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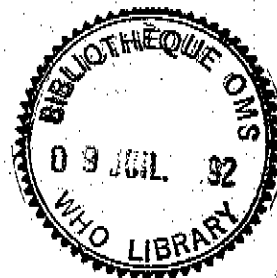
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*Countrywide Integrated Noncommunicable
Diseases Intervention (CINDI) Programme*

CINDI WORKSITE PROGRAMMES

Report on a WHO Meeting

Lisbon
22 – 23 February 1992



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EUR/HFA TARGET 4

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.^a

TARGET 4

REDUCING CHRONIC DISEASE

By the year 2000, there should be a sustained and continuing reduction in morbidity and disability due to chronic disease in the Region.

Keywords

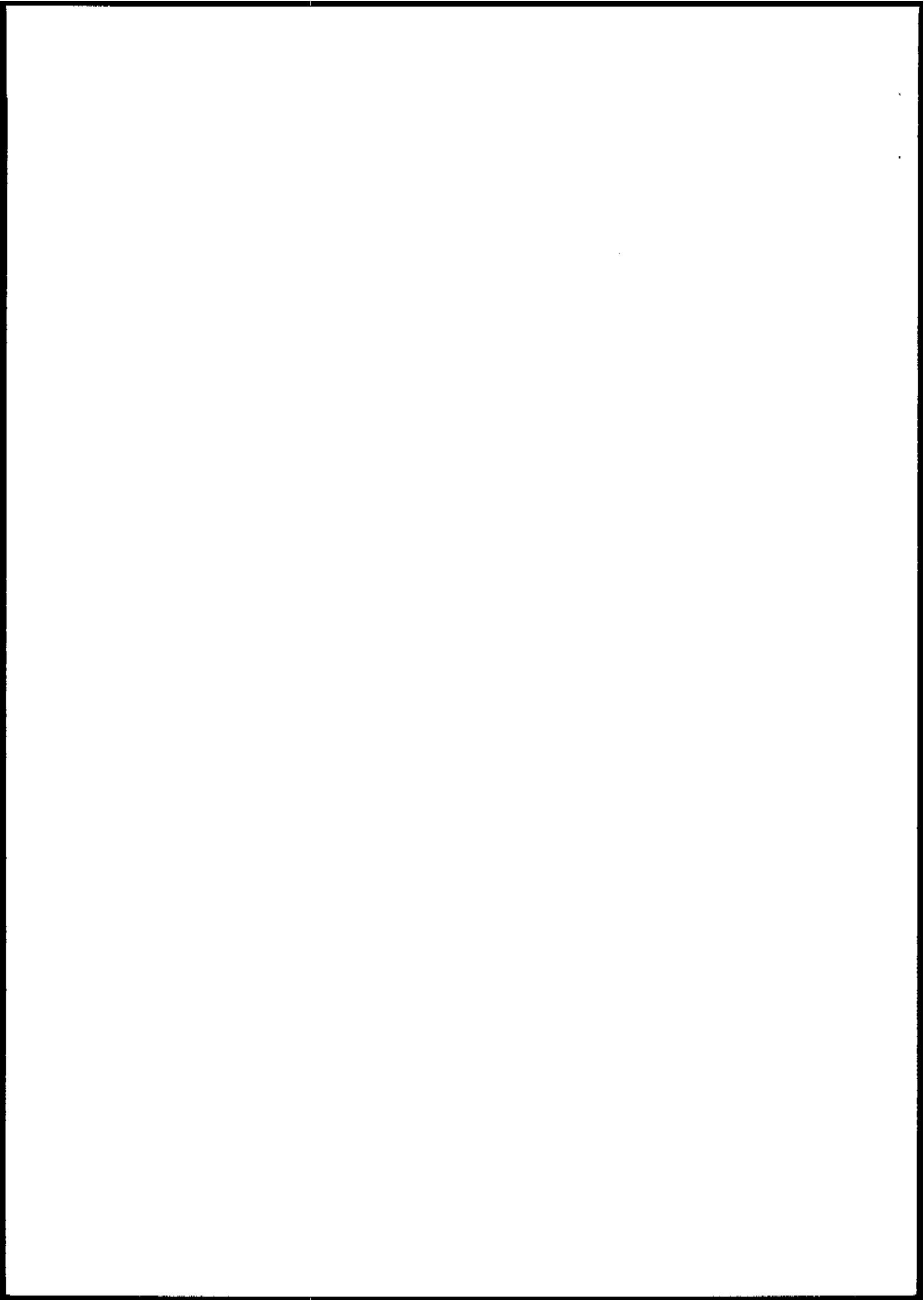
NONCOMMUNICABLE DISEASE CONTROL
EVALUATION
AUSTRIA
FINLAND
ISRAEL
PORTUGAL
RUSSIA

