WELLNESS FOR A GLOBAL WORKFORCE

Workplace wellness initiatives in low and middle-income countries

GBCHealth
Mobilizing Business for a Healthier World

Sentinel Consulting

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SUMMARY

Workplace wellness initiatives are as varied as the organizations and locations in which they operate. With the vast majority of evidence and advice centered on high-income settings, designing and implementing a wellness initiative in a low or middle-income setting can be a daunting prospect. This study aims to assist corporations by providing a snapshot of wellness programs currently implemented specifically in low and middle-income countries (LMICs), and collating evidence of impact. We explore the motivations for developing programs, the health conditions and risk factors most often targeted, how programs are implemented and evaluated, and useful lessons learned by program custodians. Finally, we include a checklist for program managers developing a wellness program for their own organization.

Contents

IN FOCUS CASE STUDIES

Introduction

Business leaders have long recognized that workers' poor health significantly impacts the ability to run a successful enterprise. Wellness became widely accepted as a concept in the 1970s, and workplace wellness programs gained widespread popularity during the 1980s.[1] As a daily gathering point, the workplace is an ideal place to reach individuals with health information and incorporate healthy behavior into the daily routine. However, to date there is no universally agreed definition of wellness, and certainly no blueprint for designing effective programs.

Workplace wellness programs are still most prevalent in North American companies, principally motivated by the reduction of healthcare costs.[2] The growing body of evidence of clinical and cost effectiveness has now shifted the debate in North America away from *whether* workplace programs should be implemented towards *how* programs should be optimized.[3]

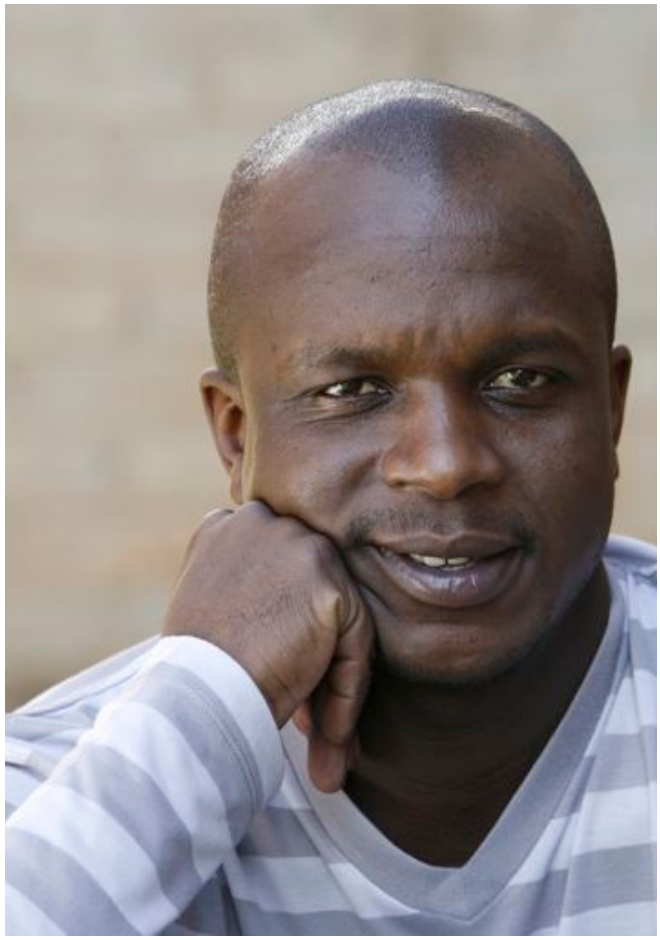
The rest of the world seems to be following North America's lead, with 47% of Asian companies, 43% of South and Central American companies and 33% of African or Middle Eastern companies running wellness programs.[4] Outside the US many state healthcare systems bear a greater proportion of healthcare costs, and the private sector is therefore less motivated by managing the total cost of health. Non-US companies cite their primary business motivations as:

- improving worker productivity and reducing presenteeism*
- reducing absenteeism
- improving workers' morale and engagement.[4]

That said, many countries are facing significant financial pressures on their state health budgets due to aging populations and rising healthcare costs. The current economic uncertainty has heightened these fiscal challenges, and many countries are planning—or have implemented—reductions in healthcare services financed by the state. Businesses have responded by elevating their attention to their health and wellness budgets worldwide.

With the vast majority of evidence and advice centered on high-income settings—specifically the US—designing and implementing a wellness initiative in a low or middle-income setting can be a daunting prospect. This study aims to assist corporations by providing a snapshot of wellness programs currently implemented specifically in low and middle-income countries (LMICs), and collating evidence of impact and useful lessons learned by program custodians. Respondents include companies such as:

- Levi Strauss & Co—who implemented an HIV program for garment factory workers in Vietnam
- Volkswagen South Africa—who designed a fully integrated wellness program targeting communicable and non-communicable diseases as well as occupational risks in a single offering
- The UN system—running programs in some of the world's most challenging locations.



> "Our program participants have become our biggest advocates, and we find each session has a ripple effect."
>
> **Liberia**

Forty programs implementing 240 different interventions in 31 countries are represented. They reflect tremendous variety in terms of industries, geographical locations and health issues targeted.

*Attending work while ill, often associated with loss of productivity.[6]

IN FOCUS NIGERIA

Chevron: Healthy Heart – a Worksite Program to address Cardiovascular Health Risks

The objectives of Chevron's Healthy Heart program are to reduce employees' risk for cardiovascular disease; increase the percentage of employees at low risk for cardiovascular disease; encourage understanding that behaviors can influence long-term health; demonstrate the link between health, productivity and safety and create a competitive advantage for Chevron with a healthy and safe workforce. The program has been deployed to 12 countries around the world, tailored to each location.

Originally called the Cardiovascular Health program, this comprehensive program was rebranded as the Healthy Heart program in 2012. The case for program development is based on medical data from Nigeria and other Chevron locations that demonstrate cardiovascular-related diseases are among the most costly medical expenses. To mitigate these costs and to address behaviors contributing to cardiovascular disease, Healthy Heart provides a risk assessment and a variety of supporting tools and resources. Participants take a personal assessment to determine their risks for cardiovascular disease. Based on this assessment, they enroll in a program where they are offered resources to assist them in modifying their risks.

Individuals also can participate in group activities including training sessions to learn how to live a healthy lifestyle (nutrition, exercise, smoking cessation, etc.) and join walking, stretching and other group fitness programs. In Nigeria, Chevron is pilot testing the use of a Peer Health Educator (PHE) model to address cardiovascular disease.

There are currently 190 high functioning PHEs across all Chevron Nigeria Limited locations. Active since 2006, the PHE program was initially designed to provide ongoing awareness and prevention information about HIV and AIDS, Malaria and Tuberculosis to the workforce and their communities. These resources are now being leveraged to address cardiovascular health and associated lifestyle risk factors. The PHE model is being used to strengthen personal health resources and decrease the stigma associated with infectious diseases by expanding the focus to whole health. Chevron will use non-communicable disease screening opportunities as a platform for HIV screening—and vice versa—in Nigeria and other locations.

> We are utilizing the peer health educator (PHE) model that has been successful in addressing infectious diseases to educate about chronic diseases.
>
> **Chevron, Nigeria**

Chevron is one of the world's leading integrated energy companies, with subsidiaries conducting business worldwide.

Methods

Organizations completed an online survey for up to three of their programs operating in LMICs, as defined by the World Bank.[5] Forty programs in 31 different countries were represented. Programs in high-income countries were excluded. Representatives of a selection of organizations were subsequently interviewed by phone to allow greater depth of understanding and provide material for case studies. Organizations also submitted written responses. Respondents were all members and partners of GBCHealth.

All responses pertain to programs currently in place or which are being implemented. Programs or program elements still in the design phase were excluded. Respondents did not necessarily hold equivalent positions in each participating organization. Participants self-selected and information was self-reported.

