support provided in the workplace can extend to *families, supply chains and the local community,* impacting in this way the broader society and complementing care provisions in low resources settings .

Action in the workplace is a crucial avenue to reaching the Sustainable Development Goals target of a 30 per cent reduction in premature deaths from NCDs by 2030.

Taking workplace health seriously can improve the quality of life of millions of working-age people, their families and local communities, and with the economic benefits felt locally and nationally.

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