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^a *Updating of the European HFA targets.* Copenhagen, WHO Regional Office Europe, 1991 (document EUR/RC41/Inf.Doc./1 Rev.1).

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Introduction

As agreed during the CINDI Programme Directors' Meeting, Belfast, Northern Ireland, 24-25 October 1991, a consultation on CINDI Worksite Programmes was arranged in Lisbon on 22-23 February 1992. In the meeting, there was representation from Austria, Finland, Portugal, Russia and from WHO/EURO (Annex 1). In addition to countries represented, there was a written report from Israel.

As host of the meeting, Professor de Padua welcomed the participants. Dr Glasunov reviewed the provisional agenda and the aims of the meeting. Professor de Padua was elected as Chairman and Dr Korhonen as Rapporteur of the meeting.

Experiences in implementing worksite programmes

Austria

In CINDI-Austria, a worksite programme is organized by the AKS (Arbeitskreis für Vorsorge und Sozialmedizin) under the specific conditions in Vorarlberg. These conditions are framed by legislative regulations which determine that occupational health care has to be offered in industries with more than 250 employees. The same law also precisely regulates what kind of examinations should be carried out, the frequency of these examinations and the qualification of physicians involved.

Another special condition is that in Vorarlberg, the free-practising physician, the family-doctor, is generally included in all health programmes; his role in activities of health promotion is strongly emphasized. The AKS, being an association of free-practising physicians, coordinates worksite programmes, takes care of planning and innovation as well as of documentation and questions of funding. AKS also organizes training programmes for physicians who are involved in worksite programmes.

Thus, the worksite programmes in Vorarlberg are organized in a very decentralized fashion. It is believed, that the combination of family-doctor know-how, qualification for worksite-specific problems and involvement in regional companies forms a reasonable, fundamental basis for continuous and flexible development, facing the rapid technological and societal changes.

The programme targets are discussed in an expert committee, presided by a qualified worksite physician. Cooperation and consensus are aimed at within an advisory board where all representations involved (unions, Chamber of Labour, Chamber of Commerce, accident insurance, etc.) participate in regular meetings. While in other Austrian provinces worksite programmes are organized by highly centralized structures, Vorarlberg intends to develop and utilize the decentralized infrastructure of the AKS in cooperation and consensus with the above-mentioned institutions and representations.

Besides medical check-ups required by law, the AKS offers additional examinations at worksites, and presently also develops intervention programmes. These programmes include activities concerning physical activity, anti-smoking programmes, stress reduction, protective measurements in connection with toxic hazards and others.

While financing of all examinations mentioned is secured, funding for intervention-programmes is presently being negotiated at a high priority for future development. Projects for the future include, among others, the development of effective public relations work to promote effectiveness and

participation, introduction of evaluation procedures and exploration of new approaches in general. It is further more a basic target to provide worksite programmes and examinations for every employee regardless of the size of enterprise he works for.

Finland

The Finnish CINDI-programme has carried out three major worksite health promotion programmes since the mid-eighties. All these programmes have taken place in North Karelia, the demonstration area of FINCINDI. There are only a few large, industrial worksites in North Karelia and most people work at small and middle-sized enterprises and offices. Thus, the programmes have also target at relatively small worksites. This is also due to the fact that the largest companies have their own well-established occupational health care services including a fair amount of preventive and health promotion activities. The smaller ones, however, have targeted purely at occupational safety issues.