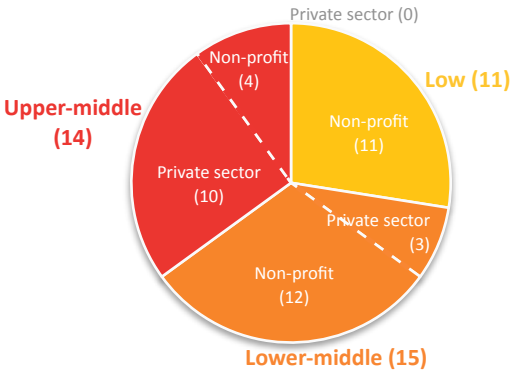


Figure 1: Country income groups of programs

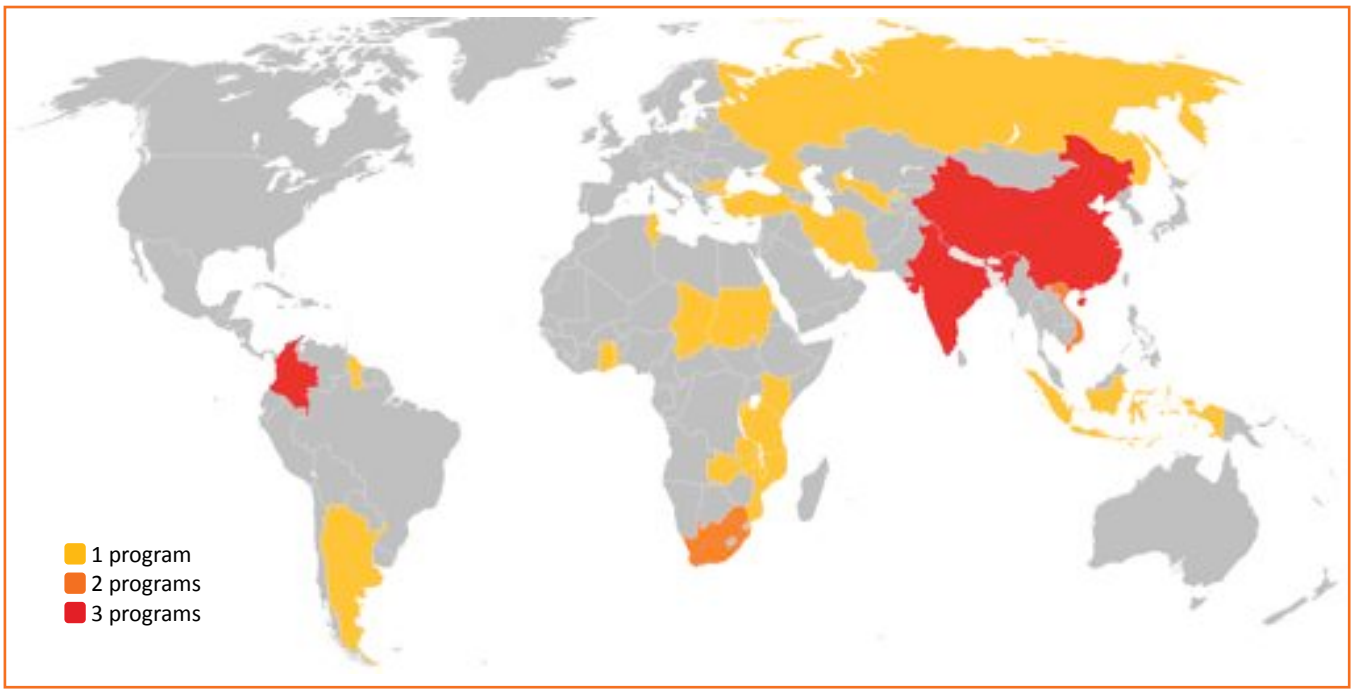


Figure 2: Geographic locations of programs

Responding organizations

Thirteen of the forty programs were implemented within private sector companies, and 27 within non-profit organizations. Programs were evenly split between low, lower-middle and upper-middle countries (Figure 1), although the division between private sector and non-profit programs was not even.

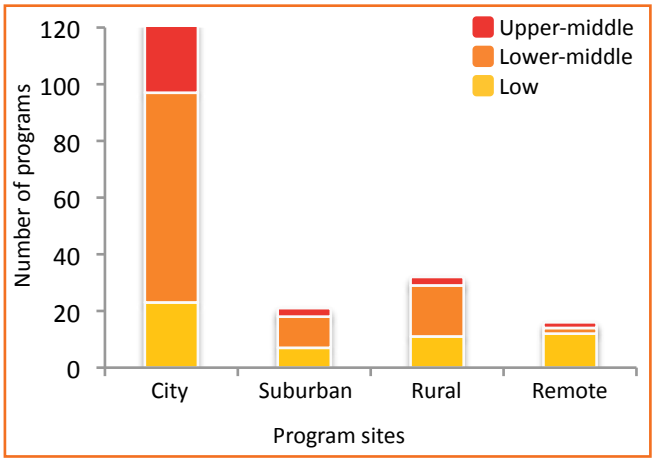


Figure 3: Locations of programs, by country income groups

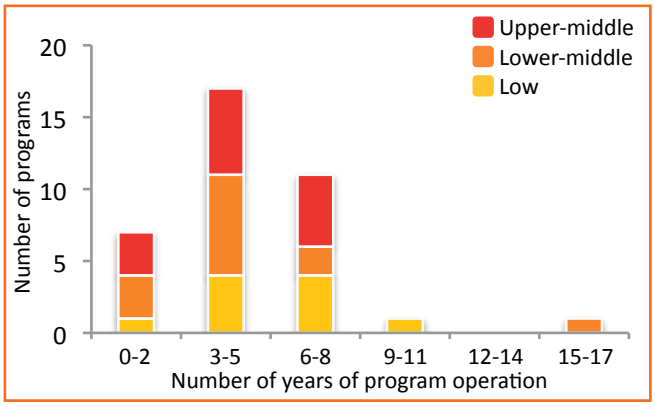


Figure 4: Duration of program operation, by country income group

Non-profit organizations were responsible for 100% of programs in low-income countries, 80% of programs in lower-middle income countries and 26% of programs in upper-middle income countries. Figure 2 shows the geographic spread of the programs, and the number of responses relating to each country. The breadth of this geographic spread demonstrates a truly global interest in wellness through work, and that wellness interventions can be implemented in a very broad range of geographic, demographic, political and physical settings and in all sectors of business. Workplace wellness programs are no longer the preserve of the private sector—the benefits are universal, and non-profit organizations are also now implementing effective programs.

A broad range of industries were represented, including healthcare, financial, public relations, metals and mining, transport, apparel and automotive. Programs varied in size from a total target population of 30 to 20,000 people (mean 2,200).

The majority of programs were implemented in office settings (64%). The remainder were implemented in a variety of settings including factories, camps, mines, hospitals and farms. Sixty-three percent of programs were implemented in city locations, 11% suburban, 17% rural and 8% remote. Programs in low-income countries were relatively evenly spread from city to remote locations. Programs in upper-middle and lower-middle income countries were predominantly located in cities (Figure 3). This reflects the correlation between urbanization and growth in income.

Sixty percent of programs were described as fully implemented. Approximately two-thirds (65%) of programs had been implemented for five years or less. There was no significant difference in the length of implementation between country income groups (Figure 4).

How are programs organized and managed?

There was a wide variety of individuals and teams responsible for program implementation. Only 7% of private sector respondents had a program team dedicating all of their time to implementing the program. Of the non-profit organizations, 47% had a dedicated program management team. The majority of programs in the private sector were managed by human resources (38%) and occupational health departments (29%). In the non-profit sector these proportions were 13% and 13% respectively.

Respondents were asked to identify at what organizational level various program functions were decided or authorized. In general programs were primarily "owned" by local teams rather than global headquarters. Country-level management accounted for the largest proportion of functions (34%). Global decision-making was less important for more operational functions—selection of target groups and implementing the interventions—but for many programs, headquarters staff were still involved in the evaluation of program effectiveness.

> We introduced games and aerobics sessions which were really popular, particularly with young people aged 15 to 24.
>
> **Ghana**

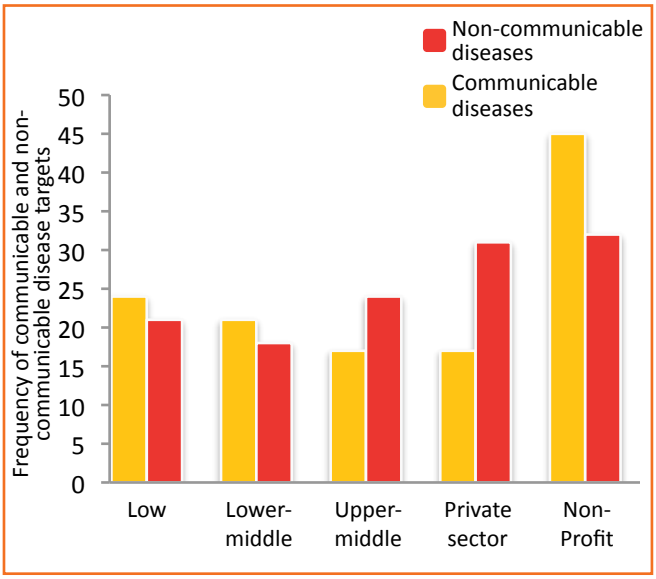


Figure 5: Frequency of communicable and non-communicable disease targets, by country income groups & organization type

No respondents completely outsourced their program design and/or implementation. Two-thirds of respondents outsourced some of it—92% of private sector respondents outsourced, compared to just 52% of non-profits, perhaps reflecting different funding models and/or willingness to outsource.

