# WELLNESS FOR A GLOBAL WORKFORCE

## Workplace wellness initiatives in low and middle-income countries

## EXECUTIVE SUMMARY

GBCHealth
Mobilizing Business for a Healthier World

Sentinel Consulting

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# INTRODUCTION

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. We showcase some highly successful programs via a series of case studies. Finally, we include a checklist for program managers developing a wellness program for their own organization.

## Methods

Organizations completed an online survey for up to three of their programs currently 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.

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).

## How are programs organized and managed?

Some organizations coordinate all health activity through a single wellness offering (Figure 1); 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.

## 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. NCDs were more often targeted by private sector organizations than non-profits.

Figure 1: Program structures

HIV was the most commonly targeted disease (Figure 2). Mental health ranked third, and was the most commonly addressed NCD, perhaps reflecting the heightened awareness of mental health issues globally. 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.

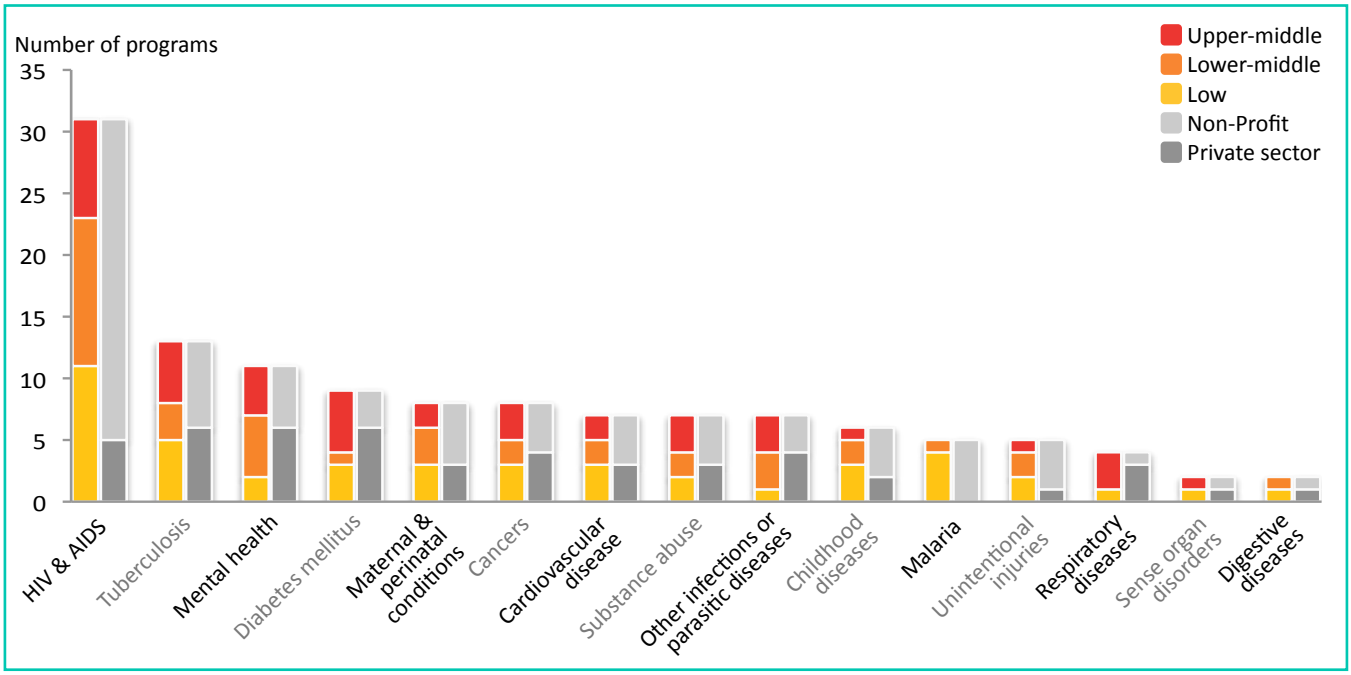


Figure 2: Disease targets, by country income groups and organization type

## 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 3).

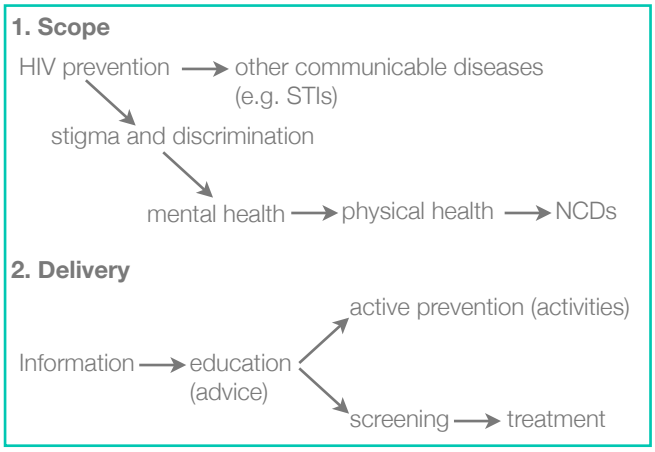


Figure 3: Two axes of program evolution

## 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.

## How are programs delivered?

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

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.

## 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.

## Making the business case

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 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.

## 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."

Many of the programs in the survey were educational and awareness-building in nature, and in the early stages of the evolutionary process. 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.

## What are the challenges?

Financial constraints were the most common challenges reported in this survey, with 70% of programs facing this issue. 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 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.

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

## 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

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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