The Finnish occupational health legislation includes precise instructions on measurements and health check-ups, compulsory according to the nature and size of the worksites. The companies receive reimbursement for the expenses from the national health insurance. In addition to the compulsory actions, the cost of some additional measurements and activities can be reimbursed. As mentioned, the largest companies have their own occupational health services. The smaller ones buy the services from municipal health centres or private occupational health centres.

In addition to the direct programmes at the worksites, there has been continuous cooperation with the food industry to promote production and marketing of low fat, low salt and other healthy products. This cooperation has taken place both nationally and in the demonstration area.

The North Karelia Worksite Intervention Study, carried out in 1984-1986, was a media-assisted programme to assess the feasibility and effectiveness of a worksite-based intervention on chronic disease risk factors. The one-year intervention combined the use of the mass media, worksite opinion leaders, risk assessment and counselling, and other health education measures. The study used medium-sized intervention worksites with the age-matched reference worksites. The study was carried out in conjunction with a national "Keys to Health" TV-programme. Results of the study indicated a clear positive effect on reduction in smoking and obvious but limited dietary changes.

The Healthy Together Programme, carried out in 1987-1989 was a comprehensive health promotion programme at 22 small and middle-sized worksites. The intervention of the programme comprised a personal risk factor measurement connected with counselling, feed-back information to the worksites, information in the local media, risk factor specific campaigns, and training. A contact person or a cooperation group comprising of representation from the employer and employees were used for implementation of the programme at the individual worksites. There was a positive effect on serum cholesterol, body mass index, blood pressure and physical activity during the intervention period among both genders. Also the proportion of smokers declined among men.

The latest worksite intervention activity has been carried out as a part of the North Karelia Cholesterol Project, a provincial programme aiming at reduction of the general cholesterol level with intensive community action. The worksites have been used as a channel for reaching the working age population. The results of this particular programme have not yet been analyzed.

All the programmes have aimed at reduction of the biological and behavioural risk factors for noncommunicable diseases, especially cardiovascular diseases. Notably smoking cessation and cholesterol reduction by means of dietary changes have been emphasized. The intervention methods have been somewhat varied between the programmes. The risk factor measurements connected with personal counselling have been one of the base for intervention. Fast feed-back to the individuals and to the worksites has been regarded as important. The mass media has been used in various ways to improve social support.

Evaluation of the programmes has been connected with the risk factor measurements. The first one of the programmes described used reference worksites to assess the net changes connected with the intervention. The later ones have been more intervention type programmes without any reference groups. However, the changes have been evaluated using classical epidemiologic measures. The evaluation procedures have also included process variables. The management has been carried out by the National Public Health Institute, responsible for the CINDI programme. Practical coordination has taken place locally in North Karelia. In the planning and implementation of the programmes, there has been cooperation with the occupational health services of the companies and consultations with the Occupational Health Institute, the national organization responsible for occupational health research.

Israel

In Israel, the worksite is regarded as an important place for early detection of noncommunicable diseases. Many firms organize a yearly check-up for their senior staff. Intervention encompassing healthy nutrition and regular physical exercise during work hours was initiated and evaluated at one worksite. Short-term life-style management courses for senior staff have been organized for firms and plants. A number of research projects have been performed, the most notable being the Cordis project: Cardiovascular occupational risk factor detection in Israel industries on the effect of environmental and occupational stress - noise, temperature and work monotony - on the cardiovascular system.

The aim has been to set up in the vicinity of existing primary care clinics which work in the framework of CINDI-Israel and in full coordination with local data base at the clinic, long term worksite programmes for the early detection of cardiovascular risk factors and CVD morbidity, and to study its effect on absenteeism due to disease.