Some organizations coordinate all health activity through a single wellness offering (Figure 6); others have a more vertical approach, including non-communicable disease (NCD) interventions within wellness, and communicable disease programs (HIV, AIDS, TB, malaria) under separate schemes. A third model brings all health activity into a wellness brand, but runs vertical programs with single-target interventions.

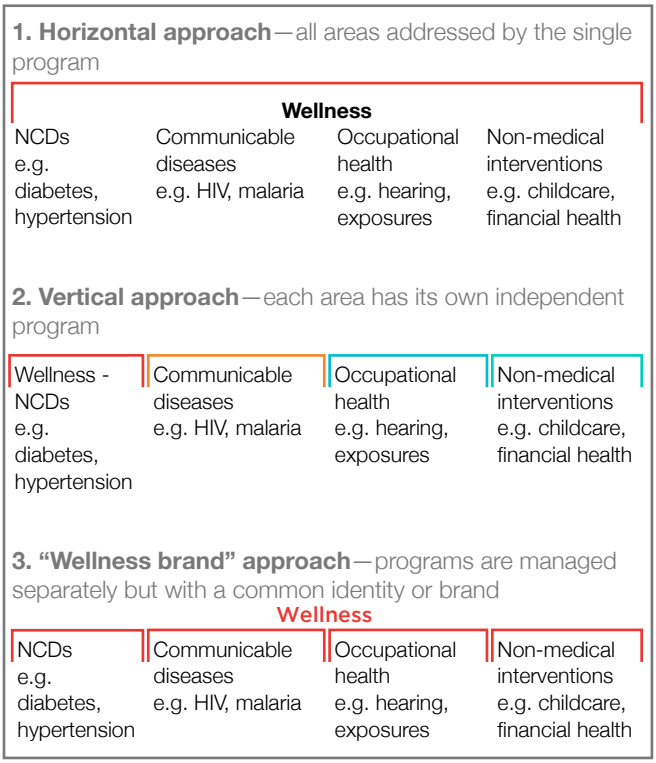


Figure 6: Program structures

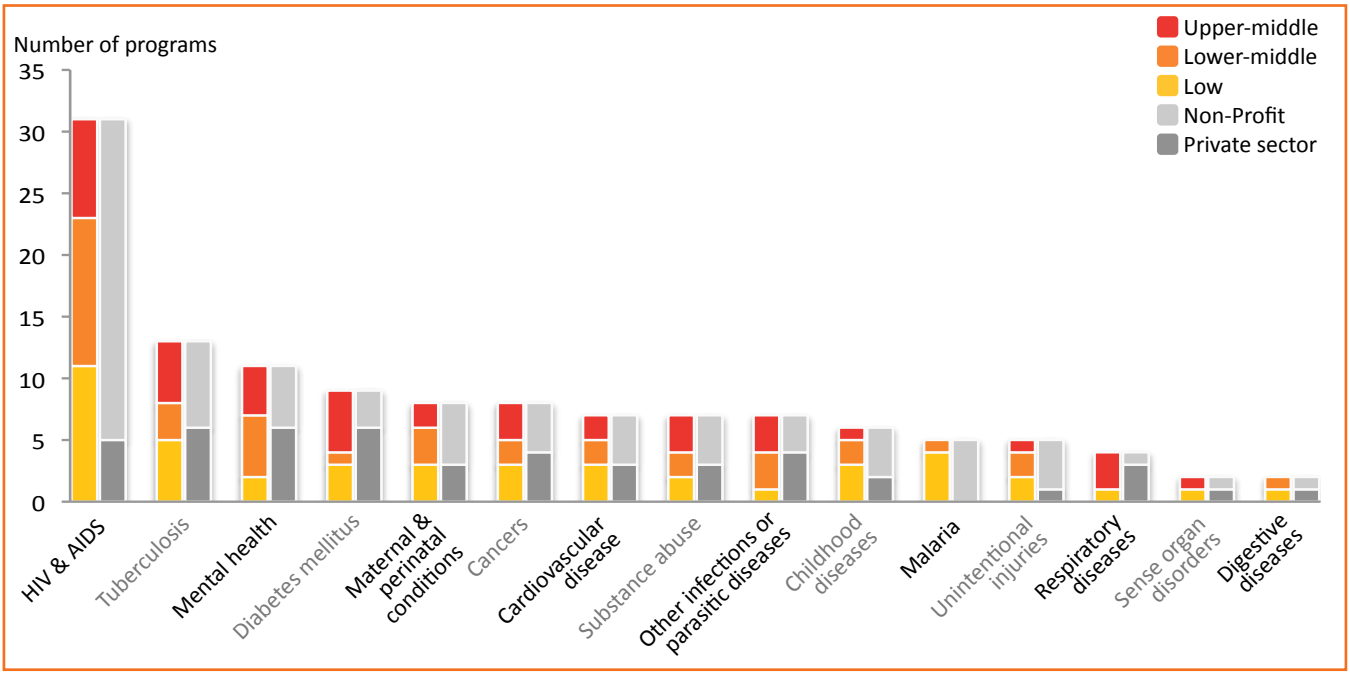


Figure 7: Disease targets, by country income groups and organization type

What health issues are targeted?

The responses highlight the diversity of ideas as to what should/can be included within the wellness portfolio. The programs targeted communicable and non-communicable disease equally (61 communicable disease targets and 58 non-communicable disease targets). NCDs were more likely to be targeted in upper-middle income countries, correlating with the higher burden of communicable disease in low-income settings (Figure 5). NCDs were more often targeted by private sector organizations than non-profits.

HIV was the most commonly targeted disease (Figure 7). Mental health ranked third, and was the most commonly addressed NCD, perhaps reflecting the heightened awareness of mental health issues globally. Variation is evident between country income groups: Diabetes mellitus is not addressed by any low-income programs in our sample despite its explosive growth in these settings, and malaria not included in programs in upper-middle income locations.* The targeted diseases were very similar between non-profit and private sector organizations, with the notable exceptions of HIV and malaria. Eighty-four percent of the HIV activities were found in the non-profit sector and 100% of the malaria activities. This is very likely to reflect a difference in the *organization* of occupational health interventions, and does not imply that private sector organizations are not addressing these issues.

IN FOCUS INDIA

Unilever: Lamplighter

The Lamplighter program comprises health risk assessment for NCDs such as hypertension, diabetes and coronary heart disease and monitors BMI, cholesterol, blood sugar and smoking to derive an individual health risk profile. The program combines this assessment with coaching in exercise, nutrition and mental resilience to help employees improve their health. Where needed we also provide physician support. Unilever has also introduced a workplace No Smoking standard worldwide.

> “Over half of our originally [higher risk] employees have moved out of the danger zone.”
>
> **Unilever, India**

Hindustan Unilever—Unilever’s Indian subsidiary—launched the Vitality Initiative in 2006. Under this program, employees are assigned a biometric grading based on their body mass index (BMI), blood pressure, cholesterol level and sugar fasting. There are three grades: green, indicating excellent health; orange, indicating the need for periodic reviews; and red, indicating the need for both focused attention and periodic reviews. Appropriate interventions are offered to people in the orange or red categories. The results have been encouraging; about 14,000 employees have participated. Over half of the original “red” employees have moved out of the danger zone, while a survey has found a widespread boost in morale among participants at all grades.

Unilever is a multinational consumer goods company whose products are sold in 180 countries.

*A high proportion of programs in upper-middle income countries were being implemented in urban locations (see Figure 3) where malaria is less likely to be a significant risk.

A natural evolution

Our study has captured a picture of evolution in workplace health programs: Starting from an HIV focus and using the delivery model of vigorous grass-roots engagement, peer facilitators and tailored activities—with highly effective and demonstrable results—workplace programs have expanded into non-HIV areas. The evolutionary path often starts with education interventions surrounding stigma and gender issues, broadening into mental health, stressors, and the effect of physical fitness on mental resilience. A starting point of information provision soon evolves into practical lifestyle interventions, then medical interventions, starting with screening for known risk factors (Figure 8).

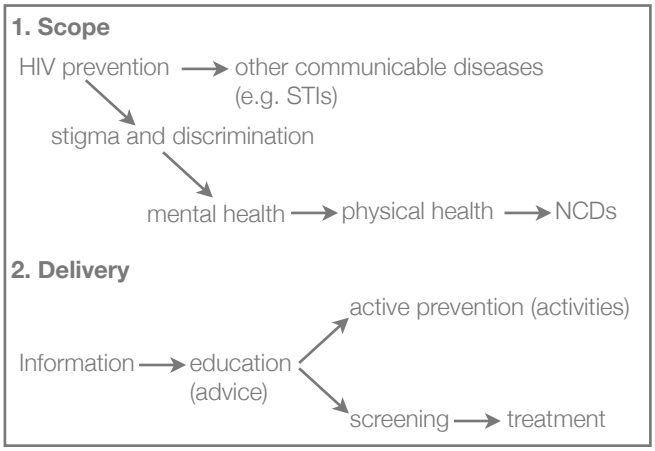


Figure 8: Two axes of program evolution

> The team is focusing on shifting the [program] platform from information-sharing to delivery-of-service.
>
> **Iran**

> Last year the session outcomes were centered around how policies can be adapted to be more effective. This year the focus will be more on identifying and designing practical interventions.
>
> **India**

The demand for further NCD interventions is clear

The global threat of the NCD epidemic has attracted increasing attention in recent years. NCDs make the largest contribution to mortality both globally and in the majority of LMICs. The largest burden—28 million deaths, 80%—occurs in LMICs. The NCD burden will increase by 17% in the next ten years globally, but by 27% in the Africa region.[7] Many of our respondents reported that participants were demanding information about NCDs, healthy lifestyles and effective interventions.

The business case for addressing NCDs is strong. For all these reasons NCDs will likely represent an increased area of focus for global organizations.

> Future developments are to use the HIV structures we've set up for initiatives on other health issues, including non-communicable diseases and family planning
>
> **Burundi**

IN FOCUS SOUTH AFRICA

Volkswagen SA: Workplace Health and Wellness

The Wellness program was initiated in 2002 with a focus on HIV and AIDS. It has since broadened to provide a comprehensive health offering. In delivering the original HIV and AIDS program, the need to also address issues such as stigma and concomitant chronic diseases was identified.

In response, in 2006 a three-month pilot study was performed, incorporating screening for NCD risk factors. *Convenience* was identified as a barrier to participation. As such a *single stop shop* design is critical. The pilot screened for cholesterol, BMI, BP, blood glucose, lung function, HIV and TB. An alarming prevalence of NCD risk factors was detected, in line with national and international trends, and this provided the evidence required to bring preventative lifestyle factors to the forefront of the program.

In 2009 a program of free comprehensive health checks was rolled out. The program of three-yearly checks includes every business sector and integrates HIV and TB screening, NCD risk factor screens and occupational health screens into a single visit. The checks also provide an opportunity to detect and address mental health and any other broader wellness issue that may be detected.

Individuals can access the program in several different ways: Firstly via the health centre, which provides primary healthcare, STD clinics and family planning clinics.

Secondly, the program can be accessed via a network of peer counsellors. Originally peer educators but now with enhanced training and support, these individuals receive monthly updates not just on HIV and TB but also a wide range of NCD-related issues. They have been guaranteed a five-minute slot in the weekly pre-shift meeting during which they will address a health issue. They regularly hold lunchtime talks, distribute educational materials, give advice and make referrals to the appropriate services. The peer educators are well respected and very active in their communities, as well as in the workplace. They regularly give talks in shebeens (bars) and churches and play their part in combating HIV-associated stigma and misinformation as well as delivering broader health messages. Thirdly, rounds of nurse-led screening appointments are held at various times of the year on-site. These generate very high levels of participation—80-89%.

Finally, services can be accessed via external service providers: Careways—an external company providing counseling services—and loveLife—an NGO offering HIV and AIDS services for young people from its new VWSA-funded R20 million (approx. $2.2 million USD) center. The numbers of users of the externally-accessed services are rising because of their convenience and independence. They also provide a source of an alternative or second opinion. The numbers using internal services are not decreasing.

This year an on-site gym facility and rehabilitation unit will be opened with the intention of increasing the workforce's fitness and also work on posture for prevention of chronic injuries. The goal is to continue to develop the program and embed its footprint firmly and irrevocably into the fabric of the company.

> "Our goal is to continue to develop the program and embed its footprint firmly and irrevocably into the fabric of the company."
>
> **Volkswagen South Africa**

Volkswagen Group South Africa is one of the biggest exporters of vehicles from the African continent.

How are programs delivered?

Forty percent of the programs' interventions were education-centered, including training, general awareness campaigns and peer-facilitated sessions (Figure 9). The rest of the reported interventions were very wide-ranging, including funding for specific research projects, at-desk massage and organized funds for healthcare.

Permanently employed staff and contracted/temporary staff were equally targeted by the program interventions (199 and 183 interventions respectively). Local staff and expatriate staff* were also subject to approximately the same number of interventions (185 and 161 respectively).

One hundred and eleven of the interventions reported in this survey included families of members of staff. This represents approximately half of the interventions aimed at permanent staff members. Interventions for families included seminars (smoking cessation, HIV and AIDS, diabetes mellitus, general lifestyle coaching, issues surrounding gender and stigma), provision of condoms or healthy food, support for new mothers, access to exercise classes, counseling services, health screening, childhood immunization, assistance programs and extension of healthcare funding to dependents.

Forty-four interventions included the whole community. Two-thirds of these were education or awareness activities to which all were invited. Including family and community members will assist with behavior change and the establishment of new healthy norms—the environment and the behavior of peers are extremely influential on an individual's behavior.[8] In addition, communicable disease programs that target employees only may be ineffective and unsustainable if infection is acquired from community members and families.

> "We collaborate with a local NGO to provide childhood immunizations to the whole community."
>
> **Togo**

Thirty respondents (75%) reported that their organizations conducted formative research in order to ensure that the selected diseases, health risks and interventions were appropriate for—and acceptable to—the target populations. Fourteen reported that their program was based on one already in place elsewhere within or outside their organization. Of these, only one quarter replicated a program running in a high-income country.

Forty-three percent of programs included personal risk assessments or biometric screening for individuals prior to their participation in one or more of the interventions. Where used, these assist personalization of interventions and goals and quantification of the individual and program achievements.