Since every company has its own special characteristics, priorities and perhaps even special health problems, it is necessary to adapt and structure the intervention programme to the needs of each individual worksite. This can be achieved through cooperation among the various groups cited above and the professional staff responsible for the programme.

Once a programme has been designed specifically for a worksite, it is ready for implementation and generally will include the following phases:

1. Risk factor screening of all employees;
2. Physical activity intervention preceded by ergometry;
3. Smoking cessation intervention;
4. Dietary and weight control intervention;
5. Hypertension intervention and follow-up;
6. Health education;
7. Stress reduction intervention;
8. Special programmes.

These various activities will be conducted on the basis of the initial screening results so that different employees will be referred to different programmes, based on the findings of their risk factor screening.

A more concrete programme will be worked out together with the departments of occupational figures in the field of occupational health in Israel.

Portugal

Occupational health hazards became a matter of great concern in Portugal in the last decade. However, by legislation only the enterprises with more than 400 employees (less than 5%) are supposed to have their own physician, who is most of the time involved in curative medicine. Several occupational hazards are under close scrutiny nowadays.

At the same time, in the last few years, prevention of labour accidents and alcohol abuse are attracting the greatest attention. A new generation of general practitioners (family doctors) is becoming more and more aware of a related albeit different problem: disease prevention and health promotion by the workers themselves.

Local experiences in this field, related not to the working environment but more specifically to the life-styles and events of the individuals, have included, until now, speeches for the blue-collar workers in the factories, concerning risk factors, mass catering and alcohol abuse among other problems as well as interventions on radio and TV programmes on health promotion and disease prevention for the general population.

Other more elaborated programmes include:

1. Cardiovascular prevention at the workplace: Under the responsibility of the National Institute of Preventive Cardiology, a community diagnosis was made on smoking habits (47% males, 9% females), blood pressure elevation (17%) and lipid levels (elevated cholesterol 26%).

Workers and occupational health physicians were informed of the results. Health education activities, either for high risk groups for the entire population, were initiated on the premises.

2. Fight against tobacco among health professionals: Under the supervision of and with support from the European Community, a programme was developed in Portugal by the National Institute for Preventive Cardiology and the movement Tobacco or Health - Choose Health, in collaboration with other groups in Spain. In Portugal, three hospitals were involved, two in the CINDI demonstration area, and the third of the University Hospital of Santa Maria in Lisbon. The most interesting findings were that:

- physicians smoke more than the general population and also more than any other occupational group of hospital workers;
- physicians who smoke are more prone to deny their role as models, either for the other health professionals or for the public in general; less frequently than the non-smokers or ex-smokers do they advise their patients to quit;
- a significant percentage of smoking physicians would like to be helped to stop.

Russia

The CINDI programme among industrial workers was implemented in ex-USSR in 1985. Several enterprises of the former Ministry of Heavy Industry in different regions of the country are the target of the programme. The total number of subjects covered by the programme is about 80 000. The aim of the programme is to create long-term measures for prevention of NCD to reduce the rates of morbidity and disability among workers.

The first five-year part of the programme was completed in 1990. According to the baseline survey among the employees in six enterprises, there was high prevalence of NCD (CHD up to 10%, chronic bronchitis up to 12%, diabetes mellitus up to 4%). Also the risk factor levels were high: arterial hypertension up to 32%, smoking around 70% among men, hypercholesterolemia around 25%, excessive body weight around 50% among women. NCD is responsible for around 40% of loss in work days due to disability in some groups of employees.

The second part of the programme was started in 1991, which included the following tasks:

- Introduction of the prevention modules created previously, with a subsequent extension of their implementation;
- Development of new preventive modules, such as prevention activities against CHD, chronic respiratory diseases, diabetes mellitus and their risk factors;
- Improvement of the information system for the conduct and evaluation of the programme;
- Perfection of integrated NCD prevention on the basis of intersectoral cooperation between all divisions of the enterprise by using self-organization, self-control and self-financing abilities.
- Estimation of medical and socio-economic effectiveness of the programme.