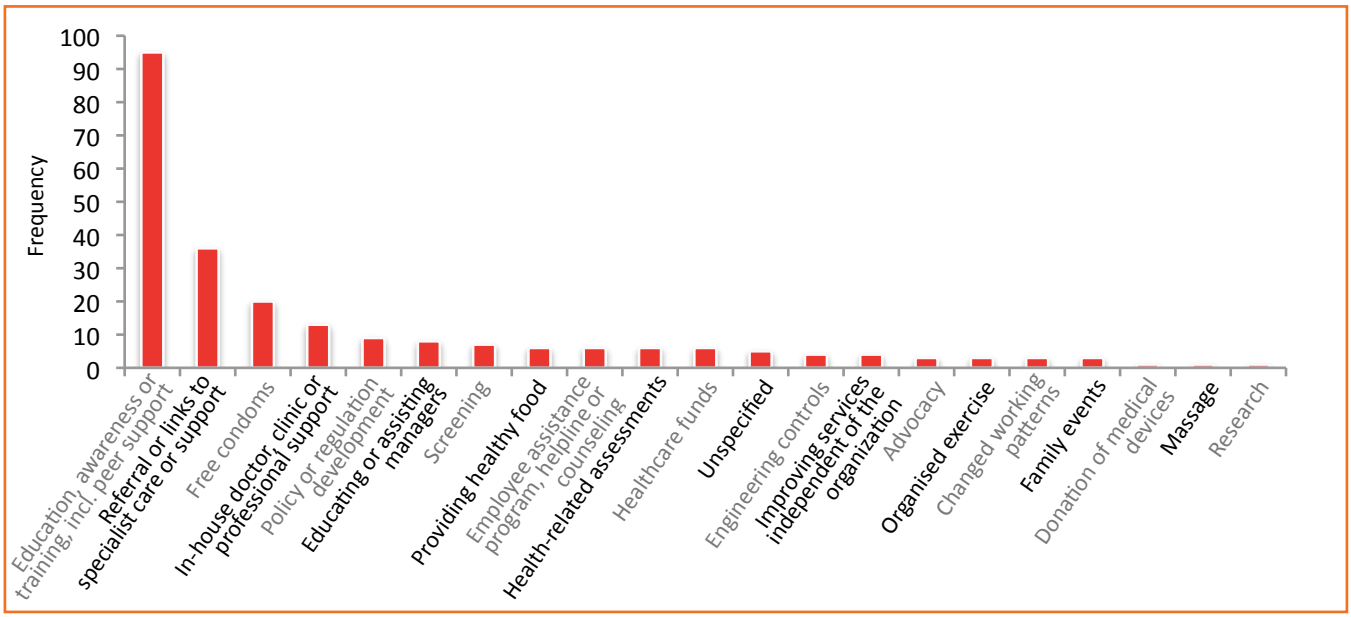


Figure 9: Nature of interventions

*Short-term travelers, rotating workers (e.g. on 28-day cycles typical of the oil industry) and long-term expatriate staff.

Education and peer support interventions are flexible

Our survey found that the majority of interventions were educational: seminars, meetings, posters and other awareness activities. In general these interventions are relatively inexpensive, universally applicable and easy to implement. The use of peer educators is thought to increase the cultural and contextual specificity of the messages, and therefore their impact. Moreover, peer educators also provide an effective channel for feedback and adaptation and personalization of topics and delivery methods. Measuring their effectiveness, however, is challenging and there is little solid evidence in support of this methodology.[9,10,11] Most respondents agreed that their peer network was critical to understanding their target populations, starting a dialogue and designing effective interventions according to need.

> Our sessions were divided by gender in 2007 after we observed that some members, especially the women, did not feel free to discuss gender-sensitive issues in mixed gender groups. These sessions became known as woman-to-woman and man-to-man groups that discussed HIV prevention and treatment, sexual reproductive health and other social and health related issues.
>
> The program scope has since broadened. At a recent gathering the women's group session focused on hypertension and diabetes. The women discussed positive steps, including physical exercise, controlling body weight, healthy diet and salt intake, along with regular blood pressure monitoring, recognizing signs and symptoms and the importance of consulting a physician.
>
> The primary focus of the men's group session was Multiple Concurrent Partnerships and low condom use.
>
> **Malawi**

IN FOCUS

PHILIPPINES

HP: Winning with Wellness

The Winning with Wellness program was developed to create a holistic culture of health that addresses three main pillars of employee well-being: Physical health, emotional health and stress management, financial wellness.

The goal was to transform and unite individual wellness programs that were offered separately in the past into an integrated and comprehensive approach to wellness that would drive engagement and productivity, and recognize diverse needs across our organization.

To address this a framework was developed, focused on our three pillars of well-being. Uniquely, the financial wellness pillar aims to help empower employees to make informed financial decisions, ultimately helping to reduce finance-related stress and its associated impact on physical health.

In the Philippines, the financial wellness programs were tailored for local employees. A gap in employee knowledge was detected—the basics of how to save money and where to put savings—and a financial training program and investors' club was created, partnering with Money Tree. The program instilled the SAVE UP concept through self-awareness and goal setting, training and practice.

> Our program is based on three pillars of wellbeing—physical health, emotional health and financial wellness.
>
> **HP, Philippines**

Training included basic and advanced classroom modules.

As the world's largest technology company, HP brings together a portfolio that spans printing, personal computing, software, services, and IT infrastructure to solve customer problems.

Making the business case

Respondents were asked to list the organizational motivations behind their programs (Figure 10). Organizations with programs in all three income groups cited workforce engagement and productivity as either the most or second-most important motivation. The importance of "Corporate Social Responsibility (CSR) or philanthropy" was related to country income group, with the greatest importance in the upper-middle income group, and the lowest in the low-income group.* The importance of CSR—historically rooted in the northern hemisphere—is spreading, as globalization exerts pressure for standards to be universally applied.[12]

In our survey, reducing "workforce absenteeism due to sickness" was important across all income groups, but the rank of reducing "absenteeism due to family sickness or caring obligations" was highest for programs in low-income countries, and lowest for those in upper-middle income countries, perhaps reflecting the greater availability of affordable home-based care or support to carers in higher-income countries. Another likely explanation is the greater prevalence on average in low-income countries of more dependents per worker—both larger nuclear families (more children) and more instances where one employee in the formal sector may be economically supporting a large extended family.

> "Our headquarters did not initially support the initiative because of the commitment to 100% reimbursement [of healthcare costs]. One argument against the program was that staff with HIV would be getting better care than those with chronic illnesses. Locally in Kenya, however, we felt strongly that this program was a good solution for the major problem of lack of access to care and treatment and absenteeism."
>
> **Kenya**

Respondents were asked how their disease targets related to their organizational motivations (Figure 11). HIV and AIDS interventions were associated with the broadest ranges of business goals, principally CSR/philanthropy, workforce productivity, improving the health of the general population and reducing absenteeism for family illness or caring obligations.

Organizational motivations were divided into inward-looking and outward-looking groups.** There was no significant difference between the health targets chosen to satisfy these two groups. Neither was there a difference in the business motivations associated with communicable disease and NCDs.

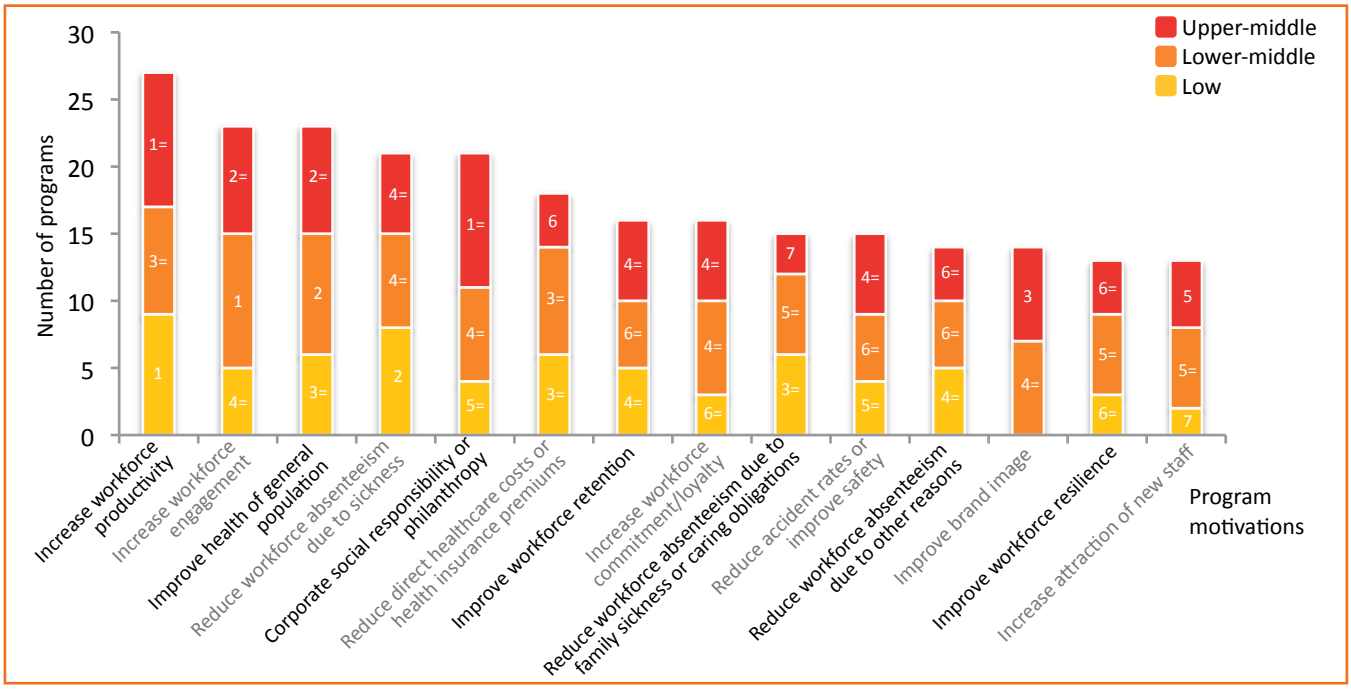


Figure 10: Organizational motivations for implementing wellness programs, by country income groups. Ranks within each country income group are indicated.

*This correlates with the proportion of private sector and non-profit organizations operating in each income group (Figure 1).

****Inward-looking:** Reduce workforce absenteeism due to sickness, Improve workforce retention, Increase workforce productivity, Reduce direct healthcare costs or health insurance premiums, Increase workforce engagement, Increase workforce commitment/loyalty, Reduce workforce absenteeism due to family sickness or caring obligations, Improve workforce resilience, Reduce workforce absenteeism due to other reasons, Reduce accident rates or improve safety, Improve health/wellbeing of workforce.

Outward-looking: Improve health of general population, Corporate Social Responsibility or philanthropy, Increase attraction of new staff, Improve brand image.

Our survey did not demonstrate a clear link between the health targets selected and the business case being made. This highlights the need for detailed assessment of the main health issues impacting the workplace in question, and the resulting impact on its key performance metrics. This would provide greater support for program custodians to make a clear case —to link the steps from intervention, to improved health, to achieved business goals together—in order to secure senior leadership buy-in and ongoing support.

Basic program monitoring was nearly universal. Ninety-three percent of programs tracked individuals for participation, and 80% for progress. Seventy-three percent of programs had systems in place to measure outcomes of some or all of their interventions, in terms of changed health status, risk or behavior of the target group, or program metrics.* Of the metrics in place, satisfaction was the most commonly measured. Only eleven programs had systems in place to effectively measure costs saved or incurred (Figure 12).

Ideally a detailed comprehensive monitoring and evaluation plan will be incorporated into the program design from the outset. However even starting with data that are easier to collect (absenteeism, safety incidents, staff turnover) and relating this to program participation may provide some evidence of effectiveness. We know that not *all* workplace health promotion and disease prevention programs in high-income settings are health- and/or cost-effective.[13] It is unlikely that programs in LMICs will be any different. Sound data is essential to highlight successful strategies and detect less effective approaches.

Disease targets

Organizational motivations	Childhood diseases	Malaria	Cardiovascular diseases	Cancers	Unintentional injuries	Maternal/perinatal conditions	Diabetes mellitus	Substance abuse	Other infectious/ parasitic diseases	Tuberculosis	Mental health	HIV & AIDS
Reduce workforce absenteeism due to sickness	2	4	3	6	3	3	4	6	7	8	8	9
Improve workforce retention	1	2	2	2	3	5	4	5	4	6	7	11
Increase workforce productivity	2	2	5	6	2	4	6	2	3	3	8	13
Improve health of general population	2	2	2	3	2	5	3	3	5	6	8	13
Reduce direct healthcare costs or health insurance premiums	2	2	2	3	3	4	3	3	4	5	8	12
Corporate social responsibility or philanthropy	2		2	4	1	2	4	2	3	3	4	14
Increase workforce engagement	2	1	3	2	2	1	3	1	3	2	4	9
Increase workforce commitment/loyalty			2	1	1	2	3	3	3	5	5	7
Reduce workforce absenteeism due to family sickness or caring obligations	2	2		1	1	3		2	1	4	4	13
Improve brand image		1	1		2	1	1	2	4	3	3	7
Increase attraction of new staff	2	1	3	2	1	3	4	1	3	2	3	7
Improve workforce resilience		1		1	2	1		2	3	3	3	9
Reduce workforce absenteeism due to other reasons	1	1			2	3		1	2	3	3	7
Reduce accident rates or improve safety			1		4		1	2	1		4	4

Frequency color coding

14 13 12 11 10 9 8 7 6 5 4 3 2 1 0

Figure 11: The relationship between the programs' health and organizational goals. Figures are the number of responses linking the targeting of a particular disease to a particular business goal.

*__Satisfaction__: Indicators of the participants' satisfaction with the program's scope, relevance, quality and accessibility. **Utilization**: The total number of people enrolled in the program. **Penetration**: The proportion of the total target population that have participated in at least one wellness activity. **Health risk status**: The proportions of employees in high, medium or low categories of the risk targeted. **Sustainability**: the number of people who continue to engage in the change offered by the program. **Costs**: Any cost incurred or saved by the program, e.g. cost of program implementation, saved healthcare costs. **Organizational culture**: E.g. trust in management, voluntary turnover, willingness to recommend the company as an employer, applicants per vacancy. **Depth**: indicators of the proportion of participants who are light or heavy users of the program. **Safety**: E.g. incident rates, lost or modified work days. **Productivity**: absenteeism, presenteeism.

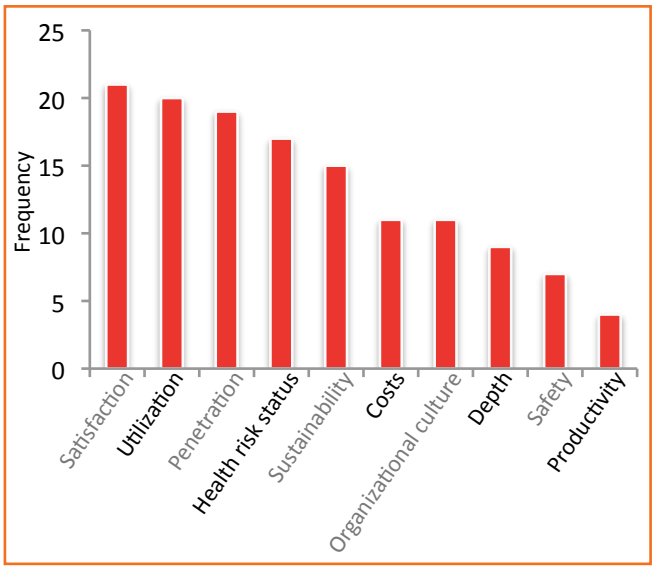


Figure 12: Program metrics in place

> Effectiveness of disease prevention is always difficult to prove, but absenteeism is tracked and a body of convincing health metrics is being formed. Thankfully the board is highly supportive of the programme and see the value of looking after the company's people—our most valuable asset. The CEO and HR director are very keen on people issues and health is very much on the board's agenda and central to policy decisions.
>
> **South Africa**

> Measuring the impact of awareness raising activities is challenging. Awareness activities need to be creative—the campaigns are competing for mental space of an audience that is bombarded with many other ideas and messages. Relying on fear or guilt to elicit long-term behavior change is less effective. Thought-provoking, benefits-based messages are more meaningful.
>
> We use multiple messages through different channels—for example drama, posters, billboards and media campaigns etc.—to be more effective. But raising awareness is only the first step in a campaign to change behavior—without followup processes, there tends to be limited long-term impact.
>
> **Sudan**

Motivation and finding time

Nearly all of the programs in this survey operated with mandatory participation for some or all of the interventions (92%). One global manager, supporting multiple locally owned programs said, "Our experience is that positive advocacy is necessary, but learning activities may need to be made mandatory for maximum participation. Our managers are encouraged to explore making participation in learning activities mandatory and making the work of the facilitators and resource persons part of their ongoing job responsibilities."

> Through the judicious use of incentives—each person completing all the required screening tests was entered into a weekly prize draw—and a shift of primary focus away from HIV towards NCDs, participation improved greatly, particularly amongst the higher-ranking staff.
>
> **South Africa**

Many of the programs in the survey were educational and awareness-building in nature, and in the early stages of the evolutionary process (Figure 9). Where programs are more mature there tends to be an increased emphasis on generating outcomes. Consequently, workplace wellness initiatives increasingly feature "take action" interventions as a followup to awareness-building. Mandating individual participation in such activities is more challenging, and strategies shift towards encouraging behavior change, for example through use of incentives. In the US, this sometimes takes the form of a "carrot and stick" approach, whereby financial incentives exist for program participation and penalties are levied for non-participation (e.g. higher health insurance premiums). Elsewhere, the "carrot" approach is more prevalent. This survey provides some evidence of use of incentives for wellness activities, and this is expected to grow. Eleven programs (28%) offered incentives for participation, including food, recognition in front of peers and money.

Aligning activities carefully to work patterns, so as not to disrupt the core business activity, and to be maximally convenient to facilitators and participants, was universally seen as a difficult but necessary balance to strike.