The programme is developed under the supervision of the Department for Prevention of NCD in Working Collectives of the National Research Centre for Preventive Medicine of Russia.

How to develop CINDI worksite programmes

The meeting considered the advantages of establishing and using worksite programmes as a channel for CINDI implementation, as well as the issues to be addressed in the programmes.

The following issues were regarded as advantages for the worksite programmes:

- The majority of the working age population can be subjected to health promotion activities via the worksites. The worksites are socially significant places because of the personal contacts and the considerable time people spend there.
- The working communities have a lot of social interaction which is remarkable potential for facilitating changes in health behaviour.

- Worksites are natural places for the integrated effort in implementing noncommunicable disease prevention and health promotion.
- Worksite programmes help in mobilizing additional resources (financial and human) for the CINDI programme.
- Worksites provide the possibility for specific interventions (e.g. mass catering, anti-smoking programmes, alcohol abuse prevention and control, physical exercise promotion, anti-stress programmes, preventive check-ups).
- Worksite activities provide the possibility to reach otherwise unattainable population groups.

The following were regarded as issues to be addressed when planning worksite programmes:

- Prevention of premature retirement.
- Prevention of early disease and disability.
- Financial schemes - how to obtain funds to carry out worksite programmes. Exploration of the role/possibilities/interests of public funds, insurance and other companies, employers and trade unions.
- Motivation of and collaboration with employers, employees, political leaders and the community at large. Possibilities to gain legislative support by collaboration with decision makers.
- Priority of short-term evaluation.
- Information system. The need to characterize the worksites (community analysis), to justify the purpose of the worksite programme to the management and to further develop the programmes. Aim of information system (product and process evaluation).
- International collaboration. Collection and use of data bases from worksites. The need to establish a CINDI working group on the topic.
- Quickly changing working conditions and occupational health services. Cooperation with the existing WHO/EURO project "Health Promotion at the Workplace" of the Occupational Health Unit.
- Collaboration with occupational health workers and institutions.
- Interaction between general and occupational health care.

Recommendations

1. Worksite programmes should be considered as an important part of CINDI. The CINDI approach with its protocol and existing experience allows good opportunity for developing integrated intersectoral collaboration for chronic disease prevention and health promotion at the worksites. Approaches of this type are necessary when looking for ways to prolong the active working period of people and prevent early disability. While planning and implementing the worksite programmes, the equal rights of each employee for health promoting activities at the worksite should be emphasized.
2. Special attention should be paid in the worksite programmes to improving cooperation with mass catering, smoking prevention and cessation (the right to a smoke-free worksite) and opportunities for physical activities.
3. Important issues to be considered in the CINDI worksite programmes include:
 - Financial schemes/fund raising. Exploring especially the role of government and public funds, insurance and other companies, employers and trade unions.
 - Motivation of and collaboration with employers, employees, political leaders and the community at large. Collaboration with decision-makers to gain legislative support.
 - Collaboration of the programmes with occupational health workers and institutions.
 - Interaction between general and occupational health care.
 - Intersectoral collaboration (existing health care system, administration, organizations).
4. An information system for the programmes is needed to characterize the worksites (community analysis), to justify the purposes of worksite management and to further develop the evaluation and monitoring of the programme. In addition to evaluation of the process and short-term changes in behavioural and biological risk factors, evaluation of the long-term effects (including socio-economic effectiveness) should be considered.
5. International collaboration was regarded useful in developing the CINDI worksite programmes. Quickly changing working conditions and occupational health services provide a challenge. Cooperation with the existing WHO/EURO project "Health Promotion at the Workplace" of the Occupational Health Unit was considered important.
6. The meeting proposed, for the consideration of the Programme Directors's Meeting, the establishment of a working group on CINDI worksite programmes. The terms of reference of the working group would include:
 - To review the recommendations for CINDI worksite programmes.
 - To explore in detail the interest of the participating countries in the activity and collect existing experiences in implementing worksite activities.
 - To formulate the future agenda of the working group
 - To explore fund-raising for the activities.

Annex 1

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