IN FOCUS
ZIMBABWE
Zimbabwe Platinum Mines: HIV and AIDS program

In response to the high prevalence of HIV in the mining industry, Zimbabwe Platinum Mines (Zimplats) initiated a workplace wellness program focused on HIV and AIDS in 2003. The program uses a wide variety of prevention and treatment approaches, and aims to prevent the spread of HIV, manage its impact on infected employees and reduce disease-related stigma and discrimination.

Interventions for employees include a network of peer educators who provide counseling and are able to make referrals to testing services, free condom distribution (and associated education activities) and the provision of free antiretroviral treatment to employees and eligible dependents. In addition, nurses have received training in the treatment of opportunistic infections, the use of antiretroviral drugs and rapid diagnostic testing for HIV, malaria and syphilis.

Recognizing the connection between the health of its workforce and that of the surrounding community, Zimplats has now extended the program beyond its workers. Activities include free condom distribution via nearby stores and nightclubs, the establishment of an STI clinic for local sex workers, the facilitation of income-generating projects for sex workers and education programs around the prevention of mother-to-child HIV transmission. These activities have involved collaborations with numerous partners, including Population Services International (PSI) and the Zimbabwe Business Council on AIDS (ZBCA). Community peer educators—employees, their families, contractors (temporary staff) and local schoolteachers—are working closely with the communities in which they live, providing education, distributing condoms and acting as a link for community members to partner organizations. In addition, they assist to identify vulnerable groups who may otherwise be overlooked.

> We have established an STI clinic for sex workers which aims to reduce high risk sexual practices and prevent transmission of HIV and STIs. As well as increasing access to treatment, we run behavior change programs and facilitate income-generating projects for the sex workers.
>
> **Zimplats, Zimbabwe**

The program was tailored to the employees' needs following a baseline survey assessing HIV prevalence, knowledge, attitudes and practices. To date, approximately 250 peer educators and 40 behavioral change facilitators have been trained. The incidence of STIs amongst employees has approximately halved, and the number of employee deaths has also decreased—from 12 per year in 2005 to fewer than 2 per year in 2012.

Zimbabwe Platinum Mines Limited (Zimplats) produces Platinum Group Metals and is a subsidiary of the mining company Implats. The company has been in operation for 11 years, has a workforce of 2,800 people and employs an additional 5,000 contractors.

What are the challenges?

Financial constraints were the most common challenges reported in this survey, with 70% of programs facing this issue (Figure 13). The more remotely located programs also reported physical and human resource issues unique to these settings including extended travel times and difficulty finding people with the specialist skills needed.

The non-profit respondents reported encountering a broader range of issues in the implementation of their programs than the private sector respondents. No

> Our principal challenge is fundraising so that we can continue to expand the program and engage hard-to-reach groups such as fishermen and seasonal workers.
>
> **Burundi**

private sector respondent reported difficulty gaining the support of their senior managers, but local legal issues were more common. While organizations may seek to develop and apply workplace wellness strategies globally, taking into account local country legislation, customs and norms is equally important.

> Although India is economically successful there are still 300 million people whom the wealth is not reaching. Gender, class and caste discrimination are still major issues. Our main threat is funding: The donor environment for workplace schemes is just not there. Funding is becoming increasingly difficult to secure, particularly in the context of the global economic downturn, and the fact that people perceive that India no longer needs this kind of help.
>
> **India**

> Our remote location was a challenge. Before building our onsite clinic, when the factory was new, our employees had to travel one hundred kilometers to Hanoi to access services, and we had issues finding a doctor who was suitably qualified.
>
> **Vietnam**

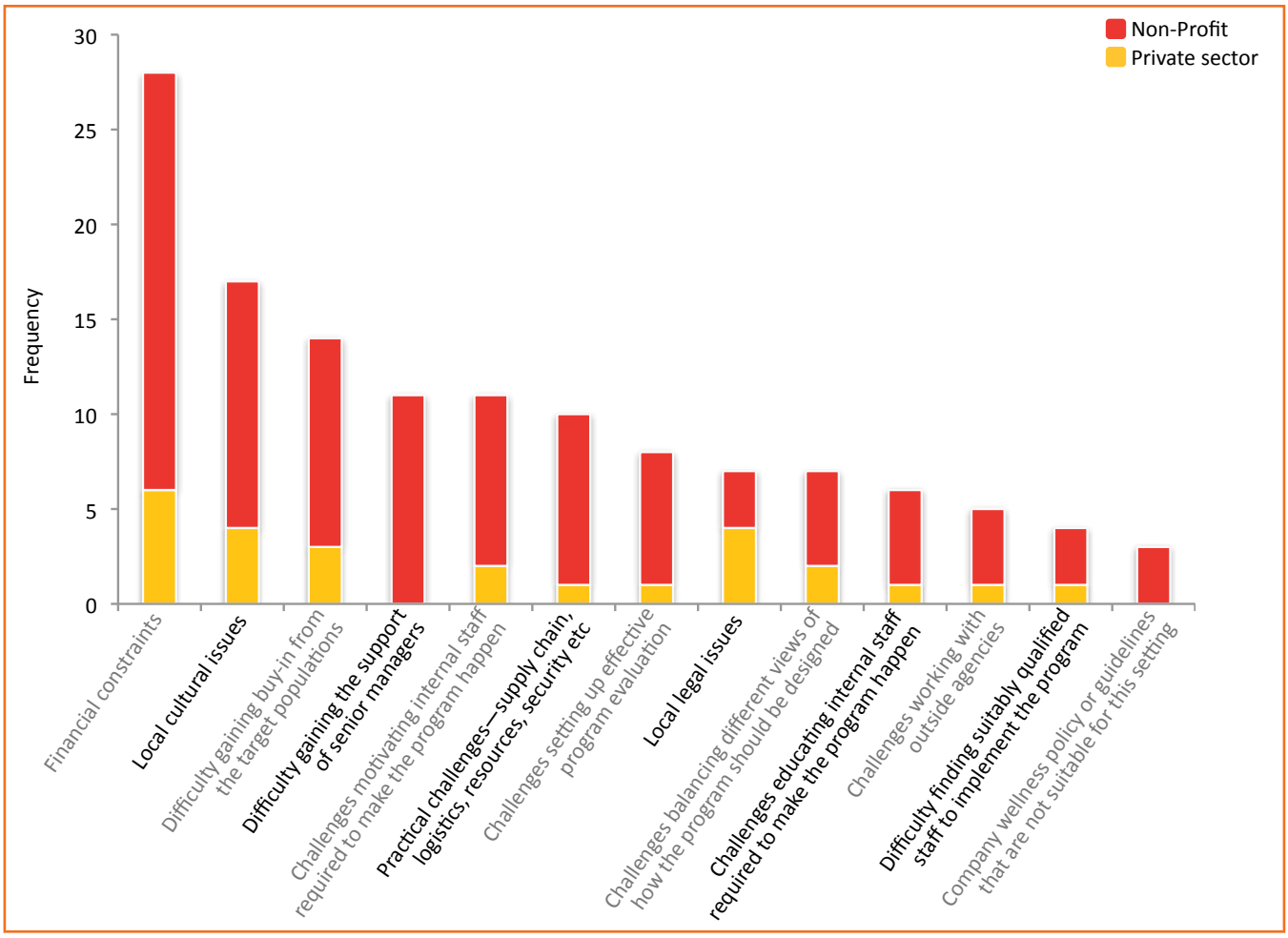
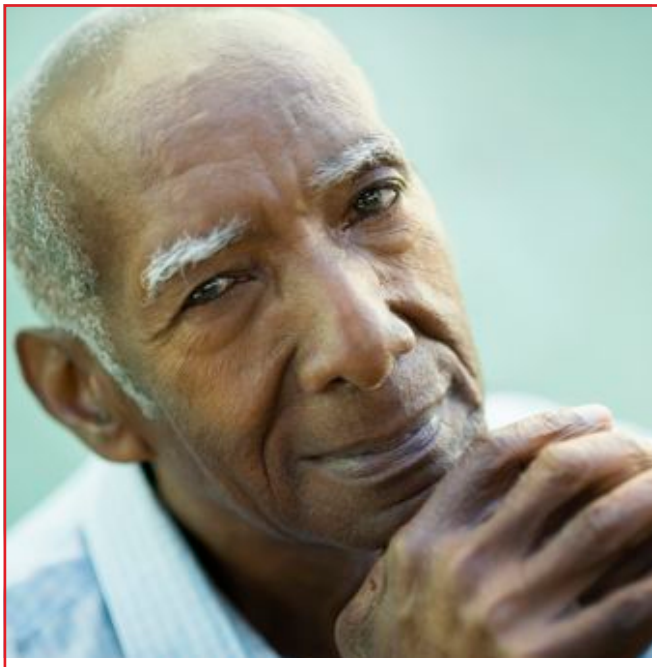


Figure 13: Challenges encountered during program implementation



IN FOCUS BRAZIL

Vale: Taking Care of Yourself is Caring for Those You Love

The program focuses on the effects of continued use of alcohol, tobacco and psychoactive drugs in employees, their family, the company and their community. Activities include numerous training events, forums, community drama, awareness using banners, brochures and billboards, and a telephone hotline. The wide reach into the community has contributed significantly to reduction of prejudice associated with this illness in the region and has broadened the program's credibility.

A coordinated technical committee and three local committees were created to advise on analysis approaches for the early identification of affected employees and their dependents. The committee helps to ensure a unified approach across all nine of our health units.

A multidisciplinary network of professionals—including psychiatrists, psychologists and therapists—has also been organized and resourced. Technical supervision, training and support of these professionals has been instrumental in driving the success of the program. Program managers have found that the quality of results depends not only on their internal approach, but also on the quality of the network of external professionals linked to the program.

> "The company pays 90% of outpatient treatment costs and 99% of hospitalization costs. The remaining costs are paid by the employee. The employee contribution has been shown to be a factor increasing adherence to the program."
>
> **Vale, Brazil**

Treatment and clinical followup can be accessed through multiple channels, including individual and group approaches. A treatment protocol has been created that addresses each person's work environment, social and family factors. This multi-contextual approach allows a broad range of factors to be identified that may increase the risk of continued drug use. It allows the professional team to create an optimized treatment plan, which has reduced treatment time and improved results. Regular case discussions facilitate excellent communication between the professionals involved. In some cases professional advisory services are contracted to support families.

Vale is a Brazilian mining company transforming mineral resources into prosperity and sustainable development.

> "Handling the heterogeneity of the participants from across various agencies and functions emerged as an important issue in the conduct of the workshops. Some participants reported feeling uncomfortable discussing sexual behavior in the presence of their senior managers and other staff. Despite this, it was also evident that the presence of senior staff members encouraged the participation of all staff."
>
> **India**

> "The learning facilitators found it challenging to balance the additional responsibilities of implementing the program along with the demands of their regular workload. Also, the workload of all staff occasionally interfered with staff participation in workplace activities and workshops."
>
> **Bolivia**

PROGRAM CHECKLIST

Key considerations when implementing or refining a workplace wellness program

Based on a distillation of our study findings—coupled with our existing expertise—we have created a checklist of key questions and considerations program custodians should address when implementing or refining a workplace wellness initiative in a low or middle-income country setting. This checklist should assist you to ensure your program is **tailored**, **effective** and **sustainable**.

1. Define your context

Define the unique set of variables, requirements and constraints applicable to this program. A participatory process including organizational, cultural, financial, medical and logistical perspectives.

What are the principal **motivations** behind your program?	Organizational, medical, social motivations
Who are your **stakeholders**? What do *they* think are the key issues?	Gather information from senior leadership, managers, workers, their dependents and the broader community via focus groups, key informant interviews, surveys and anecdotal feedback.
Is there supporting data? What else is being done?	Other programs, studies and research within and outside your organization.

2. Define your targets

Find and prioritize the issues that are critical to satisfying the program motivations. Define your aim(s) and objectives.

What broad areas should be addressed that satisfy local and organization-wide requirements, and are seen as important by all stakeholders?	Mental health? Family planning? Nutrition? Exercise? STDs?
What is/are the central **problem**(s)? What **causes** the problem(s)?	(e.g. one central *problem* is physical inactivity, *caused* by a number of factors including lack of time, embarrassment, perception only certain types can participate)
Which are the most influential causes? Which are the least influential?	
Which causes *can* be addressed by the program?	Within organizational, cultural, financial, practical constraints
Which causes *cannot* be addressed?	Does ignoring these reduce the overall impact of your program?
Capture your program **aim**(s) and **objectives**.	Ensure all stakeholders agree.

3. Design your activities

Identify the interventions and activities that effectively address the most influential causes of the central problems.

What **activities** will ensure you achieve your objectives and aims, and will be well-received?	Consult with all stakeholders—optimize your plans
Who are the target participants?	Will broadening the target group increase effectiveness?
Where, when and how do the activities take place?	Include budget, logistics, facilitators, physical resources. Convenience to participants and minimal/ no disruption to work schedules are often essential.
Can the activities be designed and run ("owned") by the target groups rather than imposed?	
What motivations to participate are there?	Peer recognition? Incentives? Disincentives?
What are the barriers to participation and behavior change?	How can these be minimized?
How are the motivations, aims and methods of the program communicated to stakeholders?	
How is confidentiality guaranteed?	Confidentiality often increases participation

4. Define your goals

Define what you aim to achieve, when, and how you will prove it. Doing this well enables you to demonstrate your success.

Define your **metrics** and **targets**.	How you demonstrate that your program achievements are satisfying the original organizational motivations and the objectives you created. Attach a value and timescale to each target. Targets must be realistic. Intermediate milestones assist you to judge whether your longer term targets will be met.
Include metrics describing	
resources	(e.g. what has been procured)
activities	(e.g. number of participants; number of smoking cessation packs distributed)
results of activities	(e.g. number of people who have stopped smoking; number who have lost weight)
impact	(e.g. reduction in stress-attributable absenteeism, increase in employee productivity)
Capture how the data is gathered and analyzed. Define control groups if possible (i.e. comparable non-participants).	Who does this? When? How? Baseline and post-intervention assessments of participants will assist attribution of trends to program interventions.

5. Define your resources

Define what you need in order to run the activities.

Specify people, equipment, buildings/locations, training materials, publicity materials etc.	Don't forget your monitoring and evaluation activities.
Internal resources or outsourcing?	Define vendor options, community collaborations, NGO partnerships
Budget required?	Any opportunities for grants or awards?
When is each resource required?	
Where does each resource come from? Is it quality assured?	Including QA of outsourced services
What one-off and ongoing training does the team require? When? Who will coordinate this?	Who will provide training? If provided externally, can a sustainability model be built in, e.g. through train-the-trainer approaches?

6. Monitor your progress

Ongoing monitoring and periodic evaluation, allowing you to continually improve your program.

Continual consultation with stakeholders to ensure activities are being received as planned.	Via focus groups, key informant interviews, surveys and/or anecdotal feedback.
Any unexpected or unintended consequences?	If so, what? Why?
Any adverse or ineffective interventions?	If so, what can be done to remediate?
Gather, analyze and collate performance and financial metrics and responses from stakeholders.	
Feed lessons learned back into program design.	Demonstrate business case to senior leadership.
Periodic objective evaluation.	Periodically assesses whether program strategy is correct and the program's contribution to broader organizational success metrics e.g. worker health and engagement on customer satisfaction.

Conclusions

This survey offers a snapshot of workplace wellness initiatives in low and middle-income countries. It describes an evolutionary process, where programs initially targeting HIV are expanding to address wider health issues, notably NCDs and their risk factors. This expansion is driven largely by demand from program participants in the face of conspicuous evidence—personal and global—of the burgeoning burden of disease attributable to NCDs. Detecting this demand requires a system to capture feedback from participants.

While workplace wellness programs in LMICs tend to be less mature than in high-income countries, notably in North America, this survey points to a more strategic interest in workplace wellness being taken by companies globally. As these organizations begin to consider employee health/well-being more strategically, demand for outcomes-focussed programs and interventions in LMICs is expected to increase.

Making a business case to evolve from awareness/education-based to more active interventions requires effective monitoring and evaluation systems capturing a much broader range of data. Moreover, it is important to organize and present this data from a *value* perspective—not just in health terms but also based on the broader impact on the organization and the communities in which it operates. Program custodians may benefit from some additional support in this area.

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Sentinel Consulting Ltd

Sentinel Consulting provides practical solutions for people and businesses operating in remote areas. Our foundations are in health, safety and logistics. We support private and non-profit organizations in reaching their highest potential in challenging locations. Whether it is research and consultancy or hands-on practical and operational support, our work is delivered by a team of experts with a wealth of experience firmly rooted to the ground. We provide clear, sustainable solutions that work.
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GBCHealth is a coalition of more than 200 member companies and organizations committed to investing their resources to making a healthier world—for their employees, for the communities in which they work, and for the world at large.
www.gbchealth.